STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING _____ B. WING _____	12/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST HEALTHCARE SERVS	802 2ND ST NW BOWMAN, ND 58623

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 11/28/11 and completed on 12/01/11, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156	1. The admission packet for new residents now includes the current version of the printed resident rights and responsibilities booklet dated August, 2009. This booklet is also posted on the bulletin board, along with current advocacy group phone numbers. 2. All new and current residents will have access to the most current Resident Rights booklet and advocacy group phone numbers. 3. The old versions of the Resident Rights booklet have been discarded. The regional ombudsman was contacted to verify correct advocacy phone numbers. 4. The ND Department of Health website and the regional ombudsman will be contacted bi-annually by the Social Services Director for any changes to Resident Rights and advocacy phone numbers. Any changes will be posted as required. Social Services Director will monitor this corrective action and report findings at Quarterly QA meetings.	12/2/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dennis Nobel	CEO	12-23-2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1	F 156		

the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter

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F 156	Continued From page 2 related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, review the facility's admission packet provided to residents and their families/legal guardians, and staff interview, the facility failed to provide residents and their families/legal guardians with access to the current version of the printed resident rights and responsibilities booklet and failed to post/provide the current telephone number of the local protection and advocacy agency during 3 of 4 days of survey (November 28-30, 2011). Failure of the facility to provide residents and/or their families/legal guardians with the current and	F 156		

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F 156	Continued From page 3 correct resident rights/responsibilities booklet and protection and advocacy agency telephone number does not ensure or allow for the resident or family/legal guardian to fully execute these rights and responsibilities. Findings include: During the entrance conference on the morning of 11/28/11, with an administrative staff nurse (#6), the survey team requested a copy of written information provided to residents regarding their rights (Resident Admission Packet). Review of the facility's resident admission packet, on the afternoon of 11/29/11, included a booklet titled "Resident's Rights - A Guide To Your Rights as a Resident of a Nursing Facility in North Dakota," dated April 2008. Observation of the facility's bulletin board, (used to provide and display resident right information, addresses, and telephone numbers)identified this same resident rights booklet, dated April 2008, posted and an incorrect telephone number for the state's local protection and advocacy telephone number. During interview on 11/30/11 at 1:38 p.m., an administrative staff member (#16) confirmed the information pertaining to resident rights available on the facility's bulletin board and provided to residents and their families and legal guardians within the admission packet is dated April 2008. This staff member stated her unawareness of a "more recent" version dated August 2009.	F 156		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226	1. Respective states registries were checked for CNA # 3 and Helper # 2.	

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F 226	Continued From page 4 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of employee files, and staff interview, the facility failed to implement established procedures regarding checking the Certified Nursing Assistant (CNA) registry for 2 of 3 newly hired staff members with a history of working as a CNA. Failure to check the CNA registry could result in the facility hiring a staff member with a history of abuse and/or neglect, placing residents at risk. Findings include: Review of the facility policy titled "Resident/Patient Abuse Prevention Policy" occurred on 12/01/11. The policy, revised January 2010, stated, "Screening Potential Employees for History of Abuse . . . Contact will be made with all state nurse aide registries of record and any other licensing authorities to ensure that a prospective employee does to have any validated allegations of abuse, neglect, or mistreatment of residents/patients or misappropriation of their property or any past criminal prosecutions. Documentation of the contacts will be kept in the applicant's personnel file." Review of personnel files occurred on 12/01/11 at 7:50 a.m. with a Human Recourses (HR) staff member (#1) and identified the following:	F 226	Check all new hire CNAs, nurses, vacs 12/29/11 for registry KH 12/29/11 Copies of registry checks were added to Personnel File. Application for Employment was updated to include request for professional licenses or certifications. Both tasks were completed by 12/22/11. 2. All individuals seeking employment at Southwest Healthcare Services will be asked on the initial application if they have ever held a professional license and/or certification. Based on documentation listed by each candidate, Human Resources (HR) will then screen each candidate through each respective state licensing registry. The results of these screens will be documented by Human Resources on a Personnel Entry Form which is retained in the personnel file. The QA Director will monitor completion of registry checks on 100% of accepted job applicants from December 2, 2011 for three weeks and for 2 months. Further monitoring will continue based on findings. The QA Director's results will be reports at Quarterly QA meetings. KH 12/29/11	12/22/11

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F 226	Continued From page 5 * The facility hired a CNA (#3) on 09/12/11. The HR staff member (#1) stated the CNA (#3) worked at the facility as a CNA in the past and had left in 2005. * The facility hired a Helper (#2) on 11/15/11. The HR staff member (#1) stated the Helper (#2) had previously worked as a CNA in South Dakota. The staff member (#1) confirmed she failed to check the CNA registries for the above staff members prior to their hire date. The staff member also stated she does not keep evidence of the registry checks in the personnel files, as stated in facility policy.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care in a manner and environment that enhances dignity for 1 of 1 sampled resident (Resident #5) with a behavior of disrobing. This practice fails to enhance a resident's sense of self-esteem and self-worth. Findings include: Review of the facility policy titled "Quality of Life - Dignity" occurred on 12/01/11. This policy, dated	F 241	1. Resident #5's care plan was revised on 12/2/11 to close the door or privacy curtain when resident is in her room, and to remove her pants and cover with a blanket when lying in bed. The care plan also states to take the resident to her room if she begins to disrobe in a public area. The Psychiatric Physician Assistant reviewed the resident's behavior symptoms and medications on 12/7/11, and continues to follow. 2. All dependent residents and residents with behavior symptoms have the potential to be affected. 3. An environment that provides for privacy and dignity for all residents will	

