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 _____	12/10/2009

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 12/07/09 and completed on 12/10/09 the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records. The sampled included 2 residents to verify specific concerns during the survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	1 & 2. Southwest Healthcare Services will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator and to the Department of Health. Two of four incidents were not reported to the ND Department of Health. 3. Policy related to Abuse Investigation was updated to include policy and procedure related to abuse reporting. See attached Policy. Occurrence Management Policy for Accident and Injury was revised. See attached Policies. Occurrence Report was revised to include Notification. Abuse Reporting Form was revised to include Notification. See attachments. Nursing Staff will be educated on the policy and procedure changes.	12/14/09 12/14/09 12/14/09 1/6/10

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

Robert S Heckle | CEO | 1/5/10

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 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility's policy and procedure, and staff interview, the facility staff failed to immediately report alleged violations involving abuse or neglect to the state survey and certification agency for 2 of 2 unreported incidents of abuse or neglect reviewed during the survey. Failure to immediately report allegations of abuse and/or neglect to the state agency could result in the facility not protecting the resident from further episodes of abuse. Findings include: Review of facility policy titled "Reporting Abuse" and dated/reviewed 06/09, occurred on 12/08/09. The policy stated, "1. Any staff witnessing or possessing reliable knowledge of any act or suspected act involving mistreatment, neglect or abuse . . . must immediately notify the charge nurse, the Administrator or his/her designee, the Director of Nursing or his/her designee. The employee must document the alleged abuse including, but not limited to, the individual(s) who committed the abusive act, the nature of the abuse, and where and when it occurred. . . . (Investigation of the Abuse Allegation) . . . 2. Investigations must be documented and all findings reported in writing as soon as possible but no later than twenty-four hours following the	F 225	All staff will be educated on the policy and procedure changes. 4. Each investigation will be monitored for immediate notification as outlined per policy by the QA Director. QA Director will report monitoring results quarterly for one year and randomly thereafter to the QA Committee. See QA monitoring form.	1/6/10 Quarterly

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F 225	Continued From page 2 alleged incident. The results of the investigations will be reported by the Administrator or designee to the State Health Department and to law enforcement officials (if warranted) within five (5) working days of the incident. . . ." The facility policy conflicts with regulatory requirements regarding immediate reporting to the state survey and certification agency. Refer to F226. -Review of the "Resident Fall Review-2009" form dated 07/04/09, occurred on 12/08/09. This form identified an incident which occurred on 07/04/09. The report identifies the fall, "Details of incident: found/floor/tub room by her w/c [wheelchair]. n1. Action taken: Res [resident] placed/BR [bathroom] in tubroom; allowed res. time for BM [bowel movement]. Res had call light @ [at] side. CNA [certified nurse assistant] had stepped out. Res fall occurred @ this time. Res assessed for injuries/bruises or skin tears. None found post fall. CNA instructed - Res no [sic] to be left alone. CP [care plan] adjusted. No further incidents. Avoidable; YES. Care plan followed: CP changed to not be left. Alarm sound: call bell accessible." The form identified the facility failed to notify the state survey and certification agency of the incident. -A review of hand written information provided by an administrative staff member (#2) occurred on 12/08/09. The information identified an incident on 04/26/09. The resident reported a staff member dropped her during a transfer in the shower room. The information identified the facility failed to notify the state survey and certification agency of the incident.	F 225		

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F 225	Continued From page 3 During interview on 12/09/09 at 9:50 a.m., when asked if an abuse and neglect investigation occurred, an administrative nurse (#2) stated, "We just did an incident investigation." The administrative nurse (#2) also confirmed they did not notify the state immediately or within five working days of the incident. She also confirmed they were unaware of the requirements regarding immediate reporting to the state survey and certification agency at that time.	F 225		
F 226 SS=C	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written 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 and staff interview, the facility abuse prohibition policy lacked 1 of 7 required components (reporting requirements). Failure to adequately address all required components increases the risk of staff to become unaware of how to properly address incidents of abuse and neglect. Findings include: Review of the facility policy titled "Resident Abuse Policy" occurred on 12/11/09. This policy, revised 06/99, stated, ". . . (Reporting Abuse) . . . 3. All alleged violations involving mistreatment, neglect, or abuse . . . will be reported to the Administrator, to the State Health Department and to law officials if warranted . . . (Investigation of the Abuse Allegation) . . . 2. . . . The results of the investigations will be reported by the	F 226	1 & 2. Southwest Healthcare Services will ensure policies and procedures for reporting of abuse,neglect, mistreatment and misappropriation of property according to Federal regulation. 3. Policy related to Abuse Investigation was updated to include policy and procedure related to abuse reporting. See attached policy. 12/14/09 Nursing staff will be educated on the policy and procedure changes. 1/6/10 All staff will be educated on the policy and procedure changes. 1/6/10 4. Further changes to the Abuse Policy will be made as needed to remain current with Federal regulations by the QA Director and/or the Director of Nursing. On-going	

