STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295079		02/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH & REHAB	201 KOONTZ LANE CARSON CITY, NV 89701

(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 This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on 2/22/10 through 2/26/10, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 138 residents. The sample size was 24 sampled residents and 1 unsampled resident. The sample also included 3 closed records. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and policy review, the facility failed to fully inform the	F 154		4/16/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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 154	Continued From page 1 resident of changes in their care and treatment by not obtaining consents for psychotropics prior to administration for 4 of 24 residents (#12, #13, #8, and #22) or obtaining consents for psychotropics that addressed changes in dosages or frequency for 4 of 24 residents (Resident #15, #12, #20, and #14). Findings include: Resident #12 Resident #12 was admitted to the facility on 9/9/09, with diagnoses that included anoxic brain damage, psychosis, hypertension and hypothyroidism. Physicians orders include medications such as Ativan for agitation, Thorazine for behaviors, and Trazodone for depression. There were two informed consents in Resident #12's record for the use of the Ativan, both dated 5/7/09. Neither were signed by the resident or his responsible party. Also present in the record was a signed consent for Ativan, dated 10/26/2005, five years ago. Employee #7 indicated that it was Social Services' responsibility to get the consents for psychotropic medications. When the social worker, Employee #8, was interviewed on 2/22/09, it was disclosed that a verbal consent had been obtained for the use of Ativan for Resident #12. The consent did not indicate that verbal consent had been obtained or that a form had been sent to the responsible party for written consent.	F 154		

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F 154	Continued From page 2 Also present in the record was an Informed Consent Form for Trazodone, dated 5/29/09. The form had not been signed by Resident #12 or his responsible party. There was no evidence that a verbal consent had been obtained. There was present, an Informed Consent Form for the use of Thorazine dated 5/29/09. This form had been signed by Resident #12's responsible party. However, the record indicated the doses of Thorazine had been changed by the physician on 2/19/10. There was no evidence that a new Informed Consent had been obtained informing and/or educating the responsible party of the need for a change of dosage for the medication. Resident #13 Resident #13 was admitted to the facility on 8/19/09. Her diagnoses included dementia with behaviors, psychosis, and hypertension. An order was written, by the physician on 8/19/09, for Ativan 0.5 mg every eight hours as needed. The Informed Consent for Ativan was not signed by the responsible party until 10/25/09. There was no evidence that a verbal consent had been obtained prior to the medication being administered. Resident #14 Resident #14 was admitted to the facility on 5/29/09, with organic brain syndrome, hypertension, dementia and type two diabetes. On 7/18/09, an order was written for Remeron, 15 mg every night for depression. The record contained an Informed Consent indicating that a	F 154		

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F 154	Continued From page 3 verbal consent had been obtained from Resident #14's representative. No date was in evidence. There was no evidence that any written consent had been obtained as a follow up since the order was originally written 7/18/2009. Also present in the record was an Informed Consent for Ativan, which had been signed by the responsible party for Resident #14. The consent did not contain a date (therefore it was not possible to determine if the consent had been obtained prior to the administration of the medication). In an interview with Employee #2, the Director of Nurses, on 2/23/10, indicated that the facility had no policy regarding obtaining consents for psychotropic medication. It was also indicated that there was no policy as to what medications required an consent for administration. Resident # 20 Resident # 20 was initially admitted to the facility in 2005, and had remained a current resident for the past five years without any readmission. Resident # 20 was her own responsible party for the length of her facility stay. Her primary diagnoses included paranoid schizophrenia and anti-social personality. Review of Resident #20's clinical record revealed that on 7/22/09, dose reduction to Ativan 0.25 mg nightly was attempted. On 7/30/09, a physician order to increase the Ativan to 0.5 mg was received when it was determined the dose reduction was unsuccessful. Further review Resident #20's clinical record revealed there was no consent for any of the Ativan therapy in the	F 154		

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F 154	Continued From page 4 active clinical record. Documentation by the interdisciplinary team and the social worker indicated that Resident # 20 had been on long term Ativan therapy and required dose adjustments. There was no evidence either by documentation or consent permission that Resident #20 was informed of the changes of doses in Ativan or gave her consent for this treatment of anti-psychotic medication. Resident #15 Resident #15 was admitted to the facility on 9/12/06, with diagnoses including vascular dementia, debility and psychosis. Medications included Haldol 1 milligram (mg) as needed for severe agitation, Zoloft 25 mg daily, Seroquel 25 mg twice a day for psychosis and Depakote Sprinkle 125 mg twice a day for agitation. Review of Resident #15's care plan specified the anti-psychotics of Depakote, Seroquel and Haldol were being used to treat behaviors which included anger towards others and verbal abuse. Additionally, the care plan specified the anti-depressant Zoloft was being used to treat behavior associated with self isolation. Review of Resident #15's clinical record revealed signed consents by the resident's durable power of attorney for Seroquel, Haldol and Zoloft, but there was no consent for the Depakote. Resident #8 Resident #8 was admitted to the facility on 1/26/09, with diagnoses including dementia,	F 154		

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F 154	Continued From page 5 hypertension, chronic obstructive pulmonary disease, and depressive disorder. Psychotropic medication orders included the anxiolytics Ativan and Xanax, the antipsychotic Haldol, the antidepressant Celexa, and the hypnotic Ambien. Review of the resident's record revealed that informed consents had not been obtained for Ativan or Ambien, and this was confirmed by the unit nurse manager, Employee #13. Resident #22 Resident #22 was admitted to the facility on 2/6/09, with diagnoses including dementia, diabetes, hypertension, and hypothyroidism. Psychotropic medication orders included the anxiolytic Ativan and the antipsychotics Haldol and Risperdal. Review of the resident's record revealed that an informed consent had not been obtained for Haldol, and this was confirmed by Employee #13.	F 154		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225		4/16/10

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F 225	Continued From page 6 other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation and review of personnel files, the facility failed to ensure that a resident to resident altercation was reported to the proper officials in accordance with State law through established procedure (including the State survey and certification agency) for 2 of 24 residents (#17 and #24). Findings include:	F 225		

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F 225	Continued From page 7 Resident #17 Resident #17 was admitted to the facility on 11/3/09, with diagnoses that included mental disorder, anxiety and hypertension. She resided in a room without a room-mate. It was noted that she was independent in ambulation and walked freely about the secured unit. Resident #24 Resident #24 had been in the facility since 3/24/08. Her diagnoses included Alzheimer's dementia, psychosis, depression and hypertension. She was also able to ambulate without assistance or mechanical devices. While performing a record review during the morning of 2/22/10, this reporter observed an altercation between Resident # 17 and #24. Resident #17 was in her room when Resident #24 entered the area. Resident #17 began screaming, "This is my room, get out." Immediately afterwards, both residents began yelling, "You hit me." At that time, staff arrived and separated the residents. Both were examined for injuries. Employee #7 was overheard saying to staff that she would notify the residents physicians and family members, but that it was not necessary to notify the state officials since no injuries had occurred. The facility policy, entitled, "Subject: Abuse, Neglect and Misappropriation of Resident Property Prohibition, (Prohibition EHC-APM 1.1, March 2004)," defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.	F 225		

