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

10-8-18 PG.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165458	A. BUILDING _____ B. WING _____	09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL VALLEY REHABILITATION AND NURSING AT SUTHERL	506 EAST FOURTH STREET SUTHERLAND, IA 51058

(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: 10-3-18 PG The following deficiencies relate to investigation of Complaint #76399-C, 77263-C, 77421-C, and 76634-C, completed on 8/9/18, to 8/20-23, 2018, and the annual survey completed September 10-13, 2018. Complaint #76399-C substantiated Complaint #77263-C substantiated Complaint #77421-C not substantiated Complaint #76634-C not substantiated. (See Code of Federal Regulations, 42 CFR, Subpart B, Requirements for Long Term Care Facilities).	F 000	**Preparation and execution of this Plan of Correction does not constitute an admission or agreement by this Provider of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to the date the facility maintains it was in compliance with requirements of participation or that corrective action was necessary.**	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550	**F000** **The Plan of Correction contained herein constitutes the facility's credible allegation of compliance as of 10/3/2018.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tasha Hill — TITLE: Administrator — (X6) DATE: 10/5/18

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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to protect the resident's right to choose when and how to bathe for 1 of 13 sampled residents (Resident #15). The facility reported a census of 22 residents. Findings included: Resident #15's 6/12/18 Minimum Data Set (MDS) documented the resident had severely impaired cognitive function. The resident required extensive staff assistance for transfers and bathing. The resident's care plan directed staff to provide a whirlpool or shower 2 times weekly or as the resident chose. The resident's care plan also included a goal for the resident to have	F 550	F-550 Resident #15, as well as all residents, will be afforded the option of receiving a bath, shower, or bed bath as per their choice as per regulatory guidelines unless otherwise requested by the resident. The facility has revised the bath sheet to indicate what type of cleansing the resident received, i.e., bath, shower, or bed bath and if the residents mood remained calm and cooperative, anxious, or agitated. The Facility ordered a whirlpool pump that was installed on 10-1-18. The facility staff, including Staff A, B, and C will continue to provide the required assistance as necessary for Resident #15, as well as all residents, with their baths, showers, or bed baths. Nursing staff currently on PRN, FMLA, PTO, or other leave status will review the necessary information prior to their next scheduled shift. Any ongoing concerns will be addressed with the QA Committee. This represents the facilities credible allegation of compliance dated 10-1-18.	

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F 550	Continued From page 2	F 550		

positive experiences in the daily routine without overly demanding tasks and without becoming overly stressed. The care plan directed staff to calm the resident if signs of distress developed (feeling overwhelmed, fatigue, agitation, restlessness, withdrawal).

On 09/11/18 at 9:36 AM a voice could be heard screaming from the shower room for at least 5 minutes. The voice screamed a high pitched scream and shouted "help me, help me," repeatedly. Staff A, Registered Nurse (RN) identified the person screaming as Resident #15. The nurse stated, "she doesn't like her bath."

During interview on 9/11/18 at 9:42 AM the Director of Nursing (DON) stated I've never seen her this bad. Her hand is pretty bruised from hitting the tub.

During interview on 9/11/18 at 9:44 AM Staff B, Certified Nursing Assistant (CNA) stated she was agency staff and had been assigned to do baths that day. She stated the resident got into the tub OK but started screaming when sprayed with water. Staff C, CNA also present said the resident always got into the tub willingly but about half the time would start screaming and become upset when sprayed with water.

Staff documented on the ADL Flowsheet the resident received 9 baths in July, 8 baths in August and as of 9/11/18 she had received 3 baths in September including the one on 9/11/18.

During interview on 09/11/18 at 9:53 AM the DON stated no documentation could be found related to difficulty bathing or alternatives attempted. She confirmed the care plan did not

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F 550	Continued From page 3 address resident distress with bathing. On 9/12/18 at 8:16 AM the resident sat at table in the dining room. She had bruising over both hands. Staff documented on 9/11/18 Skin Condition Records the resident had received a 2 by 2 centimeter (cm.) and a 1 by 0.6 cm. bruise on the top of the right hand and a 6 by 8 cm. bruise to the top of the left hand.	F 550		
F 655 SS=C	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655	F-655 Resident #9's husband reviewed and approved the baseline care plan on 9-12-18. The DON and Nurses have been informed of the importance of resident #9, as well as all residents and their representatives when available, reviewing and approving of the residents baseline care plan. The DON, or their designee, will attempt to ensure residents and their representative when available review and approve the residents baseline care plan as per regulatory guidelines. Nurses currently on PRN, FMLA, PTO, or other leave status will review the necessary information prior to their next scheduled shift. Any ongoing concerns will be addressed with the QA Committee. This represents the facilities credible allegation of compliance dated 10-3-18.	

