F329 Unnecessary Drugs

- F329 is the most common (QIS) and the 2nd most common (non-QIS) deficiency in Minnesota, cited in 66.2% and 53.1% of surveys
- Nationally, F329 is the sixth most common deficiency, cited in 19.3% of surveys
- MDH issues F329 more frequently than any other State
- New F329 Guidance to Providers and Surveyors went into effect in Minnesota on April 15, 2007

§ 483.25 Quality of care.
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 wellbeing, in accordance with the comprehensive assessment and plan of care.

(l) Unnecessary drugs –

(1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

   (i) In excessive dose (including duplicate drug therapy); or
   (ii) For excessive duration; or
   (iii) Without adequate monitoring; or
   (iv) Without adequate indications for its use; or
   (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
   (vi) Any combinations of the reasons above.

(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that –

   (i) 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

   (ii) 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 by:
Based on observation, interview and record review, the facility failed to identify, assess, and monitor clinical indications for ongoing use of medications for X of XX residents in the sample on medications. Findings include:

**Use of Antipsychotics without Evidence of Monitoring Effectiveness**
- Symptoms that justified the use of the antipsychotic continued, without any review regarding the effectiveness of the medication

**Failed to Identify Adequate Indications for the Increased Dose of Antipsychotics**
- Resident became more sleepy with the increased dose

**Excessive Dose of Acetaminophen**
- Tylenol and Oxycodone/Percocet ordered, combined use exceeded 4,000 milligrams in 24 hours

**Failure to Monitor Sleep Patterns for Insomnia**
- Resident received Ambien/Trazadone/Etc. as needed for insomnia, did not have an assessment of sleep patterns

**Failure to Have a Sleep Assessment, Indication for Use, or Non-Pharmalogical Interventions Prior to the use of Hypnotic Medications Used for Insomnia**

**Failure to Attempt Non-Pharmacologic Interventions Prior to the use of Hypnotic, Analgesic, and/or Antianxiety Medications**
- There was no non-pharmacological interventions developed to reduce the need for pain medication use
- Seroquel
- Sleep Medications

**Failure to Monitor Medications for Effectiveness**
- Residents using a narcotic for pain lacked evidence of monitoring for effectiveness (“the nurses do not always evaluate if the pain medication was effective or not”)
- Antidepressants
- Sleep Medications

**Failed to Justify the use of an Antipsychotic Medication**

**Behaviors not Assessed before Using Antipsychotics**
- Increase in resistive behaviors were treated with an antipsychotic without an assessment to determine possible causative factors for the behaviors

**Lacked Appropriate Monitoring for Adverse Effects of Psychoactive Medications**

**Failure to Ensure Systematic Reviews of Identified Behavior Symptoms for Residents who Receive Psychotropic Medications**

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• The DON stated that target behaviors were not routinely identified and monitored (frequency/intensity) for residents receiving psychotropic medications
• Failure to identify specific target behaviors

**Failure to Identify PRN Medication Administration Parameters**

**Failure to Define Parameters Regarding a Medication**
• Lanoxin (hold if pulse is less than 60 beats per minute)
• Tylenol 500 mg 1-2 tablets (no parameters of when to give 1 versus 2)
• Other prn medications

**Failure to Implement a Process to Identify Potential Adverse Drug Reactions/Interactions**

**Failure to Document Monitoring of Mood Symptoms to Ensure that Antidepressant Medications were Effective**

**Failure to Follow Physicians’ Orders**
• Failed to monitor TSH level following a dose change of synthroid according to physician orders

**Failure to Document the Clinical Need for Continued Use of a Medication**
• Anti-diarrheal
• Prilosec
• Sleep Medications
• Antibiotics

**Gradual Dose Reductions Not Attempted**

**Lack of Physician Response to Recommendations from Consultant Pharmacists**
• Contraindications
• Dose Reductions
• Duplicative Medications
• Dosages
• Questionable efficacy

**PRN Controlled Substance Orders for Pain**
• Versus Tylenol or equivalent

**Failure to Provide Appropriate Monitoring of Medications**
• TT/INR (Prothrombin Time/International Normal Ratio)(Warafin/Coumadin)
• TSH (Levothyroxine)

**Failure to Identify Medications as Contributing to Frequent Falls**
• Resident fell 12 times in five months and was on 8 different anti-hypertensive or diuretic medications

**Failure to Identify Clinical Indications for Use of Antibiotics Used to Treat UTIs**

**Failure to Provide Documented Cognitive/Mental Monitoring for Residents who Receive Cognitive Enhancing Medications**

- Aricept
- Namenda

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F282 Care Provided by Qualified Persons

- F282 is the sixth (QIS) and first (non-QIS) most common deficiency in Minnesota, cited in 41.5% and 53.1% of surveys
- Nationally, F282 is not in the top ten, cited in 13.8% of surveys

§ 483.20(k)(3)(ii) Care Provided by Qualified Persons.
The services provided by or arranged by the facility must be provided by qualified persons in accordance with each resident’s written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow the care plan for X of XX residents in the sample:

**Services not provided per the care plan...**

- Colostomy care per the care plan
- No communication device available per care plan
- Skin care as indicated on the care plan
- Not supervised during toileting per the care plan
- Nutritional supplements not provided as directed on the care plan
- Fluid intake not monitored for dehydration risk as directed on the care plan
- Resident not encouraged to feed self as directed on the care plan
- Oral care and denture care not provided per the care plan
- Wheelchair/Bed alarm was not used as indicated on the care plan
- Wheelchair/Bed alarm was not applied properly
- Food type (finger food) not provided per the care plan
- Gripper socks (resident was at risk for falls) not put on per the care plan
- Peri-Care not provided per the care plan
- Heal Protectors not in place while in bed as directed in the care plan
- Residents not toileted timely per the care plan directives
- Showers not provided as scheduled per the care plan (“short staffing”)
- Residents not repositioned timely per the care plan directives (chairs and beds)
- Passive Range of Motion not provided as directed in the care plan
- Residents not ambulated per the care plan directives
- Oxygen not provided per the care plan
- Catheter care not provided per the care plan
- Grooming (facial hair) not provided per the care plan
- Call light buttons not place within residents’ reach per the care plan
- Transfer belt, two-person lift, slide board, or appropriate mechanical lift not utilized for transfers per the care plan
- Residents not seated at proper height tables per the care plan
- Restorative nursing not provided per the care plan
F272 Comprehensive Assessments

- F272 is the second (QIS) and sixth (non-QIS) most common deficiency in Minnesota, cited in 53.8% and 42.0% of surveys
- Nationally, F272 is not even in the top ten, cited in 12.8% of surveys

§ 483.20 Resident Assessment.
The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(b) Comprehensive assessments—(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
   (i) Identification and demographic information.
   (ii) Customary routine.
   (iii) Cognitive patterns.
   (iv) Communication.
   (v) Vision.
   (vi) Mood and behavior patterns.
   (vii) Psychosocial well-being.
   (viii) Physical functioning and structural problems.
   (ix) Continence.
   (x) Disease diagnoses and health conditions.
   (xi) Dental and nutritional status.
   (xii) Skin condition.
   (xiii) Activity pursuit.
   (xiv) Medications.
   (xv) Special treatments and procedures.
   (xvi) Discharge potential.
   (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
   (xviii) Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete a comprehensive assessment for X of XX residents at risk for...

Pressure Ulcers/Skin

- The assessment did not include methods to protect the skin due to poor circulation
- Lacked a completed comprehensive pressure ulcer assessment – the assessment failed to address cognition, mood, behavior, nutrition, and hydration (it did include everything else)
- No evidence that the residents’ skin integrity after pressure was relieved had been completed
• Incomplete forms, forms not being able to be located,
• No evidence of appropriate pressure reduction to prevent pressure ulcers in the new wheelchair
• No further assessment of the data collected or data not analyzed to determine an individualized repositioning plan
• Resident not on a repositioning plan
• The residents skin risk factors were not reassessed when the resident developed a pressure ulcer
• No seating assessment had been completed
• “We reposition and toilet or check and change the residents on rounds, every two hours”
• The reason staff repositioned the residents every two hours was because it was a “standard of practice”

**Incontinence / UTI**
• The assessment did not determine the pattern of incontinence so that appropriate individualized protocols could be implemented
• Bowel and Bladder Summary did not match assessment or care plan
• No analysis of 3-day voiding pattern
• No evidence of a voiding pattern study had been completed to determine an individualized toileting schedule
• The record lacked an analysis of the data to develop and individualized toileting plan for the resident
• The record lacked evidence that the resident’s bladder function was reassessed after removal of the catheter
• The assessment lacked a physical examination of the perineum
• Incomplete and/or inaccurate bladder assessments
• No toileting plan identified
• Failed to complete a comprehensive urinary assessment when residents experienced recurrent UTIs

**Special Communication Needs**
• No comprehensive assessment of communication needs to develop an individualized approach for communication

**Catheters**
• Lacked a comprehensive bladder assessment and medical justification why a catheter was needed
• Lacked evidence that the risks and benefits of an indwelling catheter had been reviewed or if a plan for removal had been considered

**Special Behavioral Needs**
• Lacked an assessment related to “dangerous behaviors” as indicated on the pre-admission screening referral
• Lacked an assessment related to “picking” behaviors which were affecting a stoma and colostomy bag

**Dental Needs**
• Loose fitting dentures not assessed to meet the needs of the resident
• Resident had decayed/broken teeth and had not been assessed by the facility (no oral assessment) or evaluated by a dentist for treatment since the resident had been admitted (two months)
• Lacked a comprehensive assessment in relation to dental needs or dental follow-up

**Behaviors**
• Resident had an increase in resistive behaviors without an assessment to determine the cause
• Failed to have an initial and periodic comprehensive, accurate, standardized, reproducible assessment for behaviors which included self injurious behavior – lacked an assessment to identify potential causes of behavior and failed to put interventions in place outside of medications to resolve aggressive behaviors
• Lacked an assessment related to anxiety
• Failed to assess for mood and behavior concerns