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F 241	Continued From page 6 2011, stated, ". . . Bodily Privacy During Care and Treatment . . .10. Staff shall promote, maintain and protect resident privacy, including bodily privacy . . ." Review of Resident #5's medical record occurred 11/28/11 - 12/01/11. Diagnoses included Alzheimer's disease, obsessive-compulsive disorder, and hallucinations. Resident #5's quarterly Minimum Data Set (MDS), dated 11/01/11, identified long-term and short-term memory problems, and severely impaired daily decision making skills. The MDS also identified extensive-to-total assistance from one-to-two or more people for bed mobility, transfers, and toilet use. Observation on 11/28/11 at 2:20 p.m. showed Resident #5 lying near the foot of her bed with no blanket or pants covering her, and her hand inside her open incontinence brief, leaving her exposed from the waist down. The door to her room was open and staff failed to pull the privacy curtain, exposing Resident #5 unnecessarily to anyone who walked by her room. Observation on 11/29/11 at 8:45 a.m. showed two Certified Nursing Assistants (CNAs) (#10 and #14) removed Resident #5's pants and provided toileting cares. The CNAs (#10 and #14) placed a wedge on both sides of the bed, a pillow under the resident's feet, a fall mat on the side of the bed, covered the resident with a blanket, and lowered the bed. When asked why they did not put the resident's pants back on, the CNA (#14) stated, "It would be a restraint if they were half on." When asked why her pants wouldn't be pulled up to the waist, the CNA (#10) stated, "She	F 241	be maintained. Care plans will address specific privacy and/or dignity needs related to behavior symptoms. A Nursing Staff meeting was held on 12/8/11 to educate staff on changes to Resident #5's care plan.The minutes from this meeting have been posted in the Nurse and CNA communication logs at each unit. Staff reviews those daily for new information and initial after reading. Staff were reminded to provide privacy at all times to promote individual resident dignity, and to intervene to provide privacy if they observe a situation where privacy and dignity are not being maintained. They are to report such issues to the charge nurse. 4. The CNA Team Leaders or other designated CNAs will monitor for issues related to privacy and dignity, especially issues related to Resident #5. The monitor will be conducted daily at random times for two weeks beginning 12/21/11. Monitors will continue twice a week at random times for one month and monthly for one quarter. Monitors will increase in frequency and be conducted for a longer period if findings indicate the need for more frequent observations. Staff will be educated on the spot by the person monitoring if an issue related to privacy or dignity is observed. Findings will be reviewed at monthly CNA and Nurse Meetings. Education on resident	

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F 241	Continued From page 7 strips all the time." During an interview on 11/30/11 at 9:45 a.m., an administrative nurse (#6) stated, "She [Resident #5] disrobes. They cover her with a blanket if she isn't wearing pants." During an interview on 11/30/11 at 10:00 a.m., a managerial nurse (#7) stated, "She [Resident #5] is always hot and disrobing. She is constantly disrobing. They [facility staff] should close the door or close the [privacy] curtain."	F 241	rights, to include privacy and dignity, will be done annually by the DON or SS Director. QA Director will monitor this corrective action and report findings at Quarterly QA meetings.	12/21/11
F 278 SS=C	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	1. MDS corrections to remove side rails coded as restraints were submitted for residents #1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12 and 13. 2. All other residents who use side rails for positioning have the potential to have the MDS coded as a restraint. MDS Section P on all residents who use side rails for positioning were reviewed for coding of side rail as a restraint, and MDS corrections were made and submitted. 3. Unit Manager MDS Nurses reviewed MDS 3.0 sections in the RAI manual related to coding side rails and restraints. They will not code as a restraint side rails that are used by residents for repositioning and turning in bed.	

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F 278	Continued From page 8 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility staff failed to accurately complete the restraint section (Section P) of the Minimum Data Set (MDS) for 12 of 13 sampled residents (Resident #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, and #13) identified as using bed rails. Failure to accurately complete portions of the MDS does not allow each resident's comprehensive assessment to reflect care provided, consistent with their individual needs and problems. Findings include: The Long-Term Care Facility RAI User's Manual, page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . .", and page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * the Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities, such as the quality indicator/quality measure reports * the data-driven survey and certification process	F 278	4. The MDS Coordinator will monitor 100% of Section P of the MDS for accuracy of coding on each MDS prior to submission weekly for one month, then 50% monthly for one quarter, and then as needed based on findings. If inaccuracies are identified, the MDS Coordinator will discuss the coding with the Unit Manager responsible for the assessment prior to submission to ensure accuracy of coding. The QA Director will monitor this corrective action and report findings at Quarterly QA meetings.	12/15/11

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F 278	Continued From page 9 * the quality measures used for public reporting * research and policy development . . ." Each person completing a section of the MDS is required to sign the Attestation Statement (Z0400) on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care . . ." Page P-1 defines a restraint as, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." Record review for Resident #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, and #13 occurred on November 28- December 01, 2011. Review of the records revealed the facility staff failed to accurately code the restraint section (Section P) on their MDSs. Bed rails used by these residents for repositioning and turning in bed were coded as a physical restraint, even though they failed to meet the definition of a physical restraint. For Resident #1, #2, #3, #5, #6, #7, #8, #9, #10, #11, #12, and #13 review of Section P: Restraints on the current OBRA (Omnibus Budget Reconciliation Act) MDSs identified the following: * Resident #1 - admission assessment - assessment reference date (ARD) of 09/22/11 - bed rail used daily * Resident #2 - quarterly assessment - ARD of	F 278		

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F 278	Continued From page 10 11/03/11 - bed rail used daily * Resident #3 - quarterly assessment - ARD of 08/19/11 - bed rail used daily * Resident #5 - quarterly assessment - ARD of 11/01/11 - bed rail used daily * Resident #6 - quarterly assessment - ARD of 10/11/11 - bed rail used daily * Resident #7 - quarterly assessment - ARD of 09/09/11 - bed rail used daily * Resident #8 - quarterly assessment - ARD of 10/14/11 - bed rail used daily * Resident #9 - quarterly assessment - ARD of 09/10/11- bed rail used daily * Resident #10 - quarterly assessment - ARD of 09/28/11 - bed rail used daily * Resident #11 - quarterly assessment - ARD of 10/03/11 - bed rail used daily * Resident #12 - quarterly assessment - ARD of 10/06/11 - bed rail used daily * Resident #13 - quarterly assessment - ARD of 11/06/11 - bed rail used daily During an interview on afternoon of 11/30/11, administrative nurses (#7 and #11) identified bed rails used in their facility, for the above-stated residents, do not restrain. Rather these bed rails are used by the residents for repositioning and turning in bed.	F 278		
F 286 SS=C	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by:	F 286	1. Fifteen months of MDS and CAA electronic or paper clinical records are now available to nursing staff for Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13.	