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F 226	Continued From page 4 Administrator or designee to the State Health Department . . . within five working days of the incident . . ." The facility policy conflicts with regulatory requirements regarding immediate reporting of all allegations to the State survey and certification agency. Requirements also include reporting the outcome of the investigation (both substantiated and unsubstantiated) within five working days. The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding reporting of allegations. CMS has identified "Immediately" to mean as soon as possible, but ought not exceed 24 hours after discovery of the incident. Conformance with this definition requires that each State has a means to collect reports, even on off-duty hours [e.g., answering machine, voice mail, fax]. During an interview on the afternoon of 12/09/09, an administrative staff member (#1) confirmed the facility's abuse policy conflicted with regulatory requirements.	F 226		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of professional literature, the facility failed to meet professional standards regarding nursing follow up with physician on abnormal laboratory results in 1 of 8 sampled residents (Resident #1) with urinary tract infection. The facility's failure to	F 281	1. Resident #1 has not had an order for a Us and has not been treated for a UTI since 12/8/09. 1/1/10 2. Records of residents treated for a UTI were reviewed for timliness of Ua, Urine culture and treatment if abnormal lab. See attachment #1. 1/1/10 3. Ua and Urine Culture Policy-See attachment #2. Lab Director and SHS Practitioners were educated regarding the parameter required for a urine culture.See	

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F 281	Continued From page 5 ensure timely follow up with the physician regarding urinalysis results prevented the resident from receiving treatment for a urinary tract infection. Findings include: Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th Edition, 2008, page 125, stated, "Collaboration means a collegial working relationship with another health care provider in the provision of (to supply) patient care. Collaborative practice requires (may include) the discussion of patient diagnosis and cooperation in the management and delivery of care. . . . To fulfill a collaborative role, nurses need to assume accountability. . . Each professional needs to understand how an integrated delivery system centers on the client's health care needs . . ." Page 182, stated, "Because assessment is an ongoing process, verbal reports from other health care professionals serve as other potential sources of information about a client's health. . . ." Resident #1's medical record, reviewed all days of survey, identified diagnoses of Alzheimers disease, chronic bacteriuria, and a history of urinary tract infections (UTIs). The annual Minimum Data Set (MDS), dated 09/14/09, identified Resident #1 required extensive assistance for toileting, usually continent of stool, and frequently incontinent of urine. Resident #1's care plan, dated 09/25/09, identified the problem, "Urinary incontinence . . . has a dx [diagnosis] of unstable bladder and a strong history of UTI's. Goal: . . . with treatment current UTI will resolve. Approach: . . . Notify [doctor name] if Resident has s/s [signs and symptoms] of UTI. send urine	F 281	attachment #3. SHS practioners signed off on the Standing Order for Urine Cultures. See attachment #4. Nursing staff educated on the Ua and Urine Culture Policy and the Standing Order for Urine Cultures. 4. DON/Designee will monitor each ordered Ua for timeliness of Ua, Ua Culture and treatment if abnormal findings. This will be done for one year and then randomly. Results will be reported at the Quarterly QA Meeting. See attachment #5.	12/22/09 12/23/09 1/6/10 Quarterly