**Activity Preferences**
• No assessment related to activity preferences, strengths, or desires (a checklist was used but it was not “comprehensive”)
• Lacked an individualized activity program based on a comprehensive assessment (“it’s been a long time since we updated our activity assessment forms”)

**Poor Oral Intake / Nutrition / Weight Loss / Hydration**
• Lacked a comprehensive individualized assessment of fluid requirements so that appropriate protocols and interventions might be implemented (one of the few that did not have any other accompanying F-Tag related to the assessment tag)
• Weights were not accurate – therefore the nutritional assessments were not accurate
• Resident’s difficulty in eating was not identified…..”there was not an assessment that included visualization of the resident while eating”
• Resident identified as having insufficient fluid intake without a comprehensive assessment of her dehydration risk
• Residents with significant weight loss did not have updated comprehensive assessments to address the residents’ clinical conditions and nutritional risk factors
• The residents’ dehydration risk had not been comprehensively assessed to include functional, clinical, or environmental concerns
• The resident was not comprehensively assessed to address the residents fluctuating weights
- There was documented refusals of dental care and reported mouth sores but no comprehensive assessment of oral health and hygiene needs

**Falls / Ambulation**
- No assessment of the causative factors or potentially effective intervention changes
- Multiple falls without any reassessments or alternative interventions
- Ineffective interventions continue to be used (resident removes alarm) Resident states “I never fell before I got here, now I fall all the time”
- Fall interventions were not based upon a comprehensive assessment
- The assessment failed to evaluate the resident’s falls history, fall patterns, and the risk factors to modify approaches to decrease the risk of falls
- Identified as a high risk for falls, yet going home on passes multiple times per week without an assessment regarding safety while at home
- Resident who refuses to ambulate did not have an assessment to develop individualized interventions to prevent a decline in ambulation (looking for “possible causes of the ambulation refusals to determine individualized interventions”)
- Failed to comprehensively assess residents who were identified as having skin that bruised easily

**Pain**
- The MDS had not identified any pain concerns (resident was experiencing pain that had been identified by Therapy and other staff – but not addressed in the comprehensive assessment nor had any interventions been done to relieve or decrease the discomfort
- Lacked a comprehensive pain assessment to determine interventions to promote comfort (DON stated that the facility does not utilize any pain assessment forms)
- RAP did not address pain
- Residents’ pain was not comprehensively assessed
- The assessment form was blank in the following areas: pain frequency, pain relief – or worsened by changes in routine, non-medical treatments used, and prn medications utilized
- Lacked evidence if the resident’s pain has been assessed in relation to receiving ROM, if pain medications were given prior to ROM for pain control, and /or if non-pharmaceutical interventions had been attempted and consistently implemented

**Restraints**
- One Piece Outfit with Zipper In Back, considered a restraint….resident attempts to undress at times and will occasionally smear BM….non-pharmaceutical interventions are attempted prior to meds.…”Review of the Fall/Restraint/Device Risk Assessment did not address the use of one piece outfits”

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• Alarmed seat belt in place, as well as a wheelchair “chirper” alarm….lacked a comprehensive assessment that identified why the devices were still necessary (resident removes the devices and continues to fall)
• Lacked a comprehensive assessment for ongoing placement on a locked/secured dementia unit
• Lacked an assessment to ensure the resident was being restrained for the lease amount of time necessary (tray table)
• No assessment determine if the resident was or was not able to release the seat-belt independently

**Contractures / Range of Motion / Positioning**
• Failed to comprehensively assess residents for contractures in order to maintain current functioning levels
• Did not address the loss of movement objectives or interventions
• Had limitations in ROM and was not assessed to receive the necessary services to prevent further decline in ROM
• Confusion between Therapy, Nursing, and Restorative Nursing responsibilities
• No comprehensive positioning assessment while in the wheelchair (feet were dangling and unsupported)

**Sleep**
• Failed to complete a sleep assessment to ensure the resident required medication for sleep
• The facility failed to analyze the sleep data to determine if the sleep medication was necessary or effective
• The facility failed to re-assess a resident’s difficulty in sleeping before starting a sleep medication or trying non-pharmaceutical approaches
• Failed to complete assessments for residents with insomnia
• Failed to assess medications used for insomnia

**Safety – Bed Rails & Other**
• Lacked comprehensive assessments for the utilization of bed rails
• Lacked comprehensive individualized assessment for the safety of bed rails that were utilized for repositioning needs
• The record lacked the assessment of the “safety” of the bed rails
• The resident lacked an assessment to warrant the safe use of side rails (no problems with the side rails noted)
• Lacked a comprehensive assessment for the use of side rails in regards to the safety of the rails that were implemented for the resident as a mobility aide (excessive space between the vertical rails of the side rail was identified as well as excessive space between the rails and the mattress) – Resident states “the mattress moves”
• Use of bed rails when staff stated the resident is dependent upon staff for all mobility and repositioning (documents stated the resident used the siderails for mobility)

• The facility failed to assess the safety of leaving the resident on the commode alone/unattended