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F 286	Continued From page 11 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to maintain all resident assessments completed in the previous 15 months in the resident's medical record, accessible to all professional staff members, including consultants. This occurred for 13 of 13 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13) who resided in the facility for a time period over 15 months. Findings include: The Long-Term Care Facility RAI User's Manual, pages 2-6 and 2-7 state, ". . . Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g. a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS [Minimum Data Set] assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS [Centers for Medicare and Medicaid Services] and others who are authorized by law and need to review the information in order to provide care to the resident. Nursing homes that are not capable of maintaining MDSs electronically must adhere to the current requirement that either (not both) a hand written or a computer-generated copy be maintained in the clinical record - either is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) [Care	F 286	2. All residents have 15 months of MDS and CAA electronic or paper clinical records available to nursing staff. 3. Instructions are posted at each nursing unit describing how to access the MDS. Instructions include how to contact administrative staff if problems are encountered when attempting to access the record. Instructions for accessing the MDS record will be reviewed with each nurse by the Health Information Manager (HIM), or another nurse educated on the process. Education will provided to each nurse by 12-30-11 to include any Agency staff who might be working. Each nurse will follow the instructions in the presence of the instructor, and will show competency before training is verified. Information related to the instructions for accessing the MDS record will be included in Agency staff orientation packets. 4. HIM Director, or nurse trained in accessing the MDS electronically, will monitor 2 nurses each week for one month, and then 2 different nurses each month for one quarter until all nurses have been monitored. Further instruction will be given on the spot to any nurse encountering difficulty. Competency of each nurse will be checked annually by HIM Director or designee.	

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F 286	Continued From page 12 Assessment Areas] summary data completed during the previous 15-month period . . . ." CMS outlined what RAI information needs to be maintained in the clinical record. The requirement to maintain 15 months of data in the resident's active clinical record applies regardless of form of storage to all MDS records, including the CAA Summary, Quarterly Assessment records, Identification Information and Entry, discharge and Reentry Tracking Records and MDS Correction Requests (including signed attestation). MDS assessments must be kept in the resident's active clinical record for 15 months following the final completion date for all assessments, correction requests. Other assessment types require maintaining them in the resident's active clinical record for 15 months include the entry date for tracking records including re-entry; and the date of discharge or death for discharge and death in facility records. During the entrance conference on 11/28/11, an administrative staff nurse stated some of the facility's MDSs are electronic and others are hard copy. Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13 medical records occurred on November 28-December 01, 2011. The medical records, located at the nurses' station, for each of these residents lacked the MDS forms and CAAs for the entire previous 15 months. Information found under the tab titled "MDS" located in each resident's medical record stated, "MDS completed previous to April 01, 2011 are filed in the Unit Manager's office. MDS completed after April 01, 2011 are documented	F 286	The QA Director will monitor this corrective action and report findings at Quarterly QA meetings.	12/30/11

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F 286	Continued From page 13 electronically on the facility's computerized electronic medical record." During an interview on 11/29/11 at 2:00 p.m., an administrative staff member (#15) stated computerized access to all resident MDSs via the facility's electronic medical record is restricted to unit managers, medical records staff, and the quality assurance nurse, and are accessible only during normal business hours.	F 286		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being regarding pain management for 1 of 6 sampled residents (Resident #1) identified by the facility as experiencing pain. Failure to adequately assess and implement pain management interventions for Resident #1 resulted in the resident experiencing unnecessary pain. Findings include:	F 309	1. Resident #1's physician was contacted regarding frequent use of PRN (as needed) pain medications and a scheduled dose of Tramadol was added. A comprehensive pain assessment was completed on 12/6/11. Nursing staff are monitoring resident daily for presence of pain and if a PRN medication is used more than once a day for three days in a row, the physician will be notified. 2. All residents receiving PRN medications for pain have the potential to be affected. The PRN Medication Administration Record of each resident was reviewed for frequent or regular use of pain medications and the physician was contacted if indicated. 3. The Policies related to Pain Management have been reviewed and revised to include review of frequent use of PRN medications, follow-up of	

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F 309	Continued From page 14 Review of the following facility policies occurred on 11/30/11. The facility policy "Medication Administration," dated 01/10/11, stated, ". . . Documentation of Medication . . . 5. When PRN [as needed] medications are given, the MAR [Medication Administration Record] is to be initialed on the front page. The documentation should also have the date, time, name of the PRN medication dose, route and effectiveness. 9. The effectiveness should be documented within 1 hour of when the PRN was administered. 6. Any time a PRN medication is given regularly, the physician should be notified and the medication should be placed on a routine schedule. . . ." The facility policy "Pain Management," dated 02/2011, stated, "Policy: It is the policy of this Facility to ensure that all attempts are made to keep residents as pain free as possible. We believe that in accordance with the mission statement of the facility to preserve dignity at all stages of the life experience, the control of pain is essential to the continued dignity of live [sic]. Procedure: 1. It is the responsibility of all clinical staff to assess and periodically reassess the resident for pain and relief from pain. 2. Residents shall be asked to classify their pain level on a scale of 5 with 0 being the least and 5 being the most severe pain they can imagine. 3. Assessment of pain shall include nature of pain, location, duration, type, intensity, radiation, precipitating and alleviating factors. 4. Reassessment of pain shall be performed after each method of pain relief is tried to assess effectiveness of the method. 5. Attempts to control pain will be employed until the resident	F 309	effectiveness of PRN medication within one hour, and completion of pain screens and comprehensive assessments. At the nursing staff meeting on 12/8/11 frequent use of PRN medications, follow up of effectiveness of PRN pain medications, and notification of physician was discussed. The minutes from this meeting have been posted in the Nurse Communication logs at each unit. Staff reviews those daily for new information and initials after reading. The Consultant Pharmacist will do in-service education for nurses the first quarter of 2012 regarding pain management with emphasis on monitoring and reporting a pattern of PRN medication use and assessing effectiveness of PRN medication. The revised policies will be posted at both nurse's station by 12/21/11 along with a form for each nurse to sign verifying that the policy has been read and understood. Nurses must read the policy by 12/30/11. 4. Charge nurse will monitor each resident using PRN pain medication once a week for two weeks for use of PRN medication two or more times a day for three days in a row, and for follow up of effectiveness within one hour. Monitors will commence 12/21/11. A routine practice for the charge nurse to do a weekly review of PRN medication usage will be established. The Unit Managers	

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F 309	Continued From page 15 reaches an acceptable comfort level . . . ." The facility policy "Initial Pain Screen [and] Follow-Up Assessment," dated 04/18/03, stated, "Policy: It is the policy of Southwest Healthcare Services to respect and support the resident's right to optimal pain management. Optimal management of the resident experiencing pain enhances healing and promotes both physical and psychological wellness. Procedure: It is the responsibility of all nursing staff to assess and periodically reassess the resident for pain and relief from pain. 1. Within 8 hours of admission/readmission to the facility, the resident will be questioned regarding pain. This will be done during the initial nursing assessment and will be done utilizing the 'Pain Screening Form.' 2. In addition to the initial screening, the resident will have additional screenings done at the time of quarterly assessment, upon any significant change and upon the report of a 'new' type of pain occurring. 3. If the 'Pain Screening Form' indicates a score of 5 or greater, a comprehensive pain assessment must be done . . . 8. Appropriate documentation will be done in the chart . . . 10. Administer pain medication as ordered by the physician. Reassess the resident for response to ordered medication in 1 (one) hour. Document. If pain is not relieved by the ordered medication, notify the physician . . . ." Review of Resident #1's record occurred on November 28 - December 1, 2011. The facility admitted the resident in September 2011. The record identified diagnoses including recent cerebral vascular accident with left-sided weakness, osteoarthritis, adjustment disorder with anxiety, and depression. Medications	F 309	will monitor Medication Administration Records at the end of each month for one quarter for frequency and regularity of use of PRN medications. Physician will be contacted for changes in pain management as indicated. Monitors will increase in frequency or will be conducted for a longer period based on findings. The DON will review pain management and use of PRN medications annually with nurses. The QA Director will monitor this corrective action and report findings at Quarterly QA meetings.	12/21/11

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included Tylenol (a nonopioid pain reliever initiated on 10/12/11) 325 milligram (mg) 1 to 3 tablets every 4 to 6 hours (hrs) as needed with a maximum dose of 3000 mg in twenty-four hours and Tramadol (an opioid pain reliever initiated on 10/13/11) 50 to 100 mg every 6 hrs as needed.

Review of Resident #1's admission Minimum Data Set (MDS), dated 09/22/11, identified the resident as moderately impaired in cognitive functioning, received a PRN pain medication during the assessment reference date, and the resident reported occasional complaints of (c/o) pain.

Resident #1's care plan identified a focus area of "at risk for pain" initiated on 10/11/11 with a goal of "[resident name] will be comfortable" and interventions of "Encourage [resident name] to report c/o pain - Offer pain medication per orders. Report to Physician if pain medication is not effective - Edema glove to left hand during the day - Therapy per orders" and additional interventions of Tramadol added on 10/13/11 and Biofreeze added on 11/23/11.

Resident #1's pain screening scores identified:
*initial pain screening - completed on 10/04/11- score of "3"
*follow-up pain screening - completed on 10/12/11 - score of "3"
*follow-up pain screening - completed on 10/25/11 - score of "5."
Instructions listed on the facility's pain screening form stated, "A score of 5 or more requires comment . . . ."A note on this form, dated 10/25/11 stated "see progress notes." Resident #1's record lacked the completion of a

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F 309	Continued From page 17 comprehensive pain assessment, as per facility policy. Review of Resident #1's nursing progress notes, written by a unit manager (#11) stated: *10/04/11 - ". . . has a sling to [left] arm [and] a brace to [left] knee. He has swelling in [left] hand at times. PT [physical therapy] [and] OT [occupational therapy] are working [with] him . . . He states he has an aching pain in [left] shoulder [and] hand at times which is relieved [with] Tylenol or a warm pack . . . ." *10/12/11 - ". . . He states he has pain in his [left] hand [and] shoulder at times. APAP [acetaminophen also known as Tylenol] given. He wears a sling to [left arm [and] a glove to [left] hand . . . ." *10/26/11 - ". . . He continues to wear sling on [left] arm . . . has voiced c/o pain in [left] shoulder. Biofreeze [a type of medicated lotion] is applied. Warm packs are applied [and] RT [restorative therapy] massages arms. APAP was changed to Tramadol. [resident name] states he receives good effects when he takes it. At times he will refuse it. He can also have APAP between Tramadol doses. . . ." Review of Resident #1's nurse's notes from September 27 thru October 11, 2011 indicate the resident denied pain. Resident #1's nurse's note showed: *10/12/11 at 11:00 p.m. stated, "APAP 325 mg [three tablets] given at 2015 [8:15 p.m.] for shoulder pain. [resident name] rang 40 min [minutes] later, asking for more pain meds, as his shoulder was still hurting. Biofreeze was rubbed on his shoulder to try [and] help [with] pain.	F 309		

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[resident name] aware he has to wait 4-6 [hrs] before getting more APAP." Resident #1's PRN MAR identified facility staff assessed and documented the effectiveness of the 8:15 p.m. PRN pain medication at 10:20 p.m. (2 hours 5 minutes later).

*On 10/13/11, Resident #1 continued to complain of uncontrolled pain to his left shoulder. The facility contacted Resident #1's provider and received an order for Tramadol 50-100 mg every 6 hours for pain. A nurse's note dated 10/13/11 (no time documented) stated, ". . . Gave [one, 100 mg total dosage] at 1130 [11:30 a.m.] [and] by 1500 [3:00 p.m.] he still rated his pain [at] 8/10 [on 0 to 10 pain scale with 0 indicating no pain and a 10 as extreme pain]." Review of Resident #1's PRN MAR lacked evidence the nurse documented the effectiveness of the Tramadol the resident received at 11:30 a.m.

*10/15/11 at 3:10 p.m. - ". . . pain [left] elbow. Requested [and] received Tramadol 100 mg at 1230 [12:30 p.m.] this afternoon, temp [temporary] relief but didn't take the pain away. . . ." Resident #1's PRN MAR identified facility staff assessed and documented the effectiveness of the 12:30 p.m. PRN Tramadol 2 hours 40 minutes after the resident received this medication.

*10/20/11 at 9:00 p.m. - "c/o severe [left] shoulder pain. Rubbed in Biofrezze [sic] [and] Tramadol 100 mg [and] APAP 650 mg po given [with] good relief . . . ." The PRN MAR showed these medications were administrated at 7:30 p.m. and the facility's nursing staff documented Resident #1's response to the medications at 9:00 p.m. (1 hour 30 minutes later).

*10/21/11 at 10:40 a.m. - ". . . c/o [left] shoulder pain left over from last noc [night].

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Denied need for analgesics . . . ."

*10/22/11 at 1:05 p.m. - ". . . no c/o pain . . . ." Resident #1's PRN MAR showed the facility staff administered Tramadol 100 mg at 7:30 p.m. for complaints of left shoulder pain and documented Resident #1's response to this medication at 9:00 p.m. (1 hour 30 minutes later).

*10/23/11 at 11:30 a.m. - ". . . no complaints of pain. . . ." Resident #1's PRN MAR showed facility staff administered Tramadol 100 mg at 8:00 p.m. for complaints of left shoulder pain and documented Resident #1's response at 10:00 p.m. (2 hours later).

*10/26/11 at 8:00 p.m.- "c/o [left] shoulder pain. Tramadol 50 mg [two] tabs [tablets] given. . . ." The PRN MAR failed to identify the time facility nursing staff assessed Resident #1 and determined the effectiveness of the medication as "good relief."

10/27/11 (no time documented) - ". . . No c/o pain until 1745 [5:45 p.m.] [left] shoulder so Tramadol 50 mg [two] given for pain - told the noc nurse of this - resident said the medicine really helps when he has the pain." The PRN MAR showed facility staff documented Resident #1's response to 5:45 p.m. as needed pain medication at 7:45 p.m. (2 hours later).

*10/28/11 at 9:30 a.m. - ". . . Resident denies pain this a.m. . . ." Review of the PRN MAR showed facility staff administered Tramadol 100 mg at 8:30 p.m. for complaints of left shoulder pain and documented the resident's response at 10:30 p.m. (2 hours later).

*11/14/11 at 3:45 p.m.- "Has had increased anxiety reported to me by noc nurse this morning - Tramadol [two] give for leg [and] shoulder pain at 0735 [7:35 a.m.] [with] relief at 0930 [9:30 a.m.] . . . ." The PRN MAR showed facility staff

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F 309	Continued From page 20 documented Resident #1's response at 9:30 a.m. (2 hours later). *11/25/11 at 8:30 p.m. - "Tramadol 100 mg give for c/o extreme [left] shoulder pain [and] Biofreeze rubbed in." The PRN MAR showed facility staff documented Resident #1's response to this medication at 11:15 p.m. (2 hours 45 minutes later) as "little relief." *11/25/11 at 10:20 p.m. - "Resident still c/o of pain, asking for pain pill, restless. Xanax [anti-anxiety medication] 0.5 mg given." *11/25/11 at 11:15 p.m. - "Resident asking for pain pill - informed resident he could not have a pain pill yet . . . ." Review of Resident #1's MAR identified the resident received Tylenol 7 times in October and 3 times in November and Tramadol 16 times daily since ordered in October (except for October 17 and 24) and daily from November 01-29 (expect for November 06 and 23). These MARs identified facility staff failed to consistently assess Resident #1 following the administration of PRN pain medications and consistently document (within 1 hour of administration), as per facility policy, the effectiveness/result of PRN pain medications provided. During an interview on the morning of 12/01/11, an administrative nurse (#11) stated she believed Resident #1's frequent use of the Tramadol began in the beginning of November and confirmed her unawareness of the resident's frequent usage of this medication in October. She stated the physician met with Resident #1's spouse at the local clinic yesterday (11/30/11) and ordered additional labs and medications. Review of these orders identify the facility failed	F 309		