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F 281	Continued From page 6 for ua/uc [urinalysis/urine culture] as ordered. . . ." Review of Resident #1's Nurses Notes, dated 09/15/09, stated, ". . . u/a d/t [due to] ? [lower] abd [abdominal] pain. Entry dated 09/16/09, stated, "Notified clinic RN [registered nurse] @ [at] 3:45 p.m. of out of range u/a." The record showed facility staff failed to follow up on the urine report. The facility failed to ensure the receipt of reports and the facility staff take appropriate followup action within a reasonable period of time. During an interview on 12/09/09 at 4:30 p.m., an administration nursing staff member (#3) verified nursing staff failed to follow up with the clinic/physician regarding a positive urine test.	F 281		
F 309 SS=D	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 well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy/procedure, and staff interview, the facility staff failed to provide the necessary care and services to maintain the highest practicable physical well-being in accordance with the comprehensive assessment and plan of care for 1 of 2 sampled residents (Resident #1) who required manual extraction of stool. Failure to provide additional nursing/dietary interventions based on assessment and plan of care has the	F 309	1. Bowel status, scheduled laxative, use of prn laxatives and dietary interventions were assessed by DON for resident #± (6202). See attachment #1 and #3. 2. All resident's current bowell program, which include dietary interventions will be assessed by DON to determine if changes are required. See attachment #1. 3. Memo posted for nurses stating if a resident does not have a BM for 2 days, a prn standing order laxative must be given on the 3rd day. See attachment #2. Nursing staff will be educated on the updated bowel status policy. See Bowel Status	12/14/09 12/31/09 12/31/09 12/23/09 1/6/10

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F 309	Continued From page 7 potential to result in the resident having continued problems with constipation. Findings include: Review of facility policy titled, "[name of facility] PRN [as needed] Standing Orders"occurred on 12/08/09. This policy, dated 03/31/09, stated, ". . . Bowels: 1. Milk of Magnesia: 15-30 ml [milliliters] po [orally] QD [every day] prn for constipation. . . . 2. Kondremul: 15-30 ml po BID [twice a day] for constipation. . . . 3. Bisacodyl suppository 10 mg [milligrams], Oil Retention enema, SSE [soap suds enema] or phosphate enema every 3 days prn for constipation." Review of facility policy titled, "Bowel Habits" occurred on 12/08/09. This policy, dated 11/23/07, stated, ". . . The resident will be started on an appropriate bowel training program. . . . If signs/symptoms of constipation are noted, the physician and the dietician will be consulted. . . . If s/s [signs and symptoms] of constipation are noted . . . the nurse needs to offer MOM [milk of magnesia], bisacodyl suppository or an enema per standing orders, the nurse will need to contact the physician for a laxative order or increase in dosage. The dietician will also be consulted. . . ." Resident #1's medical record, reviewed all days of survey, identified diagnoses of Alzheimers disease and constipation. The current annual Minimum Data Set (MDS), dated 09/14/09, identified Resident #1 required extensive assistance for toileting, and is usually continent of stool, and frequently incontinent of bladder. Resident #1's current care plan, dated 10/05/09, regarding the problem of constipation, stated,	F 309	Policy Attachment #5. 4. The DON will perform a QA on a percentage of residents bowel status records to determine if the policy is being followed prior to 1/1/10. See attachment #3. Thereafter, the DON/designee will assess all resident records to determine if the policy is being followed. See attachment #4. This will be done monthly for one year and then randomly. Results of the QA will be reported at the Quarterly QA Meetings.	12/18/09 12/31/09 monthly quarterly

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F 309	Continued From page 8 "Goal: [Resident name] will have regular bowel function. Approach, record all bowel movement on her treatment sheet. . . . assess for s/s of constipation and give prns on standing order sheet if needed. Notify dietary to increase fiber in her diet due to increased need of laxatives. . . ." Review of Resident #1's nurses notes, dated 12/01/09 at 7:10 p.m., stated, "Physician here on RDS [rounds]: told me d'c [discontinue] scheduled morphine & [and] resume previous prn order. 7:10 p.m.: [Resident name] had to have manual removal of a baseball size hard bm [bowel movement] noc [night]; night nurse stated afterwards there was scant bleeding. . . . she has not been constipated in the recent past. . . ." Review of Resident #1's physician progress notes, dated 12/01/09, stated; "Subjective: Monthly nursing home rounds. This patient has been having problems with increased constipation now and increased sedation since we put her on scheduled morphine; so, perhaps that is not a very good idea at this point and she should just go back to the p.r.n. . . .Objective: . . . she is somewhat sedated. . . . Impression: . . . History of excessive side effects to scheduled morphine with constipation and excess sedation. Plan: Will discontinue the scheduled morphine and go back to p.r.n. . . ." Review of Resident #1's treatment sheet, dated 11/01/09 to 12/08/09, for bowel movements identified no bowel movement from 11/27/09 to 12/01/09 (five days), and no interventions implemented by nursing staff. The November 2009 medication administration record (MAR), nurses notes, and physician orders failed to identify the initiation of the standing orders or any	F 309		