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F 225	Continued From page 8 Section E of the policy, "Investigation," stated, 1.) "...facility conducts an investigation of alleged abuse, neglect or misappropriation of resident property in accordance with state and federal regulations." And further stated, 2.) "...the facility reports allegations to the state agency per state regulations."	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that 1 of 1 unsampled residents received dining assistance in a manner that maintained and enhanced her dignity (Resident #25). Findings include: Resident #25 was admitted to the facility on 4/18/08, with diagnoses including dementia, hypertension, and seizure disorder. Review of the resident's record revealed that on 1/26/10, a care conference was conducted by the interdisciplinary team, with the following documentation: "Resident requires mod to max assist with ADL's (Activities of Daily Living)...Res req (requires) assist at all meals. Appetite is good."	F 241		4/16/10

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F 241	Continued From page 9 On 2/22/10 at 12:45 PM in the 200 hall dining room, a nurse's aide, Employee #6, was observed sitting between Resident #25 and Resident #9, and assisting them with their meals. At one point, the aide was observed to stab a piece of meat with Resident #25's fork and then, while facing Resident #9, twist her arm and put the fork in Resident #25's mouth. On 2/24/10 at 1:15 PM, another certified nurse's aide (CNA), Employee #14, was observed standing for 10 minutes while assisting Resident #25. The CNA then left suddenly, and it appeared that the resident had only consumed her vegetables. At 1:30 PM the dining staff began to document the amount residents had eaten and then clear away the plates. Just as Resident #25's plate was about to be cleared, this surveyor asked a nurse on duty, Employee #15, if the resident was still hungry. The nurse stated, "I don't think she's hungry," but then she sat down and assisted the resident with her lunch. After Resident #25 was observed to eat 10 large bites of chicken and rice casserole, a biscuit, juice, and milk, Employee #15 was heard saying, "Maybe you are hungry." The CNA was interviewed at 2:00 PM and asked why she left the dining room. The CNA related that she had to take care of another resident's splints and had assumed someone else would take over assisting Resident #25. When asked if the resident had finished her lunch, the CNA said, "I think she could have eaten more. She only had a few bites. She takes a long time to eat."	F 241		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	F 250		4/16/10

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F 250	Continued From page 10 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on facility policies, staff interview, and clinical record review, the facility failed to ensure that residents were provided medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident for 9 --of 24 residents (Residents # 4, #5, #21, #6, #20, #12, #13, #16 and #22). Findings include: Review of the Social Service Director job description included the following statement in the general summary: "The Director organizes and assures the existence of a social service program designed to meet the individual psychosocial needs of residents and families." In section IV Services, the social service departments should obtain initial psychosocial assessments and social histories. The social service should have ongoing plans of care reflecting psychosocial needs and documentation is current. The social service department should also be implementing a discharge planning program, reevaluating it periodically. Assist resident with adjustment and promote satisfaction to placement in a long-term care facility, to include support system utilization. Resident records were to reflect a discharge plan on the initial care plan and re-evaluated periodically. The clinical records were also to reflect post-discharge follow-up. This job	F 250		

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F 250	Continued From page 11 description was signed by Employee #4 on 9/11/06. CLINICAL RECORDS The social worker (Employee #4) was interviewed on 2/23/10 at 9:00 AM, and confirmed the following: Clinical records of residents who had resided at the facility for more than three months, specifically Resident #5, #6, #20, and #21, were reviewed with Employee #4. Review of the social service notes for each of these residents revealed the same content; essentially "quarterly note: (Resident's name) remains stable this quarter with no significant changes." "(Resident's name) orientation and comprehension level, short and long term memory status and any behavior problems." "There was no plan for discharge and no change in care plan." Social services "...will monitor (his/her) mood and needs and will be available for support and services. " Employee #4 acknowledged she documented only what was required by Medicaid. The social worker acknowledged that although these residents had been at the facility for longer than three months, she (the social worker) did not specifically visit with them to determine what their social service needs were, or to inform them of how she could help them. Resident #4 Clinical record review revealed Resident #4 had been previously sent home from an unnamed skilled care facility, and the next day apparently sustained a fall that required the acute care hospitalization. Resident #4 was admitted to the	F 250		

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F 250	Continued From page 12 facility on 1/18/10, following this acute care hospitalization. Resident #4's primary diagnoses included hypoxemia and congestive heart failure. The clinical record indicated Resident #4 was 91 years old, but lived independently in a rural community. Resident #4's family lived in California. Review of Resident #4's clinical record revealed one entry by Employee #4 on 1/20/10. Employee #4 documented that "...the discharge plan is uncertain." Documentation of the interdisciplinary team care conference on 1/29/10, revealed a granddaughter acknowledged Resident #4's cognitive status had declined, and related that Resident #4 had a history of mini-strokes. The granddaughter acknowledged the family could not afford 24/7 hour assistance and were considering nursing home placement in Arizona. This interdisciplinary team note also included the statement, "...applying for guardianship process discussed," but this note did not indicate if the family or the facility was initiating this process. The interview on 2/23/10, with Employee #4 revealed she did not document any of the following conversations she had with the family. Employee #4 acknowledged Resident #4's daughter lived in Havasu, CA, which was on the Arizona border. The family wanted to transfer Resident #4 to this area around the first of March. The daughter was considering guardianship, but wanted to wait until Resident #4 was relocated closer to the daughter. The social worker acknowledged that she had not informed the family how long it could take for a guardian to be appointed. The social worker acknowledged Resident #4's son implied the daughter had power of attorney for financial needs, but did not	F 250		

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F 250	Continued From page 13 request a copy be sent to the facility. The social worker acknowledged she had not informed the family that they may be responsible for financial costs of a nursing home in Arizona or California depending on the type of medical insurance Resident #4 had. Resident #5 Resident #5 was interviewed on 2/22/10, and 2/24/10. Resident #5 had resided at the facility since 1/14/08, with primary diagnoses that included cerebral-vascular accident with left sided hemiplegia. Resident #5 was 64 years old. She expressed a desire to return to the community, stating she, "...was too young to be in a nursing home." Although she had family in the immediate area, Resident #5 required 24/7 care and her family was unable to provide her with the care because they worked. Resident #5 also required an electric wheelchair for mobility, and she had a 2-story home. Resident #5 acknowledged she had had no recent occupational therapy to achieve some independence. Employee #4 acknowledged that Resident #5 could be difficult to care for, but had not initiated any tracking mechanisms or behaviors contract to assist staff and Resident #5 to adjust to the nursing home placement. There was no discharge plan. Employee #4 acknowledged she had not had any conversations with Resident #5 regarding any discharge plan. Employee #4, acknowledged that the quarterly notes for the past 12 months were essentially identical and there was no plan for discharge. (See Clinical Records above, this tag.)	F 250		