• Failed to assess for the risk of entrapment in side rails

• Lacked a comprehensive individualized assessment for safety of bed rails used form repositioning

**Respiratory**

• Failed to have a comprehensive respiratory assessment and utilized oxygen therapy (oxygen was being used prn without a physician’s order)

**Secured Units**

• Failed to assess the need to be placed in a secured unit

• Continuing Need to be Located on a Secure (Locked) Unit…Failed to reassess, each quarter, the need for being on the locked unit (residents expressed desire to not be on the locked unit)

**Other**

• Lacked comprehensive assessments related to triggered areas identified on the RAI

• Undated and unsigned RAPs

• The RAPs lacked an assessment of the data that included the nature of the problem, causes, complications and risk factors and justification for proceeding or not proceeding to the care planning process

• Failed to comprehensively assess residents’ status at the time of an annual or new admission MDS

• Lacked assessment related to interests and activities

• No evidence of an assessment related to a central catheter (hemodialysis site) and related medical needs/interventions

• Lacked an assessment related to personal hygiene
F 323 Accidents & Supervision

- F323 is the third (QIS) and fifth (non-QIS) most common deficiency in Minnesota, cited in 50.8% and 47.7% of surveys
- Nationally, F323 is the most common deficiency, cited in 36.6% of surveys
- New F323 Guidance to Providers and Surveyors went into effect in Minnesota on October 1, 2007

§ 483.25 Quality of care.
(h) Accidents. The facility must ensure that –
(1) The resident environment remains as free of accident hazards as is possible; and
(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to

- Assess the safe use of XXXX
- Failed to investigate XXXX
- Failed to develop interventions to XXXX
- Failed to implement interventions…
- Failed to…

X of XX residents identified in the sample. Findings include…

Falls (67% of these deficiencies were based on falls or falls prevention)

- Many interventions in place, but residents keep falling (interventions in place appear to be ineffective), with no further interventions documented or attempted
- Multiple falls without adequate assessment to determine possible appropriate interventions to minimize the risk of falls

Bed Systems/Unsafe Siderails/Entrapment Risks

- Use of specialty mattresses that do not fit the bed, permitting entrapment zones
- Replacement (non-original) mattress that do not fit the bed, permitting entrapment zones (mattresses were too short or too narrow)
- Gaps beyond the FDA recommend measurements between siderail bars, between the headboard/footboard and mattress, and between the mattress and siderail
- Siderails that are loose and can be pulled away from the bed, creating excessive gaps

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Siderails used without assessments to determine the risks of entrapment

The facility had not assessed any siderails to determine safety or entrapment risks

The facility had not assessed that siderails in use met the FDA guidance to reduce potential entrapment

**Unsafe Storage of Chemicals**

Chemicals unlocked in areas accessible to residents (tub rooms, janitor’s closets, utility rooms, beauty shops, etc.)

**Misc. Equipment/Unsafe Use of Equipment**

Using mechanical lifts that are not matched to the residents needs/limitations (using an Easy-Stand lift on a resident who is unable to bear weight)

Permitting an unmanned hot steam table to come into contact with residents (facility failed to follow their own policy/procedure)...Unsupervised steam table accessible to confused residents

Water temperature in resident bathrooms were measured at 120 degrees or more...no system in place to routinely monitor, audit, and adjust water temperatures

Different/Wrong type of lift used than identified in the care plan (PAL, Sit-to-Stand, EZ Stand, Hoyer or equivalent, etc.)

Call lights not within reach of the residents

**Interventions not Carried Out**

Bed/Chair/Wheelchair alarm required per assessment and care plan, but not in place

Bed alarms not attached to the beds

Chair alarms not attached to the chairs

Transfer belts not used per assessment, care plan and policy

Gait/Walking belts not used per assessment, care plan and policy

Two person transfers conducted by one person
**Smoking**

- Residents smoking in non-smoking areas
- Residents who require observation/supervision when smoking were observed to be smoking without observation/supervision
- Burn holes noted on the pants of residents
- Resident smoking while using oxygen (staff were aware of this)
F279 Comprehensive Care Plans

- F279 is the fifth (QIS) and sixth (non-QIS) most common deficiency in Minnesota, cited in 44.6% and 39.5% of surveys
- Nationally, F279 is the fifth most common deficiency, cited in 22.8% of surveys

§ 483.20 (d) Use of Assessments
The facility must use the results of the assessments to develop, review and revise the resident’s comprehensive plan of care.

§ 483.20 (K) Comprehensive Care Plans
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 following:

(i) The services that are to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and

(ii) 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 by:

Based on observation, interview, record review, and policy review, the facility failed to develop a plan of care that included measurable objectives for X of XX residents in the sample. Findings included care plans that did not address….