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F 309	Continued From page 9 interventions. During an interview on 12/09/09 at 7:50 a.m., a dietary staff member (#11) stated nursing department did not dietary regarding Resident #1's constipation. During an interview on 12/09/09 at 4:00 p.m., an administrative staff member (#3), confirmed staff failed to utilize standing orders or other interventions to address Resident #1's constipation except the discontinuation of morphine.	F 309		
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide assistance to restore as much normal bladder function as possible and proper perineal cares to prevent urinary tract infections (UTIs) for 3 of 5 sampled residents (Resident #9, #11, and #12) with a history of urinary tract infections (UTIs) and requiring extensive assistance with toileting. Failure to assist residents to the toilet or check and change residents according to their	F 315	A. 1. Staff involved in pericares mentioned under Tag 312 were educated in the proper procedure. 2. Education in proper pericare technique will be provided to all CNA's: 1) Nursing Staff Meeing on 1/6/09. 2) As needed with each observation of the CNA during actual pericares. See inservice Poster. 3. All CNA's will be observed for periocare technique with corrective instruction as needed. Any CNA not correctly demonstrating proper procedure will require further supervision and instruction. Supervision will be provided by DON, Unit Managers or Education Director. See Pericare QA form.	12/11/09 1/6/10 10 1/13/09 1-7-10 @ 11:30am Telephone conversation Date changed K. Beeche Ongoing

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F 315	Continued From page 10 toileting schedule limits the ability to restore normal bladder function and places the residents at risk for skin irritation, skin breakdown, and infection. Findings include: Review of the facility policy titled, "Perineal Care" occurred on 12/10/09. This policy, dated 11/09/05, stated, ". . . Procedure . . . Wash peri-area with soap/periwash from front to back (center first then each side with clean area of the washcloth each time). If using disposable wipes, use clean area of wipe with each area cleansed . . . Cleanse rectal area with soap from peri-area to anus [front to back] changing area of washcloth of disposable wipe for each stroke . . ." - Review of Resident #9's medical record occurred on December 07-10, 2009. Medical diagnoses included UTI (urinary tract infection) 11/2009 and Pyelonephritis (kidney infection) 11/2009. A significant change Minimum Data Set (MDS), dated 12/03/09, identified this resident as incontinent of bowel and bladder and requiring total assistance with personal cares. The care plan dated 11/30/09, stated staff should check and change Resident #9 every two hours and PRN (as needed). A hospital admission history and physical, dated 11/21/09, stated, ". . . a resident of [name of nursing home] . . . who was started on ciprofloxacin [an antibiotic] on 11/19/2009 for a urinary tract infection and was found to be febrile [fever] and tachycardiac [fast heart beat] this morning . . . temperature had risen to 102.3 . . . has had decreasing oral intakes . . . admitted directly for concerns of complicated UTI. . . ."	F 315	4. Pericare QA monitoring will be done each quarter for one year. QA Director will report findings quarterly to the QA Committee. B. 1. Staff involved in untimely toileting of residents according to care plan were instructed on the importance of following the care plan. 2. Each resident's care plan was reviewed for appropriate toileting plan. See roster. Education to all CNA's regarding to timely toileting and adherence to the care plan was done at nursing staff meeting on 1/6/10. See inservice poster. 3. Other CNA's will be monitored for toileting per Care Plan by 1/13/10. Any CNA not correctly demonstrating proper procedure will require further supevision and instruction. Supervision will be provided by DON, Unit Managers or Education Director. See Toileting QA form 4. Random toileting per Care Plan will be done by Unit Managers, DON, and/or QA Director each quarter for one year and randomly thereafter with findings reported quarterly to the QA Committee by the QA	quarterly 12/11/09 12/31/09 1/6/10 1/13/10 1/13/10