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F 309	Continued From page 21 to notify the physician of Resident #1's increased use of the PRN Tramadol. During an interview on the morning of 12/01/11, an administrative nurse (#6) stated she expected nursing staff to reassess the resident within one hour after providing any type of an as needed pain medication. Failure of facility nursing staff to complete a comprehensive pain assessment, to inform Resident #1's physician of his consistent use of PRN Tramadol on a daily basis (except for three days) since 10/13/11, and failure to assess and document the effectiveness/result of all PRN medications provided may have contributed to Resident #1 experiencing unresolved left shoulder and arm pain.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, review of professional literature, and review of facility policy, the facility failed to provide adequate supervision and assistance devices for residents (Resident #1, #4, #5 and #13) transported by staff in wheelchairs on 3 of 4	F 323	1. The foot pedals will be used while transporting Residents #1, 4, 5, and 13. 2. All residents being transported while in a wheelchair have the potential to drag their feet on the floor if foot pedals are not used. 3. At the nursing staff meeting on 12/8/11, staff was educated that all residents must have foot pedals attached while being transported. The minutes from this meeting have been posted in the Nurse and CNA Communication logs at	

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F 323	Continued From page 22 days of survey. Failure of the facility staff to ensure proper use of assistance devices (wheelchair foot pedals) placed residents at risk for possible accident and/or injury. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, Pearson/Prentice Hall, Upper Saddle River, New Jersey, page 1141-1145, states, ". . . Practice Guidelines Wheelchair Safety: . . . Lower the footplate's after the transfer and place the client's feet on them . . ." Review of the facility policy titled "Wheelchair (Use Of)" occurred on 12/01/11. This policy, dated 2011, stated, ". . . 9. Lower foot rests and place resident's feet on foot rests. Position feet and legs in good body alignment. . . ." - Resident #5's medical record, reviewed November 28 - December 1, 2011, identified diagnoses including Alzheimer's disease and osteoarthrosis. The resident's quarterly MDS, dated 11/01/11, identified extensive assistance of one person required for locomotion on/off unit. Observation on 11/28/11 at 2:40 p.m. showed, a CNA (#10) transported Resident #5 in her wheelchair down the hallway towards the nurses station. The toe area of Resident #5's shoes dragged on the carpet, catching and bouncing as staff transported her down the hallway. Resident #5's left foot caught on the carpeting and then caught under the left front wheel of the wheelchair, (as the CNA (#10) made a right turn to go down a second hallway) causing the	F 323	each unit. Staff reviews those daily for new information and initial after reading. Staff was instructed to remind each other, and to assist volunteers to apply foot pedals if they observe pedals not being used during transport. Restorative Therapy aides have verified that each resident in a wheelchair has foot pedals in the foot pedal carry bag attached to the wheelchair. Other departments that transport residents have been reminded that foot pedals must be attached to wheelchairs during transport. Signs have been posted at nursing units reminding staff that foot pedals must be attached whenever they are transporting a resident. 4. Staff will be monitored by CNA Team Leaders or designated CNA daily on each shift for two weeks beginning 12/21/11 for attachment of foot pedals during transport. Random monitoring will continue once a week on both shifts for one month, then monthly for one quarter. On the spot training will be conducted for any staff person found not using foot pedals during transport. Further monitoring will be conducted based on findings. Annual education related to use of foot pedals during transport will be provided by the Staff Education/QA nurse. The QA Director will monitor this corrective action and report findings at Quarterly QA meetings.	12/21/11

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wheelchair to stop suddenly. The CNA (#10) apologized to the resident, at the same time as an unidentified staff member cued the resident to lift her feet. Observation showed a bag on the back of her wheelchair contained her foot pedals. The staff member failed to place foot pedals to ensure the resident's feet/shoes cleared the floor during transport.

- Resident #4's medical record, reviewed November 28 - December 1, 2011, identified diagnoses including Alzheimer's disease and osteoarthrosis. The resident's annual MDS, dated 09/24/11, identified supervision required for locomotion on/off unit.

Observation on 11/28/11 at 3:00 p.m. showed, a nursing staff member (#9) transported Resident #4 in his wheelchair down the hallway towards his room to provide toileting cares. The toe area of Resident #4's shoes dragged on the carpet, catching and bouncing as staff transported him down the hallway towards his room, and again when staff transported him back to the Activity Department following toileting cares. The CNA (#9) failed to place foot pedals to ensure the resident's feet/shoes cleared the floor during transport, and failed to remind the resident to lift his feet.

- Resident #1's medical record, reviewed November 28 - December 1, 2011, identified diagnoses including cerebrovascular accident with hemiplegia. The resident's admission MDS, dated 09/29/11, identified limited assistance of one person required for locomotion on unit and extensive assistance of one person required off unit.

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F 323	Continued From page 24 Observation on 11/30/11 at 7:30 a.m. showed, a restorative nursing staff member (#4) assisted Resident #1 down the hallway towards his room with his left foot placed on his left foot pedal. Observation showed a bag on the back of his wheelchair contained his right foot pedal. The heel of Resident #1's right shoe slid along the surface of the floor, making an audible noise whenever it made full contact with the floor. The resident did not lift his foot. The staff member failed to place his right foot pedal to ensure the resident's foot/shoe cleared the floor during transport, and failed to remind the resident to lift his foot. - Resident #13's medical record, reviewed November 28 - December 1, 2011, identified diagnoses including osteoporosis, osteoarthrosis, joint pain, fractured vertebrae and fractured tibia/fibia. The resident's quarterly MDS, dated 11/06/11, identified limited assistance of one person required for locomotion off unit. Observation on 11/30/11 at 10:00 a.m. showed a CNA (#8) transported Resident #13 in her wheelchair down the hallway towards her room. The toe area of Resident #13's right shoe dragged on the carpet, catching and bouncing as staff transported her down the hallway. The CNA (#2) failed to place foot pedals, to ensure the resident's right foot/shoe cleared the floor during transport, and failed to remind the resident to lift her right foot. During an interview on the morning of 12/01/11 at 8:30 a.m., a managerial nurse (#11) agreed the staff should have ensured the residents	F 323		

