STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525725	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACE LUTH COMMUNITIES-PRAIRIE POINTE REHAB SUITES	286 N WILLSON DR ALTOONA, WI 54720

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F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not give a written notice of duration of bed hold at the time of transfer to the hospital for two of four residents (R) reviewed for hospitalization s (R22, R7). R22 had three hospitalization s over the past four months and no bed hold notice was given prior to transfer to the hospital. R7 had transferred to the hospital and no bed hold notice was given. Findings include: The facility policy for Temporary Bed-Hold states, in part Federal regulations require that a resident and/or responsible party be informed in writing of Prairie Pointe's bed-hold policy prior to leaving for a hospitalization or other leave of absence (LOA) in which the resident is out of the facility over midnight (12:00 AM.) A bed-hold form must be signed to document this decision . R22's Minimum Data Set assessment, dated 02/13/20, indicated R22's Brief Interview for Mental Status (BIMS) score was 14. This indicated R22 was cognitively intact and able to make own health care decisions. Record review identified R22 was transferred to the hospital, and admitted for respiratory concerns on 11/30/19, 1/3/20, and 3/2/20. No written bed hold documents were identified on R22's medical record for any of those dates. On 03/10/20 at 2:33 PM, Surveyor interviewed Director of Nursing (DON) B about the facility bed hold process when residents are transferred to the hospital. DON B explained there is a bed hold form in the transfer packet. The nursing staff fills that out with the resident, if they are their own person, at the time of the transfer. If the resident is not able to make their own health care decisions, the staff tries to call the resident's representative and get verbal permission for the bed hold at the time of the transfer. That verbal permission is documented in the resident's medical record. DON B will look for bed hold documentation for R22's three recent hospitalization s. On 03/11/20 at 1:45 PM, Surveyor interviewed DON B who stated there was no written bed hold notification for R22's three hospitalization s. DON B agreed there should be a written bed hold document completed at the time of transfer to comply with regulations and the facility policy. 2.) Review of R7's medical record documented on 11/21/19 R7 was transferred to the hospital and was admitted with a return to the facility on [DATE]. Surveyor was unable to identify in R7's medical record that a bed hold notice was given to R7's Power of Attorney (POA). On 03/09/20 at 8:56 AM, Surveyor interviewed R7's POA asking if a bed hold notice was given at the time of R7's transfer to the hospital. POA indicated could not recall but could have talked about it 24 hours later. POA indicated she was not at the facility when R7 was transferred and the facility had called to let POA know about R7's transfer. On 03/11/20 at 2:19 PM, Surveyor interviewed DON B about the bed hold notice for R7. DON B identified there was not a bed hold notice given at the time of transfer. Notice is given at the time of admission. DON B indicated the Nursing Home Administrator stated the facility will automatically hold their bed unless they decide not to have the facility hold the bed.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did no develop a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical needs. This occurred for 4 of 13 residents' care plans reviewed (R10, R19, R6 and R28). The facility did not develop a comprehensive person-centered care plan for bleeding risks for R10, R19, R6 and R28 which are on the medication [MED]. This is evidenced by: 1. Review of R10's medical record documented current diagnosis, in part: [MEDICAL CONDITION] and [MEDICAL CONDITION] following cerebral infarction affecting left non-dominant side. Review of physician medication orders document R10 receives [MED] 2.5 mg, 2 times daily, (medication to block blood clots to form), and [MED] 60 mg delayed release 1 time daily (medication is a selective serotonin and [MEDICATION NAME] reuptake inhibitor antidepressant (SSNRI). Review of the medication guide for [MED] read in part: .[MED] can cause bleeding which can be serious and rarely may lead to death. This is because [MED] is a blood thinner medicine that reduces blood clotting. You may have a higher risk of bleeding if you take [MED] and take other medicines that increase your risk of bleeding, including: aspirin or aspirin-containing products, long-term (chronic) use of nonsteroidal anti-[MEDICAL CONDITION] drugs (NSAIDs), [MEDICATION NAME] sodium ([MEDICATION NAME], JANTOVEN), any medicine that contains [MEDICATION NAME], selective serotonin reuptake inhibitors (SSRIs) or serotonin [MEDICATION NAME] reuptake inhibitors (SNRIs) or other medicines to help prevent or treat blood clots . Review of R10's care plans identified a care plan for risk of increased bleeding was not developed. On 03/11/20 at 10:06 AM, Surveyor interviewed Registered Nurse (RN) C and Director of Nursing (DON) B asking if a care plan was developed for use of [MED] with higher risk of bleeding. RN C indicated a care plan was not developed. 2. Review of R19's medical record documented current diagnoses, in part: [MEDICAL CONDITION] and [MEDICAL CONDITION] following unspecified [MEDICAL CONDITION] disease affecting left non-dominant side; [MEDICAL CONDITION], hypertensive heart and [MEDICAL CONDITION]. Review of physician medication orders document R19 receives [MED] 5 mg 2 times daily (medication to block blood clots to form) and [MEDICATION NAME] 10 mg 1 time daily (selective serotonin reuptake inhibitor (SSRI) antidepressant). Review of R10's care plans identified a care plan for risk of increased bleeding was not developed. On 03/11/20 at 9:44 AM, Surveyor interviewed RN C and DON B asking if a care plan was developed for use of [MED] with higher risk of bleeding. RN C indicated a care plan was not developed. 3. R6 was prescribed an anticoagulant medication, [MED]. The facility did not develop a comprehensive care plan addressing R6's risk for bleeding or other potential side effects related to use of anticoagulant medication. R6 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. R6's physician's orders [REDACTED]. R6's Comprehensive Care Plan did not indicate R6 was on an anticoagulant medication which increased risk for bleeding and bruising. Comprehensive Care Plan did not include goals and interventions to prevent or identify adverse effects of anticoagulant medication. On 3/11/2020 at 12:58 PM, Surveyor interviewed DON B and RN C, who is the Minimum Data Set (MDS) Coordinator. Surveyor asked if the facility had a Care Plan in place for R6's use of anticoagulant medication. RN C stated, no, that she was working on putting a Care Plan together at this time. On 3/11/2020 at 1:47 PM, RN C delivered to Surveyor a copy of Care Plan, .R6 is at risk for bleeding related to use of [MED]; effective date: 3/11/2020. 4. R28's [DIAGNOSES REDACTED]. On 02/21/20, R28's Brief Interview for Mental Status (BIMS) was 6, indicating severe

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

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) cognitive impairment. On 03/11/20 at 9:41 a.m., Surveyor observed facility staff administer medications to R28, via a gastrostomy tube. The medication included [MED] 2.5 milligrams. At 1:16 p.m., Surveyor reviewed R28's plan of care. The plan of care did not instruct the facility staff to monitor for side effects secondary to the use of [MED] such as excessive bruising and bleeding. At 1:17 p.m., Surveyor interviewed DON B. DON B stated, R28's plan of care does not include [MED] precautions and it should.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not maintain acceptable parameters of nutritional status for usual body weight or desirable body weight range. This occurred for one resident of three reviewed for nutrition (R19). R19 had a 7.59% weight loss in one month and 13.42% weight loss within 3 months. R19 was not assessed for the weight loss and new interventions to maintain current weight or prevent further weight loss were not developed. This is evidenced by: Surveyor reviewed R19's medical record which documented current diagnoses, in part: [MEDICAL CONDITION] and [MEDICAL CONDITION], dysphagia, cognitive social or emotional deficit following cerebral infarction, [MEDICAL CONDITION] and [MEDICAL CONDITION] stage 3. R19 was admitted to the facility on [DATE]. On 11/06/19, was R19's first documented weight of 197.5 pounds. R19's weights were recorded as follows: 11/7/19: 181.5 pounds [DATE]: 185 11/9/19: missing weight 11/10/19: 181 11/11/19: 181 11/12/19: 189 with no re-weigh or notation of an 8 pound weight gain, 11/13/19: 172.5 with no re-weigh or notation of weight difference, No documented weight 11/14/19 through 11/17/19. 11/18/19: 186 11/19/19: 183 11/30/19: 181 Weights continue daily with no evaluations with weight discrepancies. On 11/06/2019, R19 weighed 197.5 pounds. On 12/06/2019, R19 weighed 182.5 pounds, which is a 7.59% loss in one month. On 11/06/2019, R19 weighed 197.5 lbs. On 02/06/2020, R19 weighed 171 pounds, which is a 13.42% loss in 3 months. On 03/08/2020, R19 weighed 167 pounds which identifies a continued weight loss since admission. Review of care plan for nutrition documented a general diet order with mechanical soft foods and nectar thickened liquids, offer snacks between meals and assistance or cues with meals as needed. Review of the Minimum Data Set ((MDS) dated [DATE] documented no weight loss. Review of nurse's notes document, in part: 11/14/19: R19 triggered for having weights that aren't consistent. This may be a documentation issue as staff monitor R19 with each meal and she is consuming 50-75% of food and fluids with each meal. R19 is weighted daily. 02/05/20 Resident was assessed today for her quarterly nutritional assessment. Current diet order is Cardiac with mechanical soft foods and nectar thickened liquids. Intakes for the past week: breakfast: 100x7, lunch: 100, 50x3, 25 dinner: 100, 75 x2, 50 x2, 25. Fluids consumed with meals range from 240-720cc. Average daily fluid consumption is ~2948cc/day. Estimated fluid needs are ~ 1925cc/day. Skin is intact. Resident eat/drinks with total assistance in the dining room. She also uses a dycem mat, and divided plate. Set-up food, provide total assistance, cue pt to sweep mouth so doesn't pocket food, supervise meals, cut up foods, orient pt. to food on tray. Position her with left tray/arm at side of table so she sits closely. She has no difficulty chewing or swallowing with current textures. Current weight is ~ 171# and has a BMI of 28.5 which is normal, weight maintenance is appropriate. Care plan has been reviewed/updated. See nutritional fact sheet for full assessment. F/U and monitor prn. This assessment did not document what R19's usual body weight is and did not assess the continued weight loss from admission and did not provide interventions to prevent weight loss or to maintain current weight. Review of the Nutritional Fact Sheet dated 11/20/19 did not document R19's usual body weight and did not address weight discrepancies. Review of the Nutritional Fact Sheet dated 02/05/20 did not document R19's usual body weight and did not address weight discrepancies. Review of R19's medical record did not identify a notification to R19's physician regarding continued weight loss. On 03/11/20 at 9:35 AM, Surveyor interviewed Director of Nursing (DON) B and Registered Nurse (RN) C asking about R19's weight loss, assessments and physician notification. DON B indicated education to staff and competence testing with weights has been completed. DON B was reviewing with staff and looking at different issues with weighing resident. DON B indicated now in NAR meetings staff are reviewing weights and hydration. Skills testing completed in December with Certified Nursing Assistants. Dietician looks at weights daily and DON B is looking at weights daily on all residents. Dietician looks at weights and brings to NAR and IDT meeting to review along with medications and intakes. Dehydration assessments are being completed on the meeting days. Surveyor requested information of physician notification of R19's continued weight loss and no further information was provided.