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F 315	Continued From page 11 Resident #9's Urinary Incontinence Resident Assessment Protocol (RAP), dated 12/03/09, stated, ". . . was hospitalized 11/21/09 - 11/25/09 with dx [diagnoses] of UTI, pyrexia [fever] & [and] pylonephritis [sic] . . . needs extensive assist with toilet use & ICPs [incontinent care products]. . . is checked and changed q [every] 2 [hours] and PRN [as needed] with good perineal cares by staff." An observation on 12/08/09 at 7:15 a.m. showed a CNA wheel Resident #9 to the facility dining room for breakfast. Observations during the morning showed the resident in the activity room, dining room and day room. At 12:35 p.m. CNA (#12) wheeled resident from the day room to the resident's room. CNAs (#12 and #13) transferred Resident #9 with a mechanical lift to bed. The CNAs placed Resident #9 on her back. One CNA (#12) removed her pants and opened the brief. Observation showed the brief wet with urine and feces. A CNA (#12) wiped the resident's front perineal area. Observation showed the wipe contained feces. The CNA wiped again and brought the cloth, with visible feces to the front perineal area. The CNAs (#12 and #13) then placed the resident on her side. Observation showed feces on the resident's brief. A CNA (#12) obtained a disposable wipe and cleaned off most of the feces from the rectal area. The CNA then obtained another disposable cloth and cleansed again. A staff nurse (#14) also present in the room communicated to the CNA to use a different cloth, stating the CNA was contaminating the area. The CNA then turned the cloth and wiped the area again. The CNAs (#12 and #13) applied a clean brief.	F 315	Director or DON.	ongoing

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F 315	Continued From page 12 An observation on 12/09/09 at 6:35 a.m. showed CNA (#12) providing morning cares to Resident #9. The CNAs then transferred resident to the wheel chair and transported the resident to the dinning room for breakfast. Observations during the morning showed the resident in the activity room, dining room and day room. At 12:25 p.m. CNA (#12) wheeled Resident #9 to residents room. CNAs (#10 and #12) transferred resident with a mechanical lift to bed. Observation showed Resident #9 lying on her back in bed and CNAs (#10 and #12) removing her brief, which showed visible feces and wet with urine. A CNA (#12) obtained a disposable cloth and wiped the perineal area to the rectal area and back to the perineal area, with visible feces on the cloth. The CNA changed cloths and continued the same process four times, each time bringing the soiled cloth through Resident #9's perineal area. The CNAs then placed the resident on her side, cleansed the rectal area, turned the cloth and cleansed and observation showed feces remained on the cloth. CNAs then applied a clean brief. Observation revealed facility staff failed to check and change Resident #9's brief every 2 hours and as needed per care plan. Observations revealed that when staff provided personal cares to Resident #9, the resident was incontinent of bowel and bladder. A time span of five to six hours occurred between episodes of care. During an interview on 12/10/09 at 12:30 p.m., administrative nurse (#2) stated, they expected facility staff to toilet residents according to their plan of care.	F 315		

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F 315	Continued From page 13 - Review of Resident #11's medical record occurred on December 09-10, 2009. Medical diagnoses included history of UTIs and UTI with Escherichia Coli (E. Coli) 02/2009. The quarterly Minimum Data Set (MDS), dated 11/18/09, identified this resident as incontinent of bowel and bladder, and required extensive/total assistance with toileting and personal hygiene. The current care plan stated, "Incontinent of B&B [bowel and bladder] . . . She will be toileted q [every] 2 hrs [hours] during the day & [and] changed if needed . . . good perineal cares wiping from front to back . . ." Review of Resident #11's urinalysis reports identified the following: * 03/02/09 - Enterococcus species * 04/09/09 - E. Coli * 06/08/09 - Candida Albicans Enterococcus and E. Coli are bacteria normally found in the gastrointestinal tract but can cause UTIs if the perineal area is contaminated with stool such as wiping from the rectal area to the perineal area. Candida Albicans is a yeast. Observation on 12/10/09 9:15 a.m., showed Resident #11 lying on her back in bed and a Certified Nursing Assistant (CNA) (#9) provided morning cares. When the CNA pushed this resident's brief down between her legs, observation showed the brief soiled with feces and urine. The CNA (#9) stated "I should've been here sooner." The CNA (#9) obtained a disposable wipe and wiped from the perineal area to the rectal area, then back to the perineal area. Observation of the disposable wipe revealed feces. The CNA placed Resident #11 on her side, and using multiple wipes, cleansed the perineal/rectal area. The CNA (#9) obtained a	F 315		

