F 221 463.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:
Based on medical record reviews, observations and interviews, it was determined the facility failed to ensure consent for restraints was obtained for 3 of 8 (Residents #2, 6 and 14) sampled residents.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 3/22/08 and a readmission date of 6/20/09 with diagnoses of Senile Dementia and Anxiety. Review of a physician's order dated 11/28/10 documented, "...VELCRO SAFETY BELT WHEN UP IN W/C [wheelchair]..." Review of the quarterly minimum data set (MDS) with an assessment reference date of 12/3/10 documented, "...Section P Restraints... 2 [used daily] E. Trunk Restraint..."
The facility was unable to provide documentation that a consent was obtained for the use of a restraint.

Observations in the lobby on 12/28/10 at 9:10 AM and on 12/28/10 at 4:00 PM, revealed Resident #2 seated in a w/c with a velcro seat belt around her waist.

Observations in the dining room on 12/28/10 at 11:35 AM and on 12/29/10 at 7:45 AM, revealed

Right to be free from physical restraints

The facility will ensure that all residents have the right to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat the residents medical symptoms by ensuring consent for restraints to be obtained.

The DON/designee will obtain consent from family or representatives for restraints. This will be monitored by DON/QA on a monthly basis. QA monitoring forms will be utilized.

Mandatory in-service will be held on January 27, 2011.

1/27/11
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 221</td>
<td>Continued From page 1 Resdient #2 seated in a w/c with a velcro seat belt around her waist. 2. Medical record review for Resident #6 documented an admission date of 3/1/10 with diagnoses of Psychosis, Depressive Disorder, Diabetes Mellitus, Hypertension and Hyperlipidemia. Review of a physician's order dated 11/22/10 documented, &quot;...W/C WITH VELCRO SAFETY SEAT BELT...&quot; Review of the quarterly MDS with an assessment reference date of 10/15/10 documented, &quot;...Section P Restraints... 2 [used daily] E. Trunk Restraint...&quot; The facility was unable to provide documentation that a consent was obtained for the use of a restraint. Observations in the lobby on 12/28/10 at 9:07 AM, revealed Resident #6 seated in a w/c with a velcro seat belt around her waist. Observations in the dining room on 12/28/10 at 10:30 AM and 12/29/10 at 7:45 AM, revealed Resident #6 seated in a w/c with a velcro seat belt around her waist. 3. Medical record review for Resident #14 documented an admission date of 11/23/10 with diagnoses of Brain Injury, Congestive Heart Failure, Hypertension and Psychosis. Review of a physician's order dated 11/23/10 documented, &quot;...UPPER TORSO POSTURE SUPPORT IN W/C...&quot; Review of the admission MDS with an assessment reference date of 12/3/10 documented, &quot;...Section P Restraints... 2 [use daily] E. Trunk Restraint...&quot; The facility was unable to provide documentation that a consent was obtained for the use of the upper torso posture support since the order was initiated.</td>
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<td>(X4) ID</td>
<td>(X) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>F 221</td>
<td>Continued From page 2 11/23/10. Observations in hallway at nurses station during the initial tour on 12/28/10 at 9:35 AM, revealed Resident #14 seated in the w/c with a vest restraint on. Observations in hallway at nurses station on 12/29/10 at 9:35 AM, 11:00 AM, 1:25 AM and 3:00 PM, revealed Resident #14 seated in the w/c with a vest restraint on. During an interview in the storage room on 12/29/10 at 11:45 AM, the Director of Nursing (DON) was asked if she had obtained consents for restraint use. The DON stated, &quot;I don't have any consents. I really don't consider it a restraint. MDS and I need to get together on what we call it.&quot;</td>
<td>F 221</td>
<td>DIGNITY &amp; 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 policy review, observation and interview, it was determined the facility failed to ensure that staff knocked on the door or gained permission prior to entering the resident's room during 1 of 2 (lunch meal on 12/28/10) dining observations. The findings included:</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>241</td>
<td>Continued From page 3 Review of the facility's &quot;DIGNITY&quot; policy documented, &quot;This policy is to 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 and privacy. Knock and gain permission before entering resident's room...&quot;</td>
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<td>280</td>
<td>SS=D</td>
<td>Observations on Hall 2 on 12/28/10 starting at 12:15 PM, revealed Certified Nursing Assistant (CNA) #1 entered resident rooms 25, 27, 28 and 35 with lunch trays. CNA #1 did not knock or obtain permission to enter prior to entering these residents rooms. During an interview at the main nurses station on 12/29/10 at 3:25 PM, the Director of Nursing stated, &quot;I would expect them [staff] to knock.&quot; 483.20(c)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
<td>280</td>
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<td><strong>F 241</strong></td>
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<td><strong>F 280</strong></td>
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<td><strong>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</strong></td>
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<td><strong>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, to participate in planning care and treatment. A comprehensive care plan will be developed and maintained by ensuring ongoing revisions to the care plan.</strong></td>
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<td><strong>The DON/QA will monitor for current revisions of comprehensive care plans with direct communications with the MDS department.</strong></td>
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<td><strong>Mandatory in-service will be held on January 27, 2011.</strong></td>
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This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to revise the comprehensive care plan for seizure activity for 1 of 14 (Resident #3) sampled residents.

The findings included:

Medical record review for Resident #3 documented an admission date of 08/14/06 with diagnoses of Cerebral Vascular Accident, Late Effect Cerebral Vascular Discourgated Defect, Convulsions, Aphasia, Senile Dementia, Anemia and Anorexia. Review of the comprehensive care plan dated 12/10/10 documented, "...At risk for falls secondary to Seizure disorder..." The care plan did not address measures to be put in place for seizure activity.

During an interview in the Director of Nursing's office, on 12/29/10 at 3:00 PM, the Minimum Data Set Coordinator confirmed there was no plan of care for seizure activity.

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections.
**No Catheter, Prevent UTI, Restore Bladder**

The facility will ensure that all residents entering this facility without an indwelling catheter are not catheterized unless the resident condition or diagnosis demonstrates catheterization was necessary and receives appropriate treatment and services to prevent urinary tract infections.

The DON/QA will monitor resident’s plan of care on a monthly basis. QA forms will be utilized.

Mandatory in-service will be held on January 27, 2011.

### Continued From page 5

Infections and to restore as much normal bladder function as possible.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review, observations and an interview, it was determined the facility failed to have a diagnosis for the need of a Foley catheter for 1 of 1 (Resident #5) sampled residents with a Foley catheter.

The findings included:

**Medical record review for Resident #5** documented an admission date of 6/18/08 with diagnoses of Dementia, Gastroesophageal Reflux Disease, Atherosclerosis, Anxiety, Hypertension, Osteoarthritis, Bipolar Affect Mixed Mood and Schizophrenia. Review of a physician’s order dated 11/22/10 documented, "...FOLEY CATHETER 18 FR [French] 15CC [cubic centimeters] BULB." There was no documentation of a medical diagnosis for the need of the Foley catheter.

Observations in Resident #5’s room on 12/28/10 at 9:13 AM, 11:35 AM and 1:50 PM and on 12/29/10 at 8:20 AM and 8:55 AM, revealed Resident #5 had a Foley catheter connected to a bedside bag.

During an interview in the Director of Nursing’s (DON) office on 12/29/10 at 11:05 AM, the DON was asked what the medical diagnosis was for the use of the Foley catheter for Resident #5. The DON stated, "...because she [Resident #5] gets so red and excoriated without the catheter."

### F 315

**NO CATHETER, PREVENT UTI, RESTORE BLADDER**

**F 315**

**F 332**

**483.25(m)(1) FREE OF MEDICATION ERROR**
**NAME OF PROVIDER OR SUPPLIER**

PARK REST HARDIN COUNTY HEALTH CENTER

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<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 332 SS=D</td>
<td>Continued From page 6, RATES OF 5% OR MORE</td>
<td>1/27/11</td>
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*The facility must ensure that it is free of medication error rates of five percent or greater.*

This REQUIREMENT is not met as evidenced by:

Based on review of the "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacist, policy review, medical record reviews, observations and an interview, it was determined the facility failed to ensure 1 of 4 nurses (Nurse #2) administered medications with a medication error rate of less than 5 percent (%). A total of 3 errors were observed out of 41 opportunities for error, resulting in a medication error rate of 7.31%.

The findings included:

1. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatability, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "...Humalog...ONSET (in hours Unless Noted)... 15 min [minutes].... TYPICAL DOSING / COMMENT... 15 minutes before or immediately after meals... Novolog... ONSET (in hours Unless Noted)... 15 min... TYPICAL DOSING / COMMENTS... 5- to 10 minutes before meals..."

2. Review of the facility's "Administering Oral Medications" policy documented, "...Always verify the "5 Rights" before administering medications: the right medication; the right dose; the right
F 332 Continued From page 7
resident; the right route; and the right time..."


Observations in Resident #6's room on 12/28/10 at 11:10 AM, revealed Nurse #2 administered 9 units of Novalog insulin and Starlix 60mg to Resident #6. Resident #6 did not receive his lunch tray until 12:05 PM. The administration of the insulin more than 15 minutes before lunch was served resulted in medication error #1. The administration of the Starlix before the time ordered by the physician resulted in medication error #2.

During an interview in the chart room on 12/28/10 at 12:30 PM, Nurse #2 stated, "We give the insulin 30 minutes before meals."

4. Medical record review for Resident #9 documented an admission date of 8/28/10 with diagnoses of Hypertension, Renal Failure, Congestive Heart Failure and Diabes Mellitus. Review of a physician's order dated 11/26/10 documented, "... Accucheck QID [four times a day] with Humalog [Humalog] insulin sliding scale, 150-200 = 3 units..."

Observations in Resident #9's room on 12/28/10
Continued From page 8
at 4:49 PM, revealed Nurse #2 administered 3 units of Humalog insulin to Resident #9. Resident #9 did not receive his meal tray until 5:30 PM. The administration of insulin more than 15 minutes before dinner was served resulted in medication error #3.

431.60(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 biologics 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 biologics 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

DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The Facility will ensure drugs & biologicals used in the facility must be labeled in accordance with accepted professional principals and will include the appropriate accessory and cautionary instructions and the expiration date when applicable. Medications will not be stored past their open/expiration date and stored in locked compartments for example, medication room, medication carts and etc.

This will be monitored and observed by DON/QA on a weekly basis. QA forms will be utilized.

Mandatory in-service will be held on January 27, 2011.
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<td>F 431</td>
<td>Continued From page 9</td>
<td>be readily detected.</td>
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This REQUIREMENT is not met as evidenced by:

Based on review of the "MED-PASS MEDICATIONS WITH SHORTENED EXPIRATION DATES" provided by the American Society of Consultant Pharmacist, policy reviews, observations and interviews, it was determined the facility failed to ensure medications were not stored past their open/expiration date; dated when opened and that medications were stored in locked compartments in 2 of 3 (Medication room and Hall one medication cart) medication storage areas.

The findings included:

1. Review of the "MED-PASS MEDICATIONS WITH SHORTENED EXPIRATION DATES" provided by the American Society of Consultant Pharmacist documented, "...Insulin: Humulin, Humalog, Novolog, Lantus, Apidra... NOTES: Vial expire 28 days after opening/puncturing or after removing from refrigerator, whichever comes first... Tubersol... NOTES: Discard vial in-use after 30 days..."

Review of the facility's "POLICY FOR MEDICATION STORAGE ROOM" documented, "...Med [medication] room will be checked for expired medications, internal and external... All containers will be labeled with expiration date and date opened..."

Observations in the medication room on 12/28/10 at 2:50 PM, revealed the following medications
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<td>F 431</td>
<td>Continued From page 10&lt;br&gt;were stored past their expiration/open date or not dated when opened:&lt;br&gt;a. Two vials of Novolin R insulin not dated when opened.&lt;br&gt;b. A vial of Humulin R insulin, with an open date of 11/26/10.&lt;br&gt;c. A vial of Novolog insulin, not dated when opened.&lt;br&gt;d. A vial of Tubersol (Tuberculin) with an open date of 11/16/10.&lt;br&gt;&lt;br&gt;During an interview in the medication room on 12/29/10 at 2:50 PM, Nurse #2 stated, &quot;They should [referring to the insulin vials] have been dated.&quot;&lt;br&gt;&lt;br&gt;2. Review of the facility's medication storage policy documented, &quot;...Compartments containing medications are locked when not in use...&quot;&lt;br&gt;&lt;br&gt;Observations on hall one on 12/29/10 at 7:34 AM, revealed the hall one medication cart was unlocked, unattended and out of the nurse's view.&lt;br&gt;&lt;br&gt;During an interview on hall one on 12/29/10 at 7:40 AM, Nurse #4 verified the hall one medication cart was unlocked.</td>
<td>F 431</td>
<td>PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY</td>
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<td>F 502 483.75(1)(1)</td>
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<td>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</td>
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<td>This REQUIREMENT is not met as evidenced by:&lt;br&gt;Based on medical record review and interview, it</td>
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<td>ID Prefix Tag</td>
<td>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</td>
<td>ID Prefix Tag</td>
<td>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</td>
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<td>F 502</td>
<td>Continued From page 11 was determined the facility failed to obtain laboratory tests as ordered by the physician for 1 of 14 (Resident #6) sampled residents. The findings included: Medical record review for Resident #6 documented an admission date of 3/1/10 with diagnoses of Hypertension, Psychosis, Diabetes Mellitus, Anxiety, Depressive Disorder, Irritable Bowel and Hyperlipidemia. Review of a physician's order dated 11/22/10 with initial order dated 3/15/10 documented, &quot;...CBC [Complete Blood Count] and CMP [Comprehensive Metabolic Panel] every 3 months...&quot; There was no documentation that the CBC and CMP were completed as ordered in June 2010. During an interview at the nurse's station on 12/29/10 at 8:45 AM the Director of Nursing stated, &quot;The labs for June [2010] were unable to obtain on June 30. They should have been carried over and done. The Doctor wasn't notified.&quot;</td>
<td>F 502</td>
<td>PROVIDE/OBTAIN LABORATORY SVC-QUALIT/ Timely The facility will ensure resident laboratory test will be obtained as ordered per physician in a timely manner. This will be monitored by DON/QA on a weekly basis. Laboratory test forms will be utilized. There will be a mandatory in-service on January 27, 2011.</td>
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