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MOUNTAIN VIEW HEALTH & REHAB	201 KOONTZ LANE CARSON CITY, NV 89701

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F 250	Continued From page 14 Resident #21 Resident #21 was admitted to the facility on 9/30/09, following an extended stay at another rehab facility. Interviews with Resident #21 on 2/22/10 and 2/25/10, revealed that he was planning to return to his private residence once he was able to ambulate and not require a wheelchair, because his home was not handicap accessible. Resident #21 was requiring total joint replacement to achieve this goal. During the initial conversation, Resident #21 acknowledged that he planned to be transferred to a rehab facility closer to his home after the joint replacement surgery, because his family could not drive the 35 miles to his current location. Employee #4 acknowledged she had not had any conversations with Resident #21 regarding any discharge plan. Employee #4, acknowledged that the quarterly notes since Resident #21's admission were essentially identical to other residents' quarterly notes and there was no plan for discharge. Employee #4 acknowledged she was not aware of what Resident #21's plans were. (See Clinical Records above, this tag.) Resident #6 Resident #6 had resided at the facility since 8/12/09, with a primary diagnosis of Alzheimer's disease. Prior to her admission, Resident #6 lived independently at home with her cats. Resident #6 currently had a public guardian. Documentation by Employee #4 revealed that Resident #6 repeatedly wanted to go home, to her cats, but there was no documentation of any evaluation to determine if Resident #6 was	F 250		

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F 250	Continued From page 15 capable of any alternative living environment. Employee #4, acknowledged that Resident #6's quarterly notes were essentially identical to other residents' quarterly notes and there was no plan for discharge. (See Clinical Records above, this tag.) Resident #20 Resident #20 had resided at the facility since 10/21/05, with the primary diagnoses that included diabetes, paranoid schizophrenia and anti-social personality. Resident #20 remains her own responsible party. Review of the social service quarterly notes for the past year revealed no evidence of any discharge plan or evaluation for alternative living environment. Employee #4, acknowledged that Resident #20's quarterly notes were essentially identical to other residents' quarterly notes and there was no plan for discharge. (See Clinical Records above, this tag.) Resident #12 Resident #12 was admitted to the facility on 9/9/09, with diagnoses that included anoxic brain damage, psychosis, hypertension and hypothyroidism. Physicians orders include medications such as Ativan for agitation, Thorazine for behaviors, and Trazodone for depression. The record contained various pieces of	F 250		

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F 250	Continued From page 16 documentation regarding a different placement for Resident #12 in order to better met his needs, as manifested by his aggressive behaviors. Local placement was documented as not being a possibility and that out-of-state placement was being considered. Staff had indicated that Resident #12 had a spouse who was very involved in his care and who visited frequently. Social service notes for 12/2/09, documented no noted moods or behaviors. The next documentation, dated 1/28/10, referenced an increase in aggressive behaviors (no specifics noted) and an attempt to have the resident evaluated by Geriatric-Psychiatric Unit. On 2/8/10, social services documented that no placement could be secured for an evaluation and it was advised that Resident #12 be placed out-of-state. On 2/12/10, it was documented that Resident #12 was involved in an altercation with another resident and that the facility was unable to find an appropriate placement for the acute behavior episode. On 2/15/10, the resident had some medication changes and his behaviors were to be monitored. None of the social services documentation contained evidence that the spouse was being kept appraised of the ongoing situations or what her concerns were about an out-of-state placement. The facility's social services job description stated, "...encourage and maintain contact with families of residents and individual contact regarding progress and concerns is documented. In an interview with Employee #8, the Social Worker, he acknowledged that an out-of-state placement for Resident #12 would be very	F 250		

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F 250	Continued From page 17 disruptive for the family, but that he had not documented any of the conversations. Resident #13 Resident #13 was admitted to the facility on 8/19/09, with diagnoses that included dementia with behaviors, psychosis and hypertension. The resident's husband was her responsible party. Review of the resident record revealed a formal letter from the facility entitled. "30 day Involuntary Discharge Letter for Non Payment of Resident Services. The letter was dated 1/18/10, and stated that Resident #13 would be discharged 2/18/10, if payment had not been received in full by that date. There was no documentation in the record as to the status of the Involuntary Discharge. An interview was conducted with Employee #8, the Social Worker for Resident #13's unit, on 2/24/10. When asked the current status of the Involuntary Discharge, Employee #8 responded that payment had been received in full and the discharge notice had been rescinded. When asked where that documentation was located, he replied that he did not document financial matters pertaining to the residents. When asked about his participation in helping the responsible party to resolve the financial problems, Employee #8 replied that he advised the husband to call the Attorney General for Medicaid and inquire as to the status of the application for Medicaid coverage. Employee #8 further disclosed that he does not help with the residents Medicaid application or track what the status of the application is in the process. The application is initiated by the Business Office.	F 250		

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F 250	Continued From page 18 On a large board located in the front lobby, there was a sign posted that social services would help with applications for Medicare/Medicaid. The facility job description for Social Services stated, "...individual counseling/contacts, assistance and referrals are provided as needed and documented. It was also stated, "...individual assistance, support, and referrals are made as necessary," and "...provide financial information to family and assistance to residents as required." Resident #16 Resident #16 was admitted to the facility 12/21/01, with diagnoses including end stage chronic obstructive disease, mild failure to thrive, cirrhosis of the liver, diabetes and anxiety. Medications included Ativan 1 milligram (mg) for anxiety and Benadryl 25 mg for allergy. Review of Resident #16's clinical record revealed an informed consent was obtained by the facility's Social Worker (Employee #4) for the Ativan and Benadryl on 9/24/09. The Ativan consent was documented on the facility's "Informed Consent - Anti-Anxiety Medication Therapy" form. The Benadryl consent was documented on the facility's "Informed Consent - Sedative/Hypnotic Medication Therapy" form. Review of the resident's record revealed a care plan, which identified Benadryl for the treatment of the resident's allergies. The consent for Benadryl was unnecessary and inappropriate in this circumstance. Resident # 22 Resident #22 was admitted to the facility on	F 250		

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F 250	Continued From page 19 2/6/09, with diagnoses including dementia, diabetes, hypertension, and hypothyroidism. Psychotropic medication orders included the anxiolytic Ativan and the antipsychotics Haldol and Risperdal. Review of the resident's record revealed that an informed consent had not been obtained for Haldol, and this was confirmed by the unit nurse manager, Employee #13. The nurse manager reported, after speaking with the Social Worker, Employee #8, that the reason there was no consent for Haldol was because the social worker thought that Haldol was the same as Ativan. The facility did not have a reference list of psychotropic medications for the social worker to use for the purpose of obtaining consents from residents or their legal guardians.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278		4/16/10

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F 278	Continued From page 20 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure the emotional and psychosocial behaviors accuracy of 2 of 24 residents (Residents #19 and #20). Findings include: Resident #19 Resident #19 was admitted to the facility on 1/5/10, following an admission to a behavioral acute care setting. Resident #19's primary diagnoses included vascular dementia and Alzheimer's disease. Documentation in the initial minimum data set (MDS) regarding emotional and psychosocial behaviors reflected the look back time period of 1/5/10-1/11/10. These sections were completed by the Social Worker, Employee #8. Review of the clinical documentation by Employee #8 on 1/8/10, revealed Resident #19 was demonstrating exit seeking (wandering) behaviors and poor safety awareness. The family had requested Resident #19 remain on a secured	F 278		

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F 278	Continued From page 21 unit. In the MDS assessment, Employee #8 indicated Resident #19 had no behaviors such as depression, anxiety, or sad mood observed in the last 30 days. Employee #8 also indicated that in the past seven days, Resident #19 had no behaviors such as wandering, verbal, physical abusive or inappropriate behaviors,or resisted care. Resident #20 Resident #20 has resided at the facility since 2005. Resident #20's primary diagnoses included paranoid schizophrenia and anti-social behaviors. Resident #20 had a annual MDS assessment performed on 8/3/10. The social service component was a seven day look-back period 7/28/09-8/3/09. Clinical record review revealed that on 7/29/09, nursing documented that Resident #20 was in her room, screaming profanities at herself and growling. She was slapping and hitting herself. Scratches were observed on Resident #20's neck. Ativan was ordered. The clinical record also revealed that on 7/29/09 and 7/30/09, the Social Worker, Employee #4, documented that Resident #20 started trying to hurt herself after a reduction of Ativan was attempted and was unsuccessful. On 8/3/09, Employee #4 documented that Resident #20 was "...stable with no significant changes." The MDS assessment completed by Employee #4 indicated Resident #20 had no behaviors such as depression, anxiety, or sad mood observed in the last 30 days. Employee #4 also indicated that in the past seven days, Resident #20 had no behaviors such as	F 278		

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F 278	Continued From page 22 wandering, verbal, physical abusive or socially inappropriate behaviors,or resisted care. An interview with the MDS coordinator, Employee #11, on 2/25/10, confirmed the behaviors identified in the narrative documentation should have been triggered in the MDS assessments for both Resident #19 and Resident #20. An interview with the Social Worker, Employee #4 on 2/25/10, confirmed she should have coded Resident #20's behaviors in the MDS assessment.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		4/16/10

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F 279	Continued From page 23 by: Based on observation, record review and staff interview, the facility failed to ensure resident care plans were developed to appropriately identify problems, address the specific and individual needs of the resident, outline appropriate and measurable interventions and goals, and update care plans to reflect changes in approaches and goals or to discontinue a care plan when goals had been met for 9 of 24 residents (Residents #15, #3, #11, #12, #13, #14, #17, #4, and #5). Findings include: Resident #15 Resident #15 was admitted to the facility on 9/12/06, with diagnoses including vascular dementia, debility, hypertension, and psychosis. The resident had declined and was no longer residing in the facility's Dementia/Alzheimer's locked unit. The resident had been placed on comfort care on 2/7/10, for end of life care due to impending death. Further orders indicated the need for a geri chair when the resident was out of bed for safety and comfort. Review of Resident #15's care plan revealed five active individual care plans which addressed the same or similar problems related to behaviors, and antidepressant and/or psychotropic drug use, the goals for these care plan were to be revisited in March 2010. One care plan, included in Resident #15's care plans, which was initiated on 9/7/09, outlined a facility issue which indicated "Dementia unit residents will not abide by assigned seating in the dining room, the goal was to have all residents to	F 279		

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F 279	Continued From page 24 sit in a seat of their choice, the approaches included allowing residents to select their seats, ensure all residents were seated in the dining room that wished to be and to serve each table before moving to the next. This care plan was to be revisited in March 2010. Review of Resident #15's Interdisciplinary Progress notes revealed a quarterly interdisciplinary note dated 12/8/09, which indicated over the last quarter there were no mood or behavior issues and that the care plans had been reviewed and remained appropriate. A care conference note dated 2/16/10, indicated the resident had declined, was to be kept comfortable. Other care plan items were not addressed. Resident #3 Resident #3 was admitted to the facility on 9/30/09, with diagnosis including dysphagia, dental caries, episodic mood disorder, malaise and fatigue. There were two active individual care plans for alteration in skin integrity. Another care plan generically outlined, "...potential for mood and behavior problem due to new admit and lack of desire to eat." The interventions were generically outlined, "Provide medications as ordered if applicable, re-direct as needed, document noted mood/behavior problems, social services referral as indicated and encourage activities of choice." The goal for this care plan indicated, "...problems will be minimized x 90 day." The care plan, for Resident #3 failed to identify what the moods or behavior were, the specific medications or the approaches used for the	F 279		

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F 279	Continued From page 25 resident. Since the care plan did not specify what the problem mood or behaviors were, one could not determine progress towards meeting the goal. Since the approaches were ill defined, one was not able to determine if a change in medication or other approaches were effective or if adjustments were needed. Resident #11 Resident #11 was admitted at the facility on 11/2/2007, with diagnoses that included Alzheimer and dysphagia. In a care plan identifying the problem as a potential for weight loss due to wandering, there was an entry dated 12/22/09, stating the problem that husband was refusing a mammogram or invasive testing. The identified problem had no bearing on the care plan for potential weight loss. Resident #12 Resident #12 was admitted to the facility on 9/9/09, with diagnoses that included anoxic brain damage, psychosis, hypertension and hypothyroidism. Physicians orders include medications such as Ativan for agitation, Thorazine for behaviors, and Trazodone for depression. Located in the record was a care plan for the resident receiving Anti-Psychotic medications for manifested behaviors (attempts to hit (tap) softly choke others). There was no date as to when the care plan was indicated but the first review date was indicated to be 6/09. The last review date was 12/09. There was documentation in	F 279		

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F 279	Continued From page 26 Resident #12's record that his aggressiveness had increased and that out-of-state placement was being considered. None of the approaches were altered, nor had additional approaches been developed to reflect the resident's current status or whether the stated approaches had been effective. Resident #12 had a care plan developed in 9/2005 for the problem of a history of hypothyroidism. Review of the care plan had been ongoing for the past five years without any revision of the approaches. There was no indication that hypothyroidism was a problem for Resident #12 indicating that the care plan should have been resolved at some point. Resident #13 Resident #13 was admitted to the facility on 8/19/09, with diagnoses that included dementia with behaviors, psychosis and hypertension. The resident's husband was her responsible party. Resident #13 had a care plan addressing, "...alteration in comfort/pain secondary to behavorial disturbances. (Note: It was not clear as to why behavioral disturbances caused discomfort and/or pain.) The record for Resident #13 also contained a care plan for the receiving of anti-anxiety medications manifested by behaviors. There was no indication as to what type of behaviors. As a result of non-specific information, the approaches were very general and could relate to most any resident. There was no indication as to when the care plan was originally developed.	F 279		

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F 279	Continued From page 27 Also contained in the record was a care plan identifying the problem as resident receiving anti-psychotic medications for manifested behaviors. Again, there was no indication as to what were the specific behaviors Resident #13 was exhibiting. There was no indication as to the date the original care plan was developed and the approaches were verbatim as the approaches for the care plan for the problem of receiving anti-anxiety medications. The same deficiencies were noted in the care plan for Resident #13 receiving antidepressant medications. Resident #14 Resident #14 was admitted to the facility on 5/29/09, with organic brain syndrome, hypertension, dementia and type two diabetes. In Resident #14's record were separate care plans for the resident receiving medications for anxiety and depression as manifested by behaviors. Neither care plan identified behavior specific to this resident. The care plans were not dated as to when they had been developed and the same non-specific approaches were employed on both care plans. Also noted in the record was a care plan for the problem of alteration in pain/comfort secondary to dementia. There was no explanation as to why dementia would cause pain. The care plan had been in place since 5/29/09 with no revision in the approaches. Resident #17	F 279		

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F 279	Continued From page 28 Resident #17 was admitted to the facility on 11/3/09, with diagnoses that included mental disorder, anxiety and hypertension. She resided in a room without a room mate. It was noted that she was independent in ambulation and walked freely about the secured unit. Present in the record for Resident #17 was a care plan identifying the problem as alteration in comfort/pain secondary to abdominal surgery in 1955 and an occasional headache. There was no indication as to why surgery in the past would continue to be a problem requiring care planning. The facility, when asked, was unable to produce a policy on developing care plans. It was indicated by Employee #11, the MDS Coordinator, that social services was responsible for the development of psycho-social issues. Other care plans were developed by Employee #11. If other licensed staff wished to develop a care plan, the plan had to go through Employee #11 first. Summary: The care plans showed no revisions in the approaches when the approaches have been in place for years, had been developed for situations that were not an ongoing problem and contained very generalized approaches. Resident #4 Resident #4 was admitted to the facility on 1/18/10, following an acute care hospitalization. Resident #4's primary diagnoses were hypoxemia, congestive heart failure, urinary tract infection and hypertension. Review of the care plans revealed a care plan alteration in skin integrity secondary to occasional	F 279		

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F 279	Continued From page 29 incontinence, multiple old skin tears and pressure ulcer to left knee and left ankle.. Nursing documentation and the minimum data set assessments indicated that Resident #4 had pressure ulcers on her left knee, Stage 3 and left ankle, Stage 4, upon admission, but these were not included in the admitting diagnoses. Further review of the skin integrity care plan included the following: 1) "Wound care as ordered by physician." There was no documentation as to what was ordered for the wound care; 2) "Pressure relieving mattress: to bed." A visual observation of Resident #4's bed revealed no additional pressure relieving devices on the bed mattress. Resident #4 had gone to the wound clinic for treatment of these wounds, but this had not been added to the care plan. An interview with Employee #7, who performed wound care on the pressure ulcers acknowledged that all the beds had pressure relieving mattresses, and that Resident #4 had no additional pressure relieving devices. Employee #7 acknowledged that since Resident #4's mattress was common throughout the facility, this was not a specific intervention to reduce pressure for Resident #4. Employee #7 acknowledged there was no specific interventions to avoid pressure at the knees or ankles where wounds/pressure sores already existed. Resident #5 Resident #5 had been admitted to the facility on 1/14/08, with the primary diagnosis of backaches. Additional diagnoses included depression, morbid	F 279		

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F 279	Continued From page 30 obesity and late effects-hemiplegia. Review of the clinical record and interview with Resident #5 on 2/24/10, revealed Resident #5 had an implanted intrathecal pump for administration of Baclofen and morphine for treatment of back muscle spasms. Resident #5 confirmed this pump had been implanted prior to her admission to the facility. Resident #5 was being treated by an independent pain clinic. Review of the care plans revealed no care plan for pain management, monitoring or coordinating care with the pain clinic. Review of care plans also revealed that the facility used master care plan for residents, and were to fill in the specifics for the individual residents. However, these "master care plans" were repeatedly copied, with the result that the care plans were hard to read and had not been revised for the specific resident, except for an addition of a diagnosis.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility standards of practice, facility policies, interviews and clinical record reviews, the facility failed to ensure professional standards were maintained for 1 of 1 resident with pressure sores (Resident #4), and for 1 of 1 resident with an intrathecal pain pump (Resident #5). Findings include:	F 281		4/16/10

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F 281	Continued From page 31 An interview with the Director of Nursing on 2/25/10 revealed the facility used, "The Lippincott Manual of Nursing Practice (Lippincott Manual)," for standards of practice. The current manual in the facility was the 8th Edition, printed 2006. The Director of Nursing confirmed the facility had policies and procedures for care, that were also their standards of practice. Review of the facility policies and Lippincott Manual regarding pressure sores revealed that pressure sores or any wounds were to be measured with the length, width and depth. Resident #4 Resident #4 was admitted to the facility on 1/18/10, following an acute care hospitalization. The initial skin assessment revealed that two wounds were identified on the left ankle/left knee. Measurements were: (A) left knee 2.2 centimeters (cm) by 2 cm and (B) left ankle 2.5 cm by 2 cm. There was no depth measured, there was no indication that there was presence of any scabs. Wound documentation by Employee #7 during Resident #4's stay at the facility continued to reflect no depth documentation although staff had identified the wound on the left knee as a stage three pressure ulcer and the wound on the left foot was identified as a stage four, but that the depth could not be determined. "The Lippincott Manual of Nursing Practice," defined pressure sores: 'A stage three pressure ulcer was defined by the facility's policies as "full thickness skin loss, involving damage or necrosis of subcutaneous	F 281		

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F 281	Continued From page 32 tissue presenting clinically as a deep crater".' And, "A stage four pressure ulcer was defined as full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures. Staging cannot be done if eschar is present." An interview with Employee #7 confirmed that she did not document any depths to either wound because there were scabs present. She acknowledged that per definition of policy, a pressure sore could not be staged if there was a scab. Employee #7 confirmed that although there was no diagnoses of pressure ulcers from the wound clinic or the acute care facility, a conference with the Director of Nursing concluded that these were pressure ulcers because of Resident #4's history of a fall and possibly crawling on her knees. Employee #7 could not provide specific evidence of this history or documentation of the conference with the Director of Nursing. Employee #7 also confirmed that in addition to no depth being recorded on the wound assessment sheets, there was no evidence of eschar or slough, which would have prevented depth to be assessed. Review of the, "Pain Management Policy," revised September 2003, described in #4 under Process: "...when an 'as needed' dose is administered, the nurse should document on the reverse side of the Medication Administration Record (MAR), the medication given, the reason and the pain evaluation score. After the 'as needed' medication has had time to take effect, the nurse documents results' effectiveness, and resulting pain evaluation score to determine the effectiveness of the 'as needed' pain medication." The example given was:	F 281		

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F 281	Continued From page 33 "Date 2/23/03 Hour 8:10 PM Initial LM Medication/treatment Vicodin tab 1 Reason back pain score 6/10 Result pain now 3/10 Time 8:45 PM" Resident #5 Resident #5 was prescribed the pain medication, Percocet 325/10 mg, every six hours as needed for severe pain. Review of the clinical record medication administration record (MARs) for January 2010, revealed that Resident #5 received pain medication 66 times without any documentation of specific details of where the pain was, the type of pain or the pain level. There was no secondary documentation of reassessment of pain level or effectiveness of the pain medication. The MARs for January estimated that Resident #5 may have been medicated for pain a minimum of 109 times (at least three times a day) in addition to the intrathecal pump pain management, without any evidence of notification of the physician or the pain management clinic.	F 281		
F 286 SS=E	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 286		4/16/10

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F 286	Continued From page 34 facility failed to maintain completed records for fifteen months of resident assessments for 5 of 24 residents. (#13, #14, #16, #9, and #22). Findings include: Resident #13 Resident #13 was admitted to the facility on 8/19/09, with diagnoses that included dementia with behaviors, psychosis and hypertension. The resident's husband was her responsible party. In review of the most recent Minimum Data Set (MDS), it was noted that there was no MDS located in the Resident #13's record between August 2009, and February 2010. A quarterly MDS would have been due. Employee #11 copied an MDS identified as a quarterly. This copy did not contain any dated signatures. There was no evidence that this quarterly was ever available to staff or contained in the resident record. Resident #14 Resident #14 was admitted to the facility on 5/29/09, with organic brain syndrome, hypertension, dementia and type two diabetes. Review of the record for Resident #14 disclosed that no MDS was present for a time period from 8/25/09 to 2/1/10. Employee #11 produced a copy of an MDS identified as an quarterly. The copy had no signatures or dates. There was no evidence that the MDS had ever been available, or located in the resident's record. Employee #11, the MDS coordinator, could not	F 286		

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F 286	Continued From page 35 offer an explanation as to where the originals were or if they had ever been in the records. Resident #16 Resident #16 was admitted to the facility on 12/21/2001. Review of the resident's minimum data set (MDS) revealed a current annual MDS with the reference date of 8/3/09, which was followed by a quarterly MDS with the reference date of 1/11/2010. The record did not contain a quarterly MDS for period of November 2009. In an interview with the facility's MDS coordinator (Employee #11), the coordinator was able to print out a copy of a quarterly MDS for November 2009, and confirmed that a signed MDS which validates completion and accuracy was not in the resident's record and could not be located. Resident #9 Resident #9 was admitted to the facility on 8/20/07. Review of the resident's record revealed it did not contain the most recent annual MDS with Resident Assessment Protocols (RAPs), with a reference date of 7/21/09. The MDS coordinator was able to print out a copy of this MDS; however, the copy did not include any dated signatures attesting to the accuracy of each portion of the assessment. Resident #22 Resident #22 was admitted to the facility on 2/16/09. Review of the resident's record revealed that a quarterly MDS assessment was missing between the quarterly assessments of 5/8/09 and 10/12/09. The MDS coordinator was unable to	F 286		

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F 286	Continued From page 36 provide a copy of this missing assessment.	F 286		
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 interview, facility policies and clinical record review, the facility failed to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, regarding assessments and wound measurements for 1 of 24 residents (Resident #4), pain management for 1 of 24 residents (Resident #5), and coordination of services for 1 of 24 residents (Resident #21). Findings include: An interview with the transport technician, Employee #18, on 2/25/10, revealed she no longer made a monthly calendar to reflect who, where and when residents were going to appointments. Employee #18 used a dry eraser board in her office to show the transport schedule on a weekly basis. Employee #18 indicated she gives the nursing staff a form indicating a resident's appointment on the day of the appointment.	F 309		4/16/10

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F 309	Continued From page 37 An interview with Employee #20 on 2/25/09, confirmed that physician or clinic appointments (wound/pain) appointments that were scheduled to be done on a regular basis were not added to the physician order recaps or the medication/ treatment records. Employee #20 acknowledged that nursing services would not be able to track these appointments to ensure that resident needs were being met. Resident #4 Resident #4 was admitted to the facility on 1/18/10. An interview with Employee #7 on 2/22/10, revealed that the facility had identified the wounds on Resident #4's left knee and left ankle as pressure sores, and subsequently classified them as a Stage 3 to the left knee. The left ankle wound was classified as a Stage 4, because the depth could not be determined. Employee #7 did confirm that the facility did not have any documentation from the wound clinic that these were pressure ulcers. These wounds were not part of the admitting diagnoses. Employee #7 indicated that a conference with the Director of Nursing decided these were pressure ulcers because, "Allegedly, Resident #4 had fallen and crawled on her knees." Employee #7 did acknowledge that if the wounds were due to crawling, they would not be considered pressure sores. Review of the clinical record revealed that although Resident #4 had gone to a wound clinic, there was no evidence the facility asked for the wound clinic to confirm whether these wounds were pressure wounds, and what stage. Clinical record review also revealed incomplete documentation of the size of the wounds, having	F 309		

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F 309	Continued From page 38 no depths documented for the Stage 3 wound. Resident #5 Resident #5 had been a resident at the facility since 1/14/08. An interview with Resident #5 on 2/24/10, revealed that she had an intrathecal pump inserted, which delivered pain medication on a regular basis to assist her with her back muscle pains. Resident #5 acknowledged this pump had been inserted prior to her admission to the facility. Resident #5 acknowledged that she went to a pain clinic for medication for the pump on a regular basis. A conversation with the pain clinic on 2/24/10, revealed that the frequency of Resident #5's pain clinic appointments and treatments could not be discussed, because there was no authorization of sharing information with the skilled care facility by the pain clinic in Resident #5's clinic record. This interview also revealed that all pain management orders should have been initiated by the pain clinic. An interview with Employee #20 on 2/22/10, revealed that the facility did not have the contact number for the pain clinic. Employee #20 confirmed there was no evidence Resident #5 had an intrathecal pump for pain management in her clinical record. There was no physician's order for pain clinic visits or their frequency, nor was there any evidence in the medication/ treatment records when these visits were to occur. Review of Resident #5's annual pain assessment	F 309		

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F 309	Continued From page 39 record completed 11/4/09, did not indicate the presence of the intrathecal pump for pain management, although it was present on the initial pain assessment completed on 12/19/08. The presence of the intrathecal pump was not added to the pain assessment until 1/22/10. An interview with the facility pharmacist on 2/23/10, confirmed he documented a request for routine pain medication for Resident #5, due to her frequent need for "as needed" oral pain management, approximately three times a day. The pharmacist confirmed he was not aware of Resident #5 having an intrathecal pump for pain management. Review of Resident #5's care plans revealed no care plan for pain management regarding assessment of effectiveness of the intrathecal pump or communicating with the pain clinic to report break-through pain. Resident #21 Resident #21 was admitted to the facility 9/30/09, following a transfer from another rehabilitation facility. Resident #21's primary diagnoses included prostate cancer and hydronephrosis and difficulty in walking. Admission information included an unsigned hand written entry "Resident has implant for prostate cancer. need injection into implant every three months. can we send to urologist? Send to VA will schedule." Review of Resident #21's clinical record, including nurses notes, physician's orders, care plans and medication/treatment records, revealed no entry of if or when Resident # 21 last had the implant injected. An interview with nursing staff revealed	F 309		