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F 323	Continued From page 25 feet/shoes cleared the floor during transport by placing the foot pedals or should have provided reminders to lift them. During an interview on the morning of 12/01/11 at 8:45 a.m., a managerial nurse (#7) agreed the staff should have ensured the residents feet/shoes cleared the floor during transport by placing the foot pedals or should have provided reminders to lift them. She stated, "That's why we have the bags on the backs of the chairs, for staff convenience. The staff can take the foot pedals out of the bags when they're going to help transport them." Failure of the facility to ensure staff properly used assistance devices (wheelchair foot pedals) placed residents at risk for possible accident and/or injury.	F 323		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 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, review of facility job description, review of professional reference, and	F 428	1. Resident #1's physician was contacted regarding frequent use of PRN Tramadol and has ordered the medication on a regular schedule. As part of the Medication Regimen Review in December for Resident #11, the consultant pharmacist will request the physician review the use of 2 opiate analgesics, make changes if indicated, or document the clinical rationale for the duplicate therapy. As part of the Medication Regimen Review in December for Resident #4, the consultant pharmacist will request the physician consider a dose reduction of the	

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F 428	Continued From page 26 policy and procedure review, the facility failed to ensure the pharmacist identified drug irregularities during the monthly drug regimen reviews and reported the irregularities to the attending physician (MD) and the director of nursing (DON) for 3 of 13 sampled residents (Resident #1, #4, and #11). Failure of the pharmacist to inform the MD or DON of Resident #1's daily use of as needed (PRN) pain medication resulted in the Resident #1's chronic pain being under-treated, resulted in Resident #11 receiving duplicate medication therapy involving two opiate analgesics for fifteen months, and had the potential for Resident #4 to not receive a gradual dose reduction of an antipsychotic medication. Findings include: Review of the facility job description "Director of Pharmacy" occurred on 12/01/11. This undated job description failed to identify monthly drug regimen review as a duty of the pharmacist. Review of the facility policy "Pharmacy Services" occurred on 12/01/11. The undated policy stated, "Resident Drug Regimen Review: This Pharmacist reviews the resident's drug regimen monthly and as needed or requested. Results of the review are recorded in the Drug Regimen Review Record and signed by the Pharmacist. Notation of the review with appropriate action is recorded on the same form and signed by the review nurse AND Physician, FNP [family nurse practitioner] or PA [physician's assistant]." The Center for Medicare/Medicaid Services has published guidelines for the pharmacist's monthly	F 428	antipsychotic medication, or to document the clinical rationale for not doing so. Consultant Pharmacist will track and recommend dose reductions twice a year in 2 separate quarters. 2. Each resident has the potential to be affected if medication irregularities are not identified by the consultant pharmacist. 3. The consultant pharmacist is again reviewing the regulatory requirements outlined under F329, "Unnecessary Drugs", and F428, "Drug Regimen Review". The pharmacist has contacted the consultant pharmacist at Med Center I responsible for medication regimen reviews in their nursing homes. They discussed this citation and recommendations for compliance. The pharmacist has developed a form to track dose reductions of psychotropic medications, use of PRN medications, and for identifying medications in the same class. This tool will be used during each residents monthly medication review. 4. Beginning with reviews due in December, each month for 3 months the Consultant Pharmacist will discuss with the Director of Nursing or designee, the medication regimen review for 10 different residents. Together they will	

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F 428	Continued From page 27 medication regimen review. During the monthly review, the pharmacist evaluates resident specific information for dose, duration, continued need, and adverse consequences of medication. For residents receiving antipsychotic medication, within the first year, the facility must attempt a Gradual Dose Reduction in two separate quarters, unless clinically contraindicated. - Review of Resident #1's record occurred on November 28 - December 1, 2011. The record identified diagnoses including recent cerebral vascular accident with left-sided weakness, adjustment disorder with anxiety, and depression. Review of physician's orders identified an order, dated 10/12/11, for Tylenol (a nonopioid pain reliever) 325 milligram (mg) 1-3 tablets every 4-6 hours (hrs) PRN pain with a maximum dose of 3000 mg in twenty-four hrs and Tramadol (an opioid pain reliever) 50-100 mg every 6 hrs PRN pain ordered on 10/13/11. Review of Resident #1's Medication Administration Record identified the resident received Tylenol 7 times in October and 3 times in November and Tramadol 16 times daily since ordered in October (except for October 17 and 24) and daily from November 01-29 (expect for November 06 and 23). Review of Resident #1's September 2011 drug regimen, dated and signed by the pharmacist on 10/28/11 and the October 2011 drug regimen, dated and signed by the pharmacist on 11/28/11, identified no recommendations. The pharmacist failed to identify Resident #1's almost daily use of PRN Tramadol and recommend a scheduled analgesic medication to help provide continued	F 428	review the medication regimen and recommendations made to physicians, paying particular attention to use of PRN medications, dose reductions for psychotropic medications, and use of two or more medications in the same class. Further monitoring of medication regimen reviews will be conducted based on findings. The QA Director will monitor this corrective action and report findings at Quarterly QA meetings.	12/30/11

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F 428	Continued From page 28 pain management relief. - Review of Resident #11's record occurred on November 30 - December 1, 2011. The record identified diagnoses including osteoarthritis and spinal stenosis. Review of physician's orders identified an order, dated 10/10/08, for Ultram (an opiate analgesic) 100 mg three times a day and an order, dated 08/02/10, for Lorcet (an opiate analgesic) 10/650 mg twice a day. Review of Resident #11's monthly drug regimen reviews for January - October 2011 failed to identify concerns regarding the resident's use of two opiate analgesics since 08/02/10. Review of physician's progress notes for the past year failed to identify the physician's clinical rational for the duplicate opiate therapy. - Review of Resident #4's record occurred on November 30 - December 1, 2011. The record identified diagnoses including Alzheimer's disease, delusions, and depression. Review of physician's orders identified an order, dated 01/24/11, for Risperdal (an antipsychotic) 0.25 mg once daily (in the morning) and an order, dated 01/24/11, for Risperdal 0.75 mg once daily (in the evening). Review of Resident #4's monthly drug regimen reviews for January - October 2011 failed to identify any concerns regarding the resident's use of an antipsychotic. The pharmacist failed to recommend a gradual dose reduction in two separate quarters during the first year.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	1. Resident #6 will have wound care and dressing changed according to	