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F 315	Continued From page 14 washcloth and wiped from the perineal area to the rectal area, then back to the perineal area. Observation of the washcloth showed feces. The CNA changed the area of the washcloth three times. Observation showed each time the washcloth soiled with feces. CNA (#9) placed Resident #11 on her back, obtained a disposable wipe, and wiped the perineal area to the rectal area and back to the perineal area. The wipe revealed feces. The CNA folded the wipe in half, wiped as before, and again the wipe revealed feces. The CNA (#9) applied Resident #11's clean brief. During an interview on 12/10/09 at 11:20 a.m., an administrative nurse (#2) agreed the CNA (#9) provided inappropriate perineal cares and failed to follow Resident #11's plan of care regarding a two hour toileting schedule. Facility staff failed to check and change Resident #11's brief since the start of the shift (approximately 6:30 a.m.) and every two hours as care planned and failed to provide proper pericare to prevent further UTIs. - Review of Resident #12's medical record occurred December 09-10, 2009. Medical diagnoses included a traumatic fracture of the right hip, dementia, and a history of UTIs. Resident #12's significant change MDS, dated 09/24/09, identified long and short term memory difficulties, moderately impaired in making daily decisions, frequently incontinent of bladder and usually continent of bowel, and required total assistance with toileting and personal hygiene. Review of Resident #12's urinalysis reports identified UTIs on 07/14/09, 09/29/09, and	F 315		

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F 315	Continued From page 15 10/29/09. This resident's current care plan stated, "Urinary incontinence: . . . [resident name] to ring with 1st urge that she has to urinate or have BM [bowel movement]. If [resident name] has not toileted per schedule, offer to toilet her or check and change . . ." Observation on 12/10/09 at 10:15 a.m., showed a CNA (#9) provided morning cares for Resident #12. Observation during perineal cares showed this resident's brief soiled with urine and feces. Further review revealed facility staff failed to check and change Resident #12's brief since the start of the shift (approximately 6:30 a.m.) and per schedule. During an interview on 12/10/09 at 12:30 p.m., an administrative nurses (#2 and #3) stated Resident #12's toilet schedule is every two hours and they expected facility staff to toilet residents according to their plan of care.	F 315		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	1. The 11 medication bottles for resident #17 now include labels with expiration dates. 2. All resident medication bottles and cassettes were reviewed to determine if expiration dates were listed on all labels. See attached QA. 3. Since only one pharmacy was out of compliance, the pharmacy that was involved was notified that all medication bottles need to include a label with an expiration date. CMA's and nurses will be educated at the staff meeting regarding the policy. See Policy.	12/14/09 12/14/09 1/6/10

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F 431	Continued From page 16 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedures, professional literature, and staff interview, the facility failed to ensure medication bottles were labeled in accordance with currently accepted professional principles for 1 of 1 supplemental resident (Resident #17) receiving medications not labeled with expiration date. Failure to include the expiration date does not provide information required and creates the potential for residents to receive expired medication. Findings include: Inspection of Unit 2's medication room and medication cart occurred on 12/09/09 at 12:30 p.m. with two nursing staff members (#5 and #6). Individual resident prescription bottles, randomly selected, lacked expiration dates. A resident	F 431	4. Quarterly, all resident medication cartridges and medication bottles will be reviewed for expiration dates by the DON or Designee. See attached QA. This will be done for one year and then randomly. Nurses and CMA's will check all medication bottles and cassettes for an expiration date when they arrive. Any cassette or bottle without an expirations date will be logged. See attached form. The pharmacist and DON will be notified. Results will be reported at the quarterly QA meeting.	quarterly ongoing quarterly

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F 431	Continued From page 17 receiving medication from an out of town pharmacy had eleven medication bottles lacking expiration dates. The medication bottles without an expiration date included; Buspirone (anxiety), Vesicare (over active bladder), Tapiramate (seizure disorder), Lorazepam (anxiety), Ibuprofen (pain medication), Baclofen (muscle relaxant), Cymbalta (anti-depressant), Lasix (diuretic), and Potassium supplement. The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding Labeling of Drugs and Biologicals. "Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. . . . Criteria for compliance states; Medication labeling identifies, at a minimum, the medication's name, strength, expiration date when applicable, and lot number, and provides instructions as necessary for safe administration; . . ." Review of the facility policy titled "Labeling and storage of drugs and biologicals" occurred on 12/03/09. This policy, not dated, stated, " . . . 2. The labels of each resident's individual medication container should clearly indicate the following: a. resident's full name, b. physician name, c. name/strength of the drug, d. date of issue, e. lot/expiration date of the drug, f. name and address of dispensing pharmacy. . . ." During an interview on 12/09/09 at 4:00 p.m., administrative staff member (#3) concurred that medication labels should have an expiration date.	F 431		
F 441	483.65(a) INFECTION CONTROL	F 441		