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility did not ensure that residents received treatment and care for pain management for 1 of 13 sampled residents (R), R26. The facility staff did not offer R26 pain medication prior to wound care, did not regularly assess resident for pain and continued wound care when resident showed obvious signs of pain during the procedure. This is evidenced by: R26's [DIAGNOSES REDACTED]. R26's latest Brief Interview for Mental Status was 10, indicating moderate cognitive impairment. On 03/11/20 at 7:20 a.m., Surveyor reviewed R26's clinical record. The Clinical Notes Report showed on 02/17/20, R26 showed increased pain with wound cares. The physician was contacted and orders were received for Narco (a narcotic pain medication) scheduled a.m. and p.m. and also 1-2 tablets every 6 hours for pain. Surveyor reviewed R26's Medication Administration Record [REDACTED]. The plan of care indicated facility staff were to offer R26 pain medication prior to therapy/treatments. R26 received wound care daily. The documentation showed R26 received 1 dose of pain medication prior to dressing changes on 02/15/20 at 1:52 p.m. There was no other documentation showing the facility staff offered R26 pain medication prior to wound cares. There was no documentation the facility staff regularly monitored R26 for signs and symptoms of pain. At 7:21 a.m., Surveyor interviewed Director of Nursing (DON) B. DON B stated, R26 is premedicated prior to wound cares, either with scheduled pain medication (Narco) or as needed pain medication. At 12:54 p.m., Surveyor observed Registered Nurse (RN) D perform wound cares. R26 stated he did not receive a pain medication prior to wound cares. During the wound cares, R26 stated, Ow, ow, ow intermittently, and also stated They hurt. R26 cringed during the wound care stating I can't help it .oh, oh. RN D stated to R26, I'm sorry .I'm sorry. RN D continued the wound care even though R26 was showing obvious signs of pain. After the procedure, Surveyor interviewed RN D. RN D stated she had not assessed R26 for pain prior to the wound care, and did not stop the treatment when R26 was in pain. RN D stated the last pain medication was given with the a.m. medications. When Surveyor asked why the as needed pain medication was not given prior to wound care, RN D stated, He has to ask for it. At 2:05 p.m., Surveyor interviewed DON B. DON B stated RN D should have premedicated R26 prior to wound care as outlined in the plan of care, and ceased wound care when R26 showed obvious signs of pain. DON B also stated the facility should be monitoring R26 regularly for signs of pain.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure residents who use [MEDICAL CONDITION] medications receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This occurred for one of four residents(R), R14. R14 receives [MEDICATION NAME] and [MEDICATION NAME] and the facility did not ensure Gradual Dose Reductions (GDR) were attempted in two separate quarters in the first year and did not have a physician rationale for continuation of the medications. This is evidenced by: Review of R14's medical record documents current diagnoses, in part: unspecified [MEDICAL CONDITION] not due to a substance or know physiological condition, anxiety disorder, [MEDICAL CONDITION] with late onset and Dementia in other diseases classified elsewhere with behavioral disturbance. Review of physician orders [REDACTED]. Pharmacist review sheet documented on 06/17/19 a request for dose reduction to be considered for [MEDICATION NAME]. Pharmacist review on 07/10/19 documented No response yet to 6-17 . Pharmacist review on 08/09/19 documented No response will revisit in September. On 09/13/19, the pharmacist documented, Please consider a GDR for us of [MEDICATION NAME]. On 10/09/19, the pharmacist documented, No response. On 11/08/19, the pharmacist documented Repeat both [MEDICATION NAME] and [MEDICATION NAME] GDR request in Nov. On 12/09/19, the pharmacist documented No response. On 02/10/20, the pharmacist documented Evaluated request for GDR - [MEDICATION NAME] and [MEDICATION NAME] on 01/24/2020 = No GDR. Review of Physician Notification Fax dated 01/24/20

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) requesting GDR for [MEDICATION NAME] 5 mg and [MEDICATION NAME] 100 mg. Physician response: No GDR @ this time. Please update on pt behaviors when requesting GDR. The physician did not document a rationale of clinical contraindication of attempting a gradual dose reduction for each medication. On 03/11/20 at 2:23 PM, Surveyor interviewed Social Worker (SW) E asking for physician rationale for not attempting GDRs. SW E indicated there was an interim pharmacist at the time of the recommendation of GDR for [MEDICATION NAME] and the facility has no documentation the information was processed to the physician for recommendations. SW E provided a document from the pharmacist dated 06/17/19, which was not addressed by a physician, read in part: R14 has a scheduled anti-depressant medication order for [MEDICATION NAME] started in November 2018 and increased to 100 mg. daily in (NAME)2019. She was recently started on [MEDICATION NAME] ([MEDICATION NAME]) 5 mg. q HS in June. Clinical notes and/or IDT evaluation have noted the a number of falls in May, periods of agitation, yelling, and screaming episodes with staff, increasing anger directed at her husband, and uncooperative behavior with cares .The increase in agitation, excitement, and yelling are common adverse effects of the use of a selective serotonin reuptatke inhibitor like [MEDICATION NAME] .Guideline, require the facility to attempt a graduated dose reduction (GDR) in two separate quarters, unless clinically contraindicated . No further information was provided to indicate GDRs had been attempted.