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F 441	Continued From page 29 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	professional standards of practice. The nurse who changed this dressing has been educated regarding when to wash hands and change gloves during a dressing change. 2. All residents who require dressing changes have the potential to be affected. 3. At the nursing staff meeting on 12/8/11, the correct process for when to wash hands and change gloves during wound care and a dressing change was reviewed. The minutes from this meeting have been posted in the Nurse Communication logs at each unit. Staff reviews those daily for new information and initial after reading. The policy for Wound Care and Dressing Change has been reviewed and revised. The policy will be posted at each nurse's station by 12/21/11 with a form for each nurse to sign verifying that the policy has been read and understood. Nurses have until 12/30/11 to review the policy. 4. Two dressing changes per week, performed by different nurses, will be observed for one month beginning the week of 12/19/11. The Director of Nursing or designee is responsible for monitoring dressing changes. On the spot training will be done if incorrect procedure is followed for changing gloves. After one month, further	

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F 441	Continued From page 30 by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, facility staff failed to follow accepted standards for practice regarding dressing changes during 1 of 2 observations of dressing changes (Resident #6). Failure to ensure staff follow standards of practice has the potential delay wound healing. Findings include: Taylor, Lillis, and LaMone, Fundamentals of Nursing, Fourth Edition, Lippincott, Philadelphia, page 909 stated, "Cleaning a Wound and Applying a Clean Dressing . . . It is important to use appropriate aseptic [without contamination] technique when changing the dressing, especially to wash hand thoroughly before and after changing dressings and to follow standard precautions. Among the most common causes of nosocomial [facility acquired] infections is carelessness in practicing asepsis when changing dressings. The wound is cleaned and the dressing changed as described in Procedure 37.1." Procedure 37.1 on page 910 stated, ". . . Don clean disposable gloves, and remove soiled dressings carefully in a clean to less clean direction . . . Discard dressings in plastic disposal bag. Pull off glove inside out and drop it in bag. . . ." Review of the facility policy titled "Dressing Change - Clean" occurred on 12/01/11. The policy, dated February 2011, stated, "Clean technique . . . is used for simple dry dressing changes and other procedures that can be performed without a sterile field or sterile gloves	F 441	monitoring will be done based on findings. The Director of Nursing will review the Dressing Change policy and procedure annually. The QA Director will monitor this corrective action and report findings at Quarterly QA meetings.	12/30/11

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but still need a level of medical asepsis to prevent complications . . . 1. Wash your hands. 2. Gather equipment and take to bedside . . . 6. Put on gloves 7. Open dressing pack 8. Put prescribed solution onto gauze to be used for cleaning 9. Remove soiled dressing and discard in plastic bag 10. cleanse wound with prescribed solution as ordered. 11. Apply prescribed medication if ordered `12. Apply dressings 13. Remove gloves and secure with tape . . .17. Wash hands." This policy conflicts with professional standards of practice quoted above which stated to change gloves after removal of the soiled dressing.

On 11/29/11 at 9:35 a.m. observation identified a licensed nurse (#5) donned gloves, removed the soiled dressing from Resident #6's left foot, and cleansed the first three toes of the resident's left foot with a 4x4 gauze, wet with sterile water. Observation showed bloody drainage from the toes. Without removing her gloves or cleansing her hands, the nurse (#5) applied ointment to the toes using a cotton swab, reached into a bag of clean supplies, removed several 4x4s and a roll of Kling (a dressing wrap), applied the 4x4s and Kling to Resident #6's left toes, then removed her gloves and cleansed her hands with alcohol based hand rub.

During an interview on 11/30/11 at 10:15 a.m., an administrative nurse (#6) stated it is her expectation that staff change gloves and wash/cleanse hands after removing a soiled dressing and prior to applying ointment and the clean dressing.

During an interview on the morning of 12/01/11 an administrative nurse (#7) confirmed staff

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F 441	Continued From page 32 should remove gloves and cleanse their hands after removing a soiled dressing.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Quality Assessment and Assurance (QA) program and staff interview, the facility failed to ensure a physician actively participated as a member of the QA committee for 2 of 4 quarters during the	F 520	We have notified Medical Director that he has to be at 100% of the Quality Assurance Meetings and that if he cannot attend in person he will attend by telephone. We also scheduled in the EMR Scheduler out a year in advance. The CEO will also educate the full Medical staff at the next scheduled Medical Staff Meeting. The Medical Director will be called, the day of the meeting, by the Medical Staff Secretary to ensure he is in attendance. We will document attendance of meetings at the beginning of each meeting, as we do now, but will not hold meeting without Medical Director in Attendance.	1/5/12

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F 520	Continued From page 33 past year. Failure to have a physician participate in the facility's quality assurance activities deprives the committee of the unique contribution a physician provides for analysis of quality concerns and assistance with decision making based on identified concerns. Findings include: During an interview on the morning of 12/01/11 at 8:15 a.m., a managerial nurse (#12) identified the facility has a QA committee, which meets quarterly, and consists of the multiple disciplines including the medical director/physician. The managerial nurse (#12) identified the physician attended the 1st and 2nd quarter meetings held in 2011. She further identified the physician did not attend the 4th quarter meeting held in 2010 or the 3rd quarter meeting held in 2011.	F 520		