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F 441 SS=D	Continued From page 18 The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of professional literature, the facility failed to offer/assist the opportunity to wash/sanitize hands after toileting for 1 of 1 resident (Resident #8) observed doing her own pericares. The facility failed to provide a clean and sanitary eating area for 1 of 1 resident (Resident #5) who utilized a urinal and observed eating breakfast in his room. Failure to provide/offer hand washing and provide a sanitary eating area has the potential to spread known or unknown infections to visitors and other residents. Findings include: -Kozier & Erb's "Fundamentals of Nursing, Concepts, Process, & Practices" 8th edition, dated 2008, page 682 states, "Hand Hygiene . . . It is important that both the nurses' and the clients' hands be cleansed at the following times to prevent the spread of microorganisms: before eating, after using the bedpan or toilet, and after the hands have come in contact with any body substances, such as sputum or drainage from a	F 441	A. 1. Interviewed Resident #5 regarding use of urinal at breakfast time. See attachment #1 regarding interview and care plan. QA performed regarding Resident #5 to assure urinal was emptied when breakfast tray was brought to the room. See attachment #2. 2. Review of all male residents care plans assessed for use of urinal. See attachment #3. 3. Care plan revised for Resident #5. See attachment #1. Staff will be educated at the Nursing Staff Meeting regarding use of a urinal and proper infection control. 4. QA will be performed by DON/ Designee monthly for one year and then randomly regarding urinal use related to infection control. Results will be reported at the Quarterly QA Meeting. See attachment #4. B. 1. Resident #8 was observed during and after toileting. CNA assisted Resident #8 with hand washing following toileting. See attachment #1B. 2. Review of all SHS residents that require assistance with toileting and handwashing	1/1/10 1/4/10 12/23/09 12/23/09 1/6/10 monthly quarterly 1/1/10

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F 441	Continued From page 19 wound. . . ." Review of Resident #8's medical record occurred on all days of survey. Resident #8's medical diagnoses included cerebral vascular accident (CVA) with hemiplegia, dysphagia with gastrointestinal feeding tube, aphasia, degenerative joint disease, and macular degeneration of eyes. The current quarterly Minimum Data Set (MDS), dated 11/05/09, identified Resident #8 as continent of bowel and frequently incontinent of bladder, and requiring extensive assist of one person for toileting and personal hygiene. Resident #8's current care plan, dated 08/14/09, regarding toileting stated she toilets on demand during the day and prior to and after laying down. Observation on 12/07/09 at 4:15 p.m., showed a certified nursing assistant (CNA) (#7) assisted Resident #8 to the bathroom. Resident #8 did her own frontal peri care and the CNA (#7) completed peri cares. The CNA wheeled the resident to her bedside where she watched television and helped herself to a drink of water. CNA (#7) failed to assist/encourage the resident to wash her hands after she wiped herself. Observation on 12/08/09 at 9:30 a.m., showed a CNA (#3) assisted Resident #8 to the bathroom. Resident #8 did her own frontal peri care and a different CNA (#7) completed peri cares, then wheeled Resident #8 to the dining room for her morning meal. The CNA (#7) failed to assist/encourage the resident to wash her hands after she wiped herself. Observation on 12/08/09 at 2:45 p.m., showed a CNA (#8) assisted Resident #8 to the bathroom.	F 441	following toileting. See attachment #2B. 1/1/10 3. QA performed on a percentage of residents to assess hand-washing after toileting. See attachment #1B. 1/5/10 Nursing staff will be educated at the Nursing Staff Meeting. 1/6/10 4. DON/Designee will perform monthly QA's for one year and then randomly to assess hand-washing after a resident has toileted. Results will be reported at the Quarterly QA Meeting. monthly quarterly	

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F 441	Continued From page 20 Resident #8 did her own frontal peri cares. The CNA (#8) failed to assist/encourage the resident to wash her hands after she wiped herself and then transported the resident to activities for bible study. Staff failure to assist the resident with washing hands after toileting placed the resident and other residents/staff who come in contact with the resident at risk of infection. - On 12/08/09 at 7:55 a.m., observation showed Resident #5 seated on his bed and a breakfast tray on his bedside table. A urinal containing amber color urine hung next to the resident on the side rail. At 8:55 a.m. observation showed the urinal remained on the side rail next to Resident #5. Facility staff failed to provide a sanitary eating environment by failing to separate the breakfast meal from the urnial.	F 441		