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F 655	Continued From page 4 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide the resident and their representative with a summary of the baseline care plan for Resident # 9. The facility reported a census of 22 residents. Findings include: Review of a Baseline Care Plan for Resident #9 showed the resident had been admitted to the facility on 4/12/18. The form included a space to document the date it was reviewed with the resident/representative. There was no documentation the review had been completed. During interview on 9/11/18 at 1:40 pm the Director of Nursing stated if it is not documented on the Baseline Care Plan form then the baseline care plan had not been reviewed with the resident or the representative.	F 655		

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F 656	Continued From page 5	F 656		
F 656 SS=C	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656	F-656 The Facility DON has been informed of the importance of ensuring any Resident receiving Coumadin has this medication, and it's potential side effects, addressed on the Residents Care Plan. Resident #8's Care Plan was revised as of 9-11-18 to include Coumadin and it's potential side effects. All other residents receiving Coumadin have been reviewed to ensure this medication and it's potential side effects are addressed on the Care Plan. Any ongoing concerns will be addressed with the QA Committee. This represents the facilities credible allegation of compliance dated 9-27-18.	

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F 656	Continued From page 6 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop and implement a comprehensive person centered care plan for 1 of 12 residents reviewed, (Resident #8). The facility reported a census of 22 residents. Findings include: 1. The Minimum Data Set with assessment reference date of 8/4/18 showed Resident #8 had taken an anticoagulant medication daily during the assessment period. Resident #8's Medication Flowsheet for 9/1/18-9/30/18 included an order dated 8/13/2018 for Coumadin (anticoagulant medication) 3 milligram once a day. Resident #8's current Care Plan did not include the use of Coumadin or interventions related to the use of the medication. On 9/11/18 at 1:35 p.m. the Director of Nursing stated she would expect to have the use of Coumadin on the residents care plan and interventions to monitor for bleeding and bruising.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an	F 660		

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F 660	Continued From page 7 effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's	F 660	F-660 Resident #23 was discharged from the facility as of 6-12-18. The DON and Interdisciplinary Team members have reviewed the Discharge to Home Protocol, the Care Plan Development Process Protocol, and have been informed of the importance of addressing Resident discharge plans on the Baseline Care Plan, as well as on an ongoing basis to try to identify and address any barriers to the Resident's discharge. The DON has been informed of the importance of ensuring a full Care Plan is created for all residents within the regulatory mandated timeframe. Any ongoing concerns will be addressed with the QA Committee. This represents the facilities credible allegation of compliance dated 10-3-18.	

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F 660	Continued From page 8 comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure discharge planning involving the interdisciplinary team and the resident or resident's representative for one resident (Resident #23). The facility reported a census of 22 residents.	F 660		

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F 660	Continued From page 9 Findings Included: Staff documented the resident admitted 4/24/18 for Medicare Skilled services following a hospitalization with peripheral vascular disease and right foot gangrene. The record included an Initial Care Plan and a Baseline Care Plan which outlined day to day care of the resident. The record lacked any documentation of a discharge plan involving the interdisciplinary team and the resident or the resident's representative. The area on the Baseline Care Plan for Initial Goals did not specify the resident's plan to discharge from the facility. The areas on the Baseline Care Plan for Discharge plans, Barriers to Resident's Discharge Goals, and signatures of those involved in development of the care plan remained blank. During interview on 9/12/18 at 1:04 PM the Director of Nursing (DON) confirmed a full care plan with discharge plans could not be found. She stated the resident had been in the facility long enough a full care plan should have been done.	F 660		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		

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F 684	Continued From page 10 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to assess 1 resident after experiencing a 'spell' with transfer and reported pain following the incident and failed to assess a change in condition (Resident #2). The facility reported a census of 22 residents. Findings include: The Minimum Data Set (MDS) assessment with a reference date of 4/13/18 for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 8 indicative of moderately impaired cognition. According to the MDS, the resident required the extensive assistance of two staff for transfers, and toilet use, dressing, personal hygiene, and bed mobility. A balance during transition and walking test identified the resident as not steady and only able to stabilize with staff assistance when moving from a seated to standing position, moving on and off toilet and surface to surface transfer. The MDS further identified functional limitation in range of motion on one side for upper and lower extremities. The resident had diagnosis that included a seizure disorder, fracture, generalized weakness, hemiparesis (weakness of an entire side of the body) and chronic obstructive pulmonary disease. The resident had had not experienced a fall prior to admission or reentry. In an interview on 8/20/18 at 3:30 p.m. the Corporate Nurse reviewed his written statement of the incident dated 6/5/18 at 2:30 p.m. The Corporate Quality Assurance (QA) Nurse documented he had observed two certified nurse aides (CNA) transfer Resident #2 from her	F 684	F-684 Resident #2's Care Plan was revised on 6-5-18 to indicate the use of the Hoyer Lift for transfers. Resident #2 was discharged from the facility on 6-8-18. All other residents requiring sit to stand lifts have been evaluated by PT. Therapy has been requested to screen residents using mechanical transfer devices on a quarterly basis during the resident MDS process or sooner as deemed necessary. The Nursing staff have reviewed the Mechanical Lift Transfer Protocol and the EZ Stand Competency Check List. The Nurses have reviewed the Assessing an Injury of Unknown Origin Protocol, the Head to Toe Assessment, the Physician Notification Guidelines for Clinical Issues, and the Notification of Change Policy. The Physician Fax Communication Sheet has been revised to try to ensure Physician orders are properly communicated and followed through. The Facility has implemented a Hot Chart System for enhanced identification of resident condition changes, incident reporting, and performance of assessments to include Physician notification of a residents change of condition.	

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F 684	Continued From page 11 electric wheelchair to the toilet using the sit to stand lift at the request of the Administrator. In the process of transferring he observed the resident have a 'spell' which caused her to slump down resulting in the sling moving up under her axillary region. Following the transfer the resident complained of pain in the right upper extremity but was unable to rate pain. The Corporate Nurse communicated to facility staff and directed to monitor for increased complaints of pain and as needed pain relief medication use. The Corporate Nurse clarified would have expected an assessment of pain and follow up after resident experienced spell which would include vitals and provider notification. Review of Nurse's notes revealed an entry dated 6/5/18 at 3:00 p.m. which documented staff using the Hoyer lift to transfer for safety. The entry failed to include an assessment of vitals or pain. Staff made no further entries until 6/6/18 at 9:30 a.m., when it was documented the resident had severe right arm pain Review of a Fax Order dated 6/6/18 documented Resident #2 complained of severe pain in the entire right arm, and requested and received orders for x-rays of the right shoulder and elbow. Review of the Final Report dated 6/6/18 of x-rays of right shoulder revealed a fracture of the proximal humeral shaft. No incident report was completed by the fa facility for the transfer and spell. No documentation of communication with the provider to inform of spell or pain following. Further review of the Nurses Notes revealed Staff B, Registered Nurse (RN) made an entry on	F 684	Cont. Nursing staff currently on PRN, FMLA, PTO, or other leave status will review the necessary information prior to their next scheduled shift. The DON, or their designee, will review the Hot Chart System to try to ensure appropriate assessments are performed to include Physician notification as necessary. Any ongoing concerns will be addressed with the QA Committee. This represents the facilities credible allegation of compliance dated 9-24-18.	

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	165458	A. BUILDING _____ B. WING _____	09/13/2018

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F 684	Continued From page 12 6/7/18 at 9:00 a.m. that documented an assessment with a temperature of 100.3, and noted lung sounds with wheezes and diminished sounds. The nurse documented she encouraged cough and deep breathing exercises and scheduled breathing medications were administered. At 10:10 a.m. nurse documented the temperature was 99.9. According to the Medications Flowsheet Staff B, RN documented a variance that all noon medications were held on 6/7/18 due to lethargy. The Medication Flowsheet further revealed the evening medications were not documented as administered, with no variance documented. Continued review of the Nurse's Notes revealed staff made no further assessment entries until 6/8/18 at 8:00 a.m. when the resident is assessed to be hot to touch with a recorded temperature of 102.5 with respiratory difficulty. A Fax order dated 6/8/18 documented communication to the provider of the residents transfer to the local hospital. In an interview on 8/21/18 at 2:49 p.m. Staff B, RN confirmed that she had held medications on 6/7/18 due to lethargy and agreed that she should have documented the change in condition. Further stated she was unsure if had reported to the next shift, but recalled had reported to the Director of Nursing. During an interview on 8/20/18 at 3:40 p.m. the Director o Nursing (DON) stated would have expected the charge nurse to assess and to re-evaluate the resident's pain in right arm and notify the provider following a seizure or spell. The DON reviewed the documentation and agreed that no assessment had been completed	F 684		

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F 684	Continued From page 13 by the charge nurse. The DON further stated that when the residents medications were held at noon on 6/7/18 due to lethargy would have expected an assessment and provider notification with condition change. The DON reviewed the Medication Administration record and nurse's progress notes and confirmed no assessment or documentation was completed. When interviewed on 8/21/18 at 2:56 p.m. the resident's Physician Assistant (PAC) stated she would expect to be notified with a condition change or with spell (seizure activity). She clarified that a condition change would include the resident being too lethargic to receive medications and running a temperature.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and interviews, the facility failed to ensure one (1) of three (3) residents received adequate supervision to protect against accidents. Clinical record review and staff interviews revealed the facility failed to provide a safe method of transfer for Resident #2. Resident #2 sustained a fracture of the right proximal humeral shaft (the top of the arm bone in the shoulder joint) during a transfer	F 689	F-689 Resident #2's Care Plan was revised on 6-5-18 to indicate the use of the Hoyer Lift for transfers. Resident #2 was discharged from the facility on 6-8-18. All other residents requiring sit to stand lifts have been evaluated by PT. Therapy has been requested to screen residents using mechanical transfer devices on a quarterly basis during the resident MDS process or sooner as deemed necessary. The Nursing staff have reviewed the Mechanical Lift Transfer Protocol and the EZ Stand Competency Check	

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F 689	Continued From page 14 with a mechanical sit to stand lift. Prior to the incident it had been identified by the facility staff that Resident #2 required assessment by physical therapy to determine the safety of the transfer using a sit to stand mechanical lift. The facility failed to determine the safety of the transfer and continued to use the sit to stand lift. The facility reported a census of 22 residents. Findings include: The Minimum Data Set (MDS) assessment with a reference date of 4/13/18 for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 8 indicative of moderately impaired cognition. According to the MDS, the resident required the extensive assistance of two staff for transfers, and toilet use, dressing, personal hygiene, and bed mobility. A balance during transition and walking test identified the resident as not steady and only able to stabilize with staff assistance when moving from a seated to standing position, moving on and off toilet and surface to surface transfer. The MDS further identified functional limitation in range of motion on one side for upper and lower extremities. The resident had diagnosis that included a seizure disorder, fracture, generalized weakness, hemiparesis (weakness of an entire side of the body) and chronic obstructive pulmonary disease. The resident had had not experienced a fall prior to admission or reentry. A provider visit note dated 6/6/18 documented facility staff had reported Resident #2 complained of severe right arm and shoulder pain, the Director of Nursing identified the injury possibly occurred during an Easy stand (sit to stand mechanical lift) transfer where the resident had	F 689	List. The Nurses have reviewed the Assessing an Injury of Unknown Origin Protocol, the Head to Toe Assessment, the Physician Notification Guidelines for Clinical Issues, and the Notification of Change Policy. The Physician Fax Communication Sheet has been revised to try to ensure Physician orders are properly communicated and followed through. The Facility has implemented a Hot Chart System for enhanced identification of resident condition changes, incident reporting, and performance of assessments to include Physician notification of a residents change of condition. Nursing staff currently on PRN, FMLA, PTO, or other leave status will review the necessary information prior to their next scheduled shift. The DON, or their designee, will review the Hot Chart System to try to ensure appropriate assessments are performed to include Physician notification as necessary. Any ongoing concerns will be addressed with the QA Committee. This represents the facilities credible allegation of compliance dated 9-24-18.	

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F 689	Continued From page 15 an episode where she went limp and did not bear weight and the strap of the lift went around her right arm. The note further documented that a portable x-ray was obtained which revealed a fracture of the proximal humeral shaft. The provider note additionally ordered an arm/shoulder immobilizer/sling to be applied, orthopedic consultation to be scheduled, pain medication, and directed Resident #2 to be transferred with a Hoyer (sling lift). A Fax Order dated 5/9/18 revealed the Director of Nursing requested and received an order for PT/OT (physical therapy/occupational therapy) to evaluate the transfer of Resident #2 in sit to stand lift. In an interview on 8/20/18 at 2:55 p.m. Staff A, Rehab department confirmed through review of computerized therapy notes that PT/OT had not received the order dated 5/9/18 to review Resident #2's transfer and further confirmed the resident was not seen in therapy in May. In an interview on 8/20/18 at 3:40 p.m. the Director of Nursing (DON) confirmed she had concerns with the sit to stand transfer for Resident #2. The DON stated had assisted the resident with the sit to stand transfer frequently and was concerned that due to right sided paralysis the resident was unable to hold onto the lift with her right arm and did not bear weight well with her right leg. The DON stated it was her understanding that to be a safe transfer the resident needed to be able to hang onto the lift with both hands, and further stated had concerns about transfer safety for Resident #2 for some time. The DON confirmed the facility is responsible to determine and provide a safe	F 689		

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F 689	Continued From page 16 transfer for residents. The DON further confirmed that the order received on 5/9/18 was requested because of the concerns identified with the safety of the sit to stand transfer. The DON further confirmed the facility failed to communicate this order and the transfer was not evaluated. In an interview on 8/20/18 at 3:30 p.m. the Corporate Nurse reviewed his written statement of the incident dated 6/5/18 at 2:30 p.m. The Corporate Quality Assurance (QA) Nurse documented he had observed two certified nurse aides (CNA) transfer Resident # 2 from her electric wheelchair to the toilet using the sit to stand lift at the request of the Administrator. In the process of transferring he observed the resident have a spell (seizure) which caused her to slump down resulting in the sling moving up under her axillary region. Following the transfer the resident complained of pain in the right upper extremity but was unable to rate pain. No incident report related to the transfer incident was completed by the facility. Review of a Fax Order dated 6/6/18 documented Resident #2 complained of severe pain in the entire right arm, and requested and received orders for x-rays of the right shoulder and elbow. Review of the Final Report dated 6/6/18 of x-rays of right shoulder revealed a fracture of the proximal humeral shaft. A care plan dated as last reviewed in April 2018 directed staff to use a mechanical lift with transfers, clarified the resident prefers the E-Z stand (sit to stand lift). On 6/6/18 the care plan was edited to direct staff to use the hoyer (mechanical sling) lift for transfers.	F 689		

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F 689	Continued From page 17 In an interview on 8/21/18 at 12:00 noon, the Administrator confirmed that the facility relied on PT/OT to determine the method of transfer for residents. An order was received for evaluation of Resident #2's transfer because staff had observed the transfer to be unsafe due to right sided paralysis. The Administrator further stated that the facility failed to communicate the order for PT/OT to evaluate the safety of the sit to stand transfer for Resident #2. The Administrator further admitted that the resident continued to be a sit to stand transfer until the incident on 6/5/18 almost a month after the order to evaluate the transfer was received and in that time no one at the facility pursued the reason evaluation had not been completed.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(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	F 758	**F-758** Resident #12's Zyprexa 2.5mg 1 tab po every HS was discontinued per Physician order as of 9-11-18. The DON, or their designee, will continue to review Resident #12's, as well as all residents, medication and attempt to obtain appropriate diagnoses for psychoactive medications in consultation with the Pharmacy Consultant and the Resident's Physician. Any ongoing concerns will be addressed with the QA Committee. This represents the facilities credible allegation of compliance dated 9-14-18.	

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F 758	Continued From page 18 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used without adequate indications for its use for 1 resident, (Resident #12). The facility reported a census of 22 residents. Findings include:	F 758		

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F 758	Continued From page 19 According to the Minimum data Set with assessment reference date 8/11/18 Resident #12 had a BIMS score of 3, severely impaired cognitive skills for daily decision making. The resident did not display any signs and symptoms of delirium, psychosis or negative behaviors during the assessment behavior. The resident had diagnosis of Alzheimers and anxiety. Resident #12 had taken a antipsychotic medication every day of the assessment period. A facsimile dated 6/30/18 noted Resident #12's spouse explained to staff the resident is much more agitated on evenings and unable to calm/quiet down to go to sleep, chatters constantly and he would like medications reviewed. Facsimile was returned to the facility on 7/3/18 with new orders for Zyprexa (antipsychotic medication) 2.5milligrams every night. Resident #12's Nurse Notes lacked documentation of increased agitation or difficulty sleeping. On 9/11/18 at 12:50 pm. the Director of Nursing stated she was unable to find documentation in the residents record to support the use of Zyprexa.	F 758		