- Safety related to self-administration of medications – Inhalers
- Integrated plan of care with Hospice Providers being utilized
- No measurable objectives in the care plan
- Oral/Dental needs
- Dialysis services
- The need for eyeglasses
- Nutritional needs/risk
- Braces or special personal equipment
- Falls and being at risk for falls
- Range of Motion
- Repositioning
- Safe toileting
- Behaviors/Mood
- Assessment for psychotropic medications
- Sleep management
- Bathing

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• Hand Hygiene
• Adjustment to living in a long-term care setting
• Alcohol problems/issues
• Use of siderails on the bed
• Smoking when at risk for burns
• Parameters for use of restraints
• Pain
• Fluid restrictions
• Hydration
• Activities interests, hobbies, needs, and preferences
F315 Urinary Incontinence

- F315 is the eighth (QIS) and 3rd (non-QIS) most common deficiency in Minnesota, cited in 38.5% and 50.6% of surveys
- Nationally, F315 is the ninth most common deficiency, cited in 18.3% of surveys
- MDH issues F315 more frequently than any other State
- New F315 Guidance to Providers and Surveyors went into effect in Minnesota on November 7, 2005

§ 483.20 Resident assessment.
The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that –

(1) 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

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide services to X out of XX resident in the sample to:
- Restore as much bladder function as possible
- Identify/Prevent/Treat Urinary Tract Infections
- Remove catheters that are not supported by a clinical condition

Staff Timing of Checking/Toileting/Changing (received appropriate services)
- Resident XX did not receive timely assistance with toileting (followed by a surveyor observation of the time frame between checking or toileting – up to 6 hours 15 minutes)
- Failed to provide timely incontinence cares
- Failed to provide timely assistance with toileting
- At no time during the observation were staff observed to ask residents if they needed to use the bathroom
- Residents did not receive appropriate incontinence care during the night shift
Assessment Process

- Resident XX did not have a comprehensive bladder assessment completed after the onset of urinary incontinence
- Resident XX lacked a comprehensive assessment of his continence status
- There was no evidence that a bowel and bladder assessment was completed
- Failed to assess urinary incontinence risk factors and conditions
- Failed to reassess after readmission from the hospital (change in urinary incontinence)
- Failed to reassess for urinary incontinence after a change in urinary continence was noted
- Lacked a comprehensive urinary assessment that included perineal exam and comprehensive analysis of data
- Failed to identify the type of incontinence so that individualized protocols could be implemented

Developing Individualized Toileting Plans

- No documentation of any individualized toileting plan
- Resident XX lacked a comprehensive individualized incontinence assessment to determine appropriate toileting intervals for the resident
- Did not have an individualized plan of care developed for incontinence care which had been based on analysis of a 3 day voiding diary

Failure to Follow Physician’s Orders

- Resident XX lacked implementation of urologist recommendations regarding toileting and fluid intake (nurse remembered that the resident had seen a urologist, but did not recall implementing any of the urologists recommendations)
- Physician ordered Macrobid for lab supported UTI, facility did not give the medication for over a day after it was ordered (med was ordered an delivered timely, just not provided timely)

Identify/Treat/Prevent UTIs

- The facility treated residents XX for UTIs without adequate indications that an infection was present
• Failed to ensure residents has documented symptoms of infection prior to antibiotic therapy for suspected UTIs (“staff had not requested further information/clarification from the physician as to why antibiotic treatment had been ordered with no apparent previous symptoms”) (ordered during a physicians office visit)

• Resident XX developed a UTI and a vaginal yeast infection that was not treated timely

• Lacked a comprehensive assessment for his recurrent UTIs

• Failure to follow facility policy when identifying and treating suspected UTIs

• Asymptomatic UTIs were treated with antibiotics (no clinical signs or symptoms)

• The facility failed to ensure that 3 clinical signs and symptoms of a UTI were identified prior to treatment

• Was not reassessed for her risk to develop UTIs after the discontinuation of prophylactic antibiotics

Catheters
• Failed to assess the need for an indwelling catheter for X of XX residents

• The assessment failed to identify any diagnosis or indicators for the use of an indwelling catheter

• The progress note identified the resident wanted to keep the catheter but failed address justification for it’s use (the facility done a good job documenting that it had provided education to the resident about the risks of UTIs related to the use of the catheter)

• These are usually related to failing to address a catheter 4-10 days after return from a hospitalization…”interview with the DON confirmed that there had been no attempts to remove the catheter since the resident was hospitalized”.

• Suprapubic Catheters – Failed to provide appropriate treatment and services to prevent UTIs (bags dragging on the floor, improper use of handwashing/gloves, etc.)

• Leaking Suprapubic catheter, without a reassessment as to the cause of the leakage

• There was not plan for removal nor had a trial removal been tried
• The plan of care lacked approaches to manage and care for the indwelling catheter

• Catheter care was not provided in accordance with appropriate infection control techniques or facility policy (tubes touching the floor, bags on the floor, handwashing, gloving, improper tube cleaning, etc.)

**Conflicts Between Assessment, Data Gathering Tools, Nurses Notes, and Care Plan**

• Failed to offer the opportunity to use the bathroom or commode (as identified in the care plan) just changed incontinence product

• Care plan says two different things…Toilet every 2.5 – 3 hours, and also stated toilet in the AM when assisted up for the day, after meals, and a HS and prn

• A review of the record indicated that there were two different recommendations given as to how often the resident was to be toileted

• Resident care plan did not address continence

**General**

• Incomplete Bowel and Bladder sheets/diaries (“mostly left blank”)

• Failure to provide correct perineal cleansing

• Failure to provide appropriate assistance with personal hygiene as indicated

• The RAPs lacked an assessment of the data that included the nature of the problem, causes, complications and risk factors and justification for proceeding or not proceeding to the care planning process

• Failed to comprehensively assess residents’ status at the time of an annual or new admission MDS

• Staff told resident it was OK to void in a brief, rather than be brought to the bathroom (resident was aware of his need to void)
§ 483.25 Quality of care.
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 wellbeing, in accordance with the comprehensive assessment and plan of care.

(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that —

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide care and services to promote healing or minimize development of a new pressure ulcer for X of XX residents identified by the facility at risk for pressure ulcer development. Findings include…

Timely Repositioning
- Resident XX was observed from XX:XX pm to XX:XX pm as she sat in her chair/wheelchair/recliner. The resident was not repositioned for a time period of XX:XX. At that time the resident was gotten up and taken to toilet/bed and was found to have a reddened area/open area/bright red area/etc. The residents skin assessment and care plan identified that the resident was to be repositioned every XX:XX.

- The facility failed to insure that individualized repositioning schedules were developed for X or XX residents (two-hour standardized schedules)

Inconsistent Information
- The Care Plan indicated the resident was to be repositioned every XX:XX, but the Assessment (including tissue tolerance form) indicated a suggested repositioning period of every XX:XX, or the facilities repositioning schedule listed a different timeframe
• Hospice care plan interventions/repositioning different that the facility’s approaches

• Physician’s repositioning orders different than care plan

**Failure to Assess or Reassess**

• Resident X who had recurrent pressure ulcers, had not been consistently reassessed following the development of each pressure ulcer

• Resident X who was identified as at serious risk for pressure ulcers lacked a comprehensive skin assessment

• Incomplete assessments

• No reassessment upon change of skin, incontinence, or mobility status

**Failure to Provide Appropriate Interventions**

• The facility failed to consistently implement interventions to promote healing and prevent progression of wounds (cushions, wheelchairs, mattresses, heal pads, treatments, dressing, repositioning, perineal care, skin barrier cream, heals raised off the bed,

• Failure to assess a device (seating surface, mattress, etc.) to ensure the device was providing adequate pressure relief to promote healing of current pressure sores and prevent the development of new ones

• Failure to use an intervention properly (multiple pads or eggcrate pads on top of a pressure relieving mattress, specialized wheelchair cushions used upside-down, etc.)

**Tissue Tolerance**

• The resident was identified at risk for pressure ulcers, but his/her skin was not assessed for individual ability to sit or lay down without causing pressure areas on his/her skin

**Failure to Observe, Report, or Document**

• The surveyor observed a reddened area/open area/blister/etc. that was not noted anywhere in the chart, assessments, etc.

• Physicians not notified of new open areas or significant changes in skin condition

• Documentation failed to provide any measurements of the pressure ulcer

• Mis-staged ulcers
• Treatments conducted without updating the documentation or wound status

**Inadequate Offloading**

• The resident was repositioned quickly, without an appropriate period of time for the tissue to offload pressure

• Transferred via a sling mechanical lift, with no opportunity for offloading
F371 Sanitary Conditions
• F371 is the seventh (QIS) or eighth (non-QIS) most common deficiency in Minnesota, cited in 51.5% and 38.3% of surveys
• Nationally, F371 is the second most common deficiency, cited in 35.1% of surveys
• MDH begin implementing new F371 Federal Guidance on October 1, 2008.

§ 483.35(i) Sanitary Conditions.
The facility must -
§ 483.35(i)(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities.
§ 483.35(i)(2) Store, prepare, distribute, and serve food under sanitary conditions.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to identify, assess, and monitor clinical indications for ongoing use of medications for X of XX residents in the sample on medications. Findings include…

Kitchen Cleanliness
• Steam table with dried food on it
• Garbage cans without covers
• Dirty meat slicers, blenders, microwaves, mixers
• Dirty air vents and fans
• Dusty shelves, vents, pipes, etc.
• Pots with blackened and pitted areas
• Interior of ice machines had not been cleaned per manufacturer’s recommendations
• Sticky kitchen floors
• Designated handwashing sinks with food debris in them
• Pans that no longer had their “original finish”

Storage Issues
• Food not stored in its original packaging was not labeled or dated
• Food stored beyond expiration dates
• Ice buildup on the bottom of freezers
• Butter containers not labeled
• Scoops stored in dry storage bins
• Pans and steam table pans put away with moisture still on them
• Scoops put away with moisture still on them
• Cereal bowls not allowed to air dry before being stored
• Items stored on the floor in a kitchen storage room

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• Ice cream containers that were opened were not dated to show when they were opened

**Other Issues**
• Staff unable to demonstrate the proper technique for testing the water for adequate chemical sanitation in a three-compartment sink
• Refrigerator and Freezer temperatures were not documented or logged
• Staff without hairnets, or hairnets that did not cover all their hair (bangs, long hair, etc.)
• Staff buttered bread with bare (ungloved) hands
• Inadequate food holding/serving temperatures (less than 135 degrees F)
• Kitchen floor with gouges and/or missing tiles
• Kitchen staff failing to wash hands prior to starting meal service
• Kitchen staff with gloved hands touching food, then equipment, without washing hands and re-gloving.
F465 Other Environmental Conditions

- F465 is the seventeenth (QIS) and ninth (non-QIS) most common deficiency in Minnesota cited in 20.0% and 35.8% of surveys
- Nationally, F465 is not in the top ten, cited in 11.4% of surveys

§ 483.70(h) Other Environmental Conditions.
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to…

Building Maintenance Issues (non-kitchen)

- Chipped Paint
- Peeling wallpaper
- Rough edges of chairs, doors, etc.
- Missing tile grout
- Stained tile grout
- Missing or Chipped floor or wall tiles
- Dirty Windows
- Stained Carpet
- Boxes in storage rooms directly on the floor
- Sharp edges on radiators
- Call–light strings in bathrooms discolored (dark yellow)
- Dirty fans and/or airconditioners
- Stained furniture
- Dusty Vents
- Water stained ceiling tiles
- Torn, bent, or missing plastic door guards
F280 Care Planning

- F280 is the ninth (QIS) and 11\textsuperscript{th} (non-QIS) most common deficiency in Minnesota, cited in 36.9\% and 27.2\% of surveys
- Nationally, F280 is cited in 12\% of surveys

§ 483.10(d)(3) Care Planning.
The resident has the right to – unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State – participate in planning of care and treatment or changes in care and treatment.

§ 483.10(k)(2)
A comprehensive care plan must be –

(i) Developed within 7 days after the completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a RN with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and. To the extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative, and;

(iii) Be periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to review/revise the plan of care for X of XX residents in the sample.

Examples of circumstances that occurred that did not result in a review or revision of the care plan...

- Bed alarms, special mattresses were being used per progress notes, but were not on the care plan (post falls)
- Discontinuation of tube feeding (to oral feeding) not addressed on the care plan
- Urinary continence status not updated on the care plan
- Change to accommodate safe smoking procedures not addressed on care plan (oxygen in use)
- Hospice status not addressed on the care plan
- Plan(s) to deal with excessive falls was not addressed on the care plan
- Change in diet orders not addressed on the care plan
- Change in ability to self-administer meds not addressed in the care plan
- Change in hemodialysis schedule not addressed in the care plan
- Change in ROM and contracture formation not addressed in the care plan
- Change in repositioning schedule not addressed in the care plan
- Change in condition not addressed in the care plan (pain control after injuries)
- Change in the use of bedrails not addressed in the care plan
• Change in “dining abilities” or weight loss not addressed in the care plan
F428 Drug Regimen Review

- F428 is the fourth (QIS) and twenty-third (non-QIS) most common deficiency in Minnesota, cited in 49.2% and 14.8% of surveys
- Nationally, F428 is not in the top ten, cited in 8.7% of surveys

§ 483.60(c)(1) Drug Regimen Review.
The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§ 483.60(c)(2) Drug Regimen Review.
The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview…Findings include:

**Drug Irregularity**

- Receiving Prilosec after Prednisone had been discontinued (appetite stimulation)
- Use of psychoactive medications
  - Mood monitoring for Trazodone
  - Mood monitoring for Prozac
  - Mood monitoring for Celexa
  - Mood/Behavior monitoring for Seroquel
  - Mood monitoring for Paxil
  - Mood monitoring for Lexapro
  - Mood monitoring for Remeron
  - Mood monitoring for Cymbalta
- PRN Tylenol used without identified parameters for use
- Greater than 4 grams of acetaminophen in 24 hours
- No target behaviors or monitoring for behaviors with Alprazolam
- No quantitative monitoring for efficacy with Clonazepam

**Continued Need for Medications**

- Prilosec for greater than 6 months
- Prophylactic use of antibiotics (Macrodantin, Bactrim for UTIs)
- Zoloft (no depression indicators – resident denied depression, no dose reduction attempt)
- Effexor XR – lacked clinical indications for continued use
- Haldol – lacked justification for continued use
- Three different medications for hypertension without justification for the use of multiple medications
- Prevacid without documentation for continued use
- Rationale was not provided for the continued use of Risperdal
- Two medications for sleep without justification or monitoring sleep patterns
Other

- No non-pharmacological interventions attempted for sleep
- Medication errors regarding sliding scale insulin had not been identified
- Lacked parameters for the use of Ativan for monitoring and effectiveness
F274 Comprehensive Assessments after a Significant Change in Condition

- F274 is the fifteenth (QIS) and tenth (non-QIS) most common deficiency in Minnesota, cited in 21.5% and 33.3% of surveys
- Nationally, F274 is not even in the top ten, cited in 3.4% of surveys

§ 483.20(b)(2)(ii) Comprehensive Assessment after a Significant Change in Condition.

A facility must conduct a comprehensive of a resident as follows:

(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition. (for purposes of this section, a “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and required interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility did not comprehensively reassess X of XX residents in the sample with a significant change in condition…

Top Three Changes in Condition that did not Trigger a New Assessment
- Decline in bladder function/urinary continence status
- Change in falls status (assessment to determine the causative factors in order to determine the appropriate interventions to minimize the risk of falls)
- Change in skin condition or pressure ulcer

Other Changes in Condition that did not Trigger a New Assessment
- Weight loss (5% or more in 30 days, or 10% or more in 180 days)
- Declined ambulation/mobility status
- Change in elopement risk
- Change in sleep/insomnia patterns
- Change in mood
- Significant change in 3 areas/ADLs
- Change in dressing and/or personal hygiene skills
- Change in hydration status
- Change in bed mobility
- No longer needed a secured unit (had become immobile)
- Change in thinking/decision-making/cognition
- Hospice

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**K50 Fire Drills**

- K50 is the most common K-Tag in Minnesota, cited in 30% of surveys
- Nationally, K50 is the seventh most common K-Tag, cited in 17% of surveys

Fire drills are held at unexpected time under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 p.m. and 6:00 a.m. a coded announcement may be used instead of audible alarms.

18.7.1.2, 19.7.1.2

This requirement is NOT MET as evidenced by…

**Example**

- Staff could not differentiate between an alarmed door and a fire alarm
- Facility failed to vary the times of the fire drills on each shift
- Missing fire drill documentation
- Staff did not know the proper procedures when the fire alarm was sounded
- Fire drills not conducted on each shift
- Staff do not sign-in at drills, making it impossible to know who participated in the drills
K52 Fire Alarm System

- K52 is the second most common K-Tag in Minnesota, cited in 24% of surveys
- Nationally, K52 is the tenth most common K-Tag, cited in 14% of surveys

A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system shall have an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72.9.6.1.4.

This requirement is NOT MET as evidenced by…

Example

- Fire alarm testing and maintenance documents were not available for review
- No documentation showing that the off-site fire alarm notification system had been tested during fire alarms
- Smoke detectors not installed in all required areas
- Smoke detectors installed in wrong areas (within 3 feet of an air supply/return vent)
- No sensitivity testing for smoke alarms
- No smoke detector within 5 feet of the fire alarm and DACT panels
-
**K38 Accessible Exits**

- K38 is the third most common K-Tag in Minnesota, cited in 24% of surveys
- Nationally, K-38 is the fifth most common K-Tag, cited in 21% of surveys

Exit access is so arranged that exits are readily accessible at all times In accordance with 7.1.  18.2.1, 19.2.1

This requirement is NOT MET as evidenced by…

**Example**

- Magnetic locking exit doors did not have manual un-locking/re-locking devices
- Uneven pathways leading from exit doors
- Exit doors difficult to open
- Exit door hardware not mounted between 34” and 48” from the floor
- Unable to determine if all cognitively intact residents understood how to open a magnetically latched door
- Proper signage missing at delayed egress doors
- Surface bolt-type locks used
**K29 Hazardous Areas**
- K29 is the fourth most common K-Tag in Minnesota, cited in 23% of surveys
- Nationally, K-29 is the second most common K-Tag, cited in 29% of surveys

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 Inches from the bottom of the door are permitted. 19.3.2.1.

This requirement is NOT MET as evidenced by…

**Example**
- Rooms converted from sleeping rooms to storage rooms do not have self closing ¾ hour fire doors on the corridor nor adjoining bathrooms
- Self closing doors to hazardous areas (kitchen, laundry rooms) were held open
- Missing latches, or latches that did not positively latch
- Self-closing mechanisms not working properly
- Penetrations through smoke barriers not sealed
K56 Automatic Sprinkler Systems

- K56 is the fifth most common K-Tag in Minnesota, cited in 23% of surveys
- Nationally, K56 is the eighth most common K-Tag, cited in 16% of surveys

There is an automatic sprinkler system installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devise and equipment, to provide complete coverage of all portions of the facility. The systems shall be maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It shall be a reliable, adequate water supply for the systems. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system.

18.3.5

This requirement is NOT MET as evidenced by…

Example

- Sprinkler heads obstructed by ceiling tiles
- No exterior waterflow alarm
- Elevator areas were not sprinklered
- Storage within 18 inches from sprinkler heads
- Sprinkler heads do not have escutcheon plates installed
- Gauge on the fire sprinkler system had not been replaced or recalibrated (must be every 5 years)
- Walk-in cooler did not have sprinkler protection
- Rusted sprinkler heads
- Lint build-up on sprinkler heads
- Cubical curtains did not provide 18” clearance from sprinkler heads
- Not all areas required to be sprinklered were sprinklered
- Ceiling tiles not in place
K67 HVAC
- K67 is the sixth most common K-Tag in Minnesota, cited in 20% of surveys
- Nationally, K67 is not in the top ten K-Tags issued

Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.

18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2

This requirement is NOT MET as evidenced by…

Example
- Using a corridor as a plenum – annual waiver applied for
- Fire/Smoke dampers in the HVAC had not been inspected, tested, or maintained within the past 4 years