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F 309	Continued From page 40 staff was not aware that Resident #21 required injections every three months. Nursing staff's response was that the transport technician tracked these appointments and let nursing know the day of the appointment. There was no evidence that the VA was contacted or coordinating these visits. Review of Resident #21's clinical notes did reveal that there was an entry written on the nurse's notes: "12/29/09: (Resident #21) returned to facility with two family members. Review of the physician's orders indicated the resident was to go out on pass, and the nursing staff was to provide Resident #21 with the necessary medications for the duration of the pass." Review of the medication administration record revealed that the resident may have been out of the facility from 12/23/09-12/29/09, but there was no documentation in the nurse's notes that indicated 1) that Resident #21 ever left the facility, 2) that Resident #21 received the prescribed medications ordered for the length of the pass. There was also no evidence Resident #21 signed out on the leave of absence log. Review of the clinical record also revealed that prior to Resident #21's leave/pass, he was participating in the restorative (RA) program. Upon his return on 12/29/10, Resident #21's record revealed no further RA therapy participation. There was no physician order to discontinue the RA program. There was no change in the comprehensive care plan. An interview with a restorative aide (Employee #19) on 2/25/10, revealed that if a resident left the	F 309		

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F 309	Continued From page 41 building for two or more days, that resident would be dropped from the RA program. A review of the RA program description did not include this qualifier. An interview with the RA supervisor, Employee #9, on 2/25/10, revealed she was not aware of this process of discharging a resident from the RA program after any two day absence.	F 309		
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 drugs. This REQUIREMENT is not met as evidenced	F 329		4/16/10

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F 329	Continued From page 42 by: Based on record review and interview, the facility failed to ensure all physician orders included diagnoses or other clinical indications to support the use of medications for 3 of 24 residents (Residents #22, #20, and #3). Findings include: Resident #22 Resident #22 was admitted to the facility on 2/6/09, with diagnoses including dementia, diabetes, hypertension, and hypothyroidism. Review of the resident's physician recap orders revealed no clinical indications for the following medications: Gemfibrozil, Synthroid, Lasix, Enalapril, Reglan, and Metformin. The unit nurse manager, Employee #13, agreed that the diagnoses should be included on the recaps. Resident #20 Resident #20 was admitted to the facility in 2005. Resident #20's primary diagnoses included paranoid schizophrenia and antisocial behaviors. Review of her physician recap orders and medication administration record (MAR) revealed Resident #20 was prescribed Ativan. There was no diagnosis listed on the physician's orders or MAR to indicate why Resident #20 was receiving this medication. Resident #3 Resident #3 was admitted to the facility on 9/30/09. Review of the resident's clinical record and medications listed in the physician's orders failed to reveal medical justification for Albuterol	F 329		

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F 329	Continued From page 43 MDI inhaler ordered 11/29/09, Paxil ordered 12/24/09, and Baclofen ordered 12/26/09.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;	F 334		4/16/10

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F 334	Continued From page 44 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy review, the facility failed to develop policy and procedure to ensure residents and/or their legal representatives routinely received education on the benefits and side effects of the influenza immunization prior to annual immunization for 3 of 24 residents (Residents #15, #16, #20).	F 334		

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F 334	Continued From page 45 Findings include: Review of the facility's flu policy, entitled, "Immunizations: Influenza (Flu) Vaccination of Residents and Staff," dated June 2005, which was taken from the Infection Control Manual Patient Care policies ICM 6.7, indicated current and newly admitted residents would be offered the influenza vaccine each year from September through the end of March of the following year; informed consent in the form of a discussion regarding risks and benefits of vaccination were to be done prior to vaccination (...if signed consent is required it would occur at this point); residents may refuse vaccination, refusal and reasons why were to be documented; body temperature was to be taken prior to giving the vaccination, if temp was 101 degrees or high or if being treated for an infection resident was not to receive vaccine until he/she recovered; vaccine administration was to be documented in the medical record (e.g., medication sheet, nurses' notes, immunization record, or progress sheet). The policy and procedure failed to outline the educational information which was to be provided and specify that it was to be provided and reviewed with the resident and/or their legal representative each year prior to the offering and/or administration of the influenza vaccination. Resident #15 Resident #15 was admitted to the facility on 9/12/06. The resident's son was indicated as the resident's legal (durable power of attorney) representative. Review of the resident's record failed to reveal that educational risks and benefits had been provided to the legal representative.	F 334		

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F 334	Continued From page 46 The resident's immunization record indicated the Influenza immunization had been refused and/or declined in 2006, 2007, on 10/10/08 and in 2009. Review of the record failed to reveal why the immunization had been refused and/or declined. Resident #15's immunization record and consents were reviewed with facility's Unit Coordinator (Employee # 13). The nurse acknowledged that annual information on risks and benefits, and documentation regarding why immunizations had been declined were not obtained or documented. Resident# 16 Resident #16 was admitted to the facility on 12/21/01. Review of the resident's clinical record revealed: The resident's immunization record indicated the resident had received the Influenza immunization in 2007, 2008 and 2009. The signed Influenza administration forms in Resident #16's records were not identified as "facility forms" and were not consistent in the information (risks, benefits, side effects) provided. Resident #20 Resident #20 has resided at the facility since 2005. Review of Resident #20's immunization record revealed that for both the 2008 and 2009 flu season, Resident #20 refused the vaccination. Review of the clinical record revealed no evidence that Resident #20 received education on a yearly basis regarding the benefits and potential side effects of the vaccination.	F 334		
F 361 SS=D	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS	F 361		4/16/10

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F 361	Continued From page 47 The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interview, the facility failed to ensure nutritional evaluations were completed annually per facility policy for 1 of 24 residents (Resident #15). Findings include: Resident #15 was admitted to the facility on 9/12/06. The resident had declined and was currently in end-stage dementia. The resident was placed on comfort care 2/7/10. The resident's admission height was five foot five inches and admission weight was 196 pounds. The last weight documented in 2007 was 153 pound on 4/3/07. From 4/3/07 to 11/2/08 it was documented that the resident's legal representative did not want the resident weighed. The last documented weight in the resident's record, which was done at the legal	F 361		

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F 361	Continued From page 48 representatives request on 11/2/08 was 106 pounds. Documentation dated 2/11/10 revealed the resident had developed pressure sores on her coccyx and left hip at which time the facility's dietician (Employee #21) recommended nutritional interventions for wound healing. The last documented annual nutritional assessment was done in August 2007. Review of the facility's policy entitled, "Nutrition Evaluation," which was dated July 2008, specified the dietician was to evaluate the nutritional status of each resident within 14 days of admission and annually, and that the evaluation(s) were to be document on the Nutrition Evaluation form. On 2/25/10 at 2:30 PM, an interview with the facility's Dietician (Employee #21) was conducted. The Dietician reviewed Resident #15's clinical record and confirmed that an annual nutritional assessment had not been completed since August 2007. The Dietician indicated she relied on the facility's Minimum Data Set Coordinator to let her know when the annual MDS was due, at which time she (dietician) completed the annual resident nutritional assessment.	F 361		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		4/16/10

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F 371	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner. Findings include: A tour of the facility's kitchen on 2/22/10, at 7:00 AM revealed the following: 1. In the walk-in refrigerator, large, deep pans of pork and bean soup, both dated 2/21/10, were 49.5 degrees Fahrenheit (F) and 46.3 degrees respectively. The kitchen manager related that the pork and soup had been put into the refrigerator the previous day to cool, and he acknowledged that the pans were too large to allow for the required cooling to 41 degrees F within six hours. 2. Floors under equipment and in corners of the kitchen were soiled with debris. 3. There was a hole in the wall at the corner of the kitchen near the 3-compartment sink, and another wall hole around a pipe. 4. Sanitized pans were "wet-stacked" on racks. 5. The pH of the quaternary-based sanitizing solution in a wiping cloth bucket was over-concentrated at above 500 ppm. According to the facility's "Sanitizing Solution" policy, dated 2/2007, "New solution is prepared prior to each meal and tested for proper concentration (200 ppm) by using Quaternary test strips." 6. A gallon of milk in the refrigerator at the 200 hall nursing station had been opened but not date-marked with an open date. The kitchen manager confirmed that according to facility policy, all potentially hazardous foods should be	F 371		

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F 371	Continued From page 50 date-marked when opened.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 431		4/16/10

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F 431	Continued From page 51 by: Based on observation and staff interview, the facility failed to ensure the safe storage and handling of medications and biologicals. Findings include: On the morning of 2/23/09, an observation of Station 1's medication room and one of the station's medication carts was completed. Medication room observations revealed: - Bisacodyl suppositories were stored in a drawer instead of the refrigerator; - There were multiple individual resident's prescriptions on the counter and in one cupboard, which were not indicated as returns or overstock; - An Emergency Narcotic box was kept in a locked drawer, the drawer was not identified and the disposition of the box was not accounted for from shift to shift; and - A list of narcotic and non-narcotic emergency medications was not available. The medication room findings were reviewed with the facility's Minimum Data Set Coordinator (Employee #11). The coordinator acknowledged the suppositories should have been stored in the refrigerator. Several of the drawers of the medication cart were soiled. One bottle of Robitussin cough syrup was sticky and needed to be cleaned off. Several house stock items were not fully dated with the year on the "Date open." The bottom exterior of the medication cart was soiled and not clean. The medication cart findings were reviewed and	F 431		

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F 431	Continued From page 52 acknowledged by the medication nurse (Employee #17). In separate interview with the medication nurse (Employee #17) and the Director of Nurses (Employee #2), both acknowledged there was not a list of narcotic and non-narcotic emergency medications, and that there was not a process in place to account for the Emergency Narcotic box kept in the medication room.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		4/16/10

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F 441	Continued From page 53 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and interview, the facility failed to ensure snacks and ice were distributed in a sanitary manner, and that tuberculosis testing was completed according to facility policy for 1 of 10 employees (Employee #11). Findings include: On 2/22/10 at 10:30 AM, a nurse's aide, Employee #6, was observed passing out cookies with bare hands. According to the facility's policy on glove use, dated 2/2007, "Bare hand food contact is prohibited." On 2/24/10 at 10:00 AM, an ice chest used for residents was observed in an employee room. The ice scoop was being stored on a pull-out tray attached to the ice chest, and the tray had water with debris in it. The tray could not be removed for efficient cleaning. The kitchen manager acknowledged that the scoop was not being held in a sanitary manner. The facility's policy on ice, dated 2/07, outlined the following process: "Ice buckets, other containers, and scoops are kept clean and are stored and handled in a sanitary	F 441		

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F 441	Continued From page 54 manner." Review of the personnel file for Employee #11 revealed that her annual skin test for Tuberculosis was administered on 12/09/08. The annual test for 2009 was administered on 12/14/09. Facility policy entitled, "Tuberculosis Control Plan", effective June 2005, stated in section d. Annual Personnel Screening that employees with negative skin test history will have an annual PPD skin test. Employee #11 annual test was not administered in a timely manner.	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		4/16/10

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F 520	Continued From page 55 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that plans of action, developed by the quality assessment and assurance (QAA) committee to correct identified quality deficiencies, were systematically implemented, monitored and evaluated. Findings include: In an interview with the Administrator on 2/25/10 at 10:00 AM, and on 2/26/10 at 12:30 PM, the Administrator related that the QAA committee had identified and addressed, within the past six months, the following three issues: consents for psychotropic medications, kitchen sanitation, and expired medications. The Administrator related that the issue of consents was addressed because the lack of required consents was cited in the previous recertification survey. According to the Administrator, Medical Records was originally assigned the task of reviewing charts to ensure all necessary consents were present. However, not all charts were reviewed due to staff turnover in Medical Records. In January 2010, the nursing administration team was assigned the same task, and were told, "If you're looking at a chart, look at consents." The Administrator acknowledged that there was no systematic approach in place for the team to document their findings, in order to	F 520		

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F 520	Continued From page 56 effectively monitor and evaluate the findings. The Administrator indicated that he relied on the nursing staff to let him know if any discrepancies existed in the area of consents. The issue of kitchen sanitation - specifically broken floor tiles and a leaking pipe - was identified as a concern in the January 2010 QAA committee meeting as a result of a complaint to the facility. The Administrator reported that those specific issues were quickly rectified; however, a system was not put in place to continue to monitor and evaluate kitchen sanitation. During the recertification survey, on 2/22/10, more damaged floor tiles were discovered, along with two holes in the wall. The Administrator provided a facility "Dietary Services Comprehensive Summary" form to be used to monitor food service operations; however, there was no evidence this form was being used on a consistent basis. The Administrator explained that the issue of expired medications was being addressed by the QAA committee as a result of a citation from the previous survey. The Administrator related that the nursing staff was to continually check the dates of medication and discard outdated medications. There was no formal system in place to document the findings of the nursing staff (in order to determine if any training was necessary in this area). When asked how staff were informed of any implemented changes stemming from QAA committee decisions, the Administrator indicated that sometimes the changes were posted for staff in the employee room. The Administrator acknowledged that there was no system in place	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295079		02/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH & REHAB	201 KOONTZ LANE CARSON CITY, NV 89701

(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 520	Continued From page 57 to ensure that staff read and understood the changes.	F 520		