DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	05/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CARE CENTER	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 05/10/10 and completed on 05/13/10, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed record for review. The sample included 5 additional residents and 2 additional closed record reviews to verify specific concerns during the survey.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	1. N/A 2. N/A 3. Education provided for all nursing department staff on 6/9/10 & 6/10/10. Included will be protecting resident rights, medication administration, eye drop/ointment administration, pericare for residents, revised all policies and procedures. See exhibits A, B, C, D. 4. 6/10/10 5. DON or designee will conduct weekly audits on privacy and confidentiality of records and cares beginning 6/14/10 1x/week x 3 months then 1x/month indefinately. See exhibits E, F, G. Audits will be reviewed at the end of the month IDT meetings and quarterly QA meetings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karissa Olson | TITLE: Administrator | (X6) DATE: 6-10-10

A 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 164	Continued From page 1	F 164		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and review of information regarding resident rights, the facility failed to protect resident privacy on 2 of 4 days of survey. Failure to provide privacy to residents is a violation of resident's rights.

Findings include:

The facility provides to all residents/family members the "RESIDENT'S RIGHTS: A Guide to your RIGHTS as a Resident of a Nursing Facility in North Dakota," during the admission process. Review of this Guide occurred on 05/13/10. The Guide, dated 08/2009, stated, "PERSONAL AND PRIVACY RIGHTS . . . YOU HAVE THE RIGHT: . . . To privacy in medical treatment and personal care . . ."

- On 05/12/10 at 4:05 p.m., two certified nursing assistants (CNAs #5 and #6) entered Resident #12's room to assist her with toileting. The CNAs closed the door upon entering the room. Resident #12's roommate lay in bed, sleeping. The roommate's bed had a direct view into the bathroom. Neither CNA pulled the curtain around this resident's bed. The two CNAs assisted Resident #12 into the bathroom in her wheelchair. The CNAs then assisted Resident #12 into a standing position. She stood with her backside to the door holding onto a rail. The CNAs pushed the wheelchair into the doorway, leaving the door open. A CNA (#5) lowered Resident #12's pants and brief, exposing her buttocks. The roommate remained in her bed, directly in front of the open bathroom door. The bathroom door remained

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F 164	Continued From page 2 open while Resident #12 voided and also while a CNA (#6) cleansed the resident, placed a new brief, and pulled up the resident's pants. Two administrative staff members (#1 and #2), during interview on 05/13/10 at 12:45 p.m., indicated all staff are taught to provide privacy and also indicated privacy is one area that is reviewed when observing staff provide care to residents. .- During observation of medication pass on 05/11/10 at 8:00 a.m., a licensed nurse (#3) administered eye ointment to Resident #16 in the hallway by the medication cart, within view of other residents and staff members passing by. - Observation on 05/11/10 at 9:25 a.m., showed a licensed nurse (#3) administered eye drops to Resident #19 while the resident sat in the beauty shop getting her hair fixed, within view of other residents and volunteers present in the room. During an interview on 05/13/10 at 8:20 a.m., an administrative nurse (#2) stated she expected eye ointment and eye drops administered in a private area. Review of the facility policy titled "Medication Administration Oral" occurred on 05/13/10. This policy, not dated, stated ". . . I.) The medication cart is to be kept in clear view and in reach of the person administering medications at all times. . . ." - An observation of medication pass on 05/12/10 from 7:35 a.m. to 8:55 a.m. showed the nurse (#11) left the medication cart unattended (out of view and out of reach) with the medication	F 164		

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F 164	Continued From page 3 administration record (MAR) open to resident's health information, twice. Visitors were observed to stand by the medication cart the first time, and another staff member covered the MAR the second time. The MAR identified the following protected resident information: name, admission date, room number, age, diagnosis, physician name, medical record number, sex, allergies, Medicaid/Medicare number, and religion. During an interview with a staff nurse (#12) and an administrative nurse (#13), on 05/13/10 at 1:08 p.m., these staff members identified staff are to cover the MAR before leaving the medication cart. The staff nurse (#12) identified a card the facility developed to cover the MAR when unattended, which stated "MAR must be covered at all times."	F 164		
F 174 SS=C	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on a resident group interview and staff interview, the facility failed to provide access to a telephone, in a location where residents may place a phone call without being overheard, during 4 of 4 days of survey. Findings include: The Centers for Medicare and Medicaid Services	F 174	1. A telephone will be placed in the A-Solarium, which is a resident lounge. This telephone will be cordless. 2. N/A 3. N/A 4. June 17, 2010 5. Maintenance will add telephone access to their monthly QA. As part of their QA they will continue to monitor that the cordless phone works.	

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F 174	Continued From page 4 provided guidance that telephones in staff offices or at nurses' stations do not meet the provisions of the requirement for reasonable access to the use of a telephone where calls can be made without being overheard. A resident group interview occurred on 05/11/10 at 3:30 p.m. with nine residents identified by the facility staff as interviewable. The interview revealed the phones available for use by residents, who do not have their own phone, are located in the hallways or at the front desk. During an interview at 5:00 p.m. on 05/11/10, two administrative staff members (#1 and #2) confirmed the facility no longer had a cordless phone available for use by residents. The staff members indicated residents can use the phones located in the hallways or they can go into the New Wing staff charting room. These staff members also indicated residents can use the telephone in the social worker's office. On the morning of 05/12/10, an administrative staff member (#2) indicated the cordless phone, available to residents for private use, has not been available for about three months.	F 174		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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, review of professional literature, and staff interview, the	F 226	1. N/A 2. N/A 3. Current abuse policy revised see exhibit I to relect clarifications on reporting allegations dated 1/8/10 & 3/31/10 from NDDOH. Reviewed by Social Services, Administration and DON. 4. 6/1/10 5. CMS and DOH changes at quarterly QA meeting. QA agenda	(cont.)

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F 226	Continued From page 5 facility failed to follow their abuse prohibition policy for 1 of 7 required components (reporting requirements). Failure to develop and implement policies and procedures requiring immediate reporting of alleged violations involving abuse or neglect to the state survey agency has the potential to affect residents if abuse/neglect allegations go unreported. Findings include: Review of the facility policy titled "Resident Abuse" occurred on 05/13/10. This policy, dated November 2006, stated " . . . V. Investigation: . . . 3) All alleged acts or suspected acts of abuse involving injuries of unknown origin and misappropriation of resident property shall be immediately and thoroughly investigated and reported, if appropriate, to other officials through established procedures and in accordance with state law (including to the State Survey and Certification Agency) . . . The results of the investigation must be reported to the Administrator or his designated representatives and to the State Survey and Certification Agency within five (5) working days of the incident. If the alleged allegation is verified, appropriate corrective actions must be taken. . . ." 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 requirements regarding reporting of allegations. CMS has identified	F 226	has been revised. See exhibit H. The QA Committee Coordinator will be responsible for the corrective action.	

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F 226	Continued From page 6 "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 05/13/10 at 8:00 a.m., when asked when the facility contacts the State Agency regarding any instances of abuse, an administrative nursing staff member (#2) stated the facility only notifies the State Survey and Certification Agency with substantiated abuse allegations. An interview with a social services staff member (#4) occurred on 05/13/10 at 9:15 a.m. When asked when the facility makes first contact with the State Survey and Certification Agency regarding an abuse allegation, the staff member (#4) stated if they feel an investigation of abuse is substantiated, then they call the State Survey Agency. If they are unsure, they will call their consultant social worker or the ombudsman.	F 226		
F 323 SS=D	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, review of	F 323	1. Resident #9 assessed for use of Pal lift. Does not require Pal lift at this time. Residents overall strength has improved. If necessary to use mechanical lift in future, resident #9 will be evaluated by a nurse manager for appropriate transfer technique. If necessary, physical therapy will evaluate and give recommendations. See exhibit J for assessment.	(cont.)

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F 323	Continued From page 7 nursing and nursing assistant meeting records, and staff interview, the facility failed to ensure residents received adequate supervision, assistance, and assessment of 1 of 3 sampled residents (Resident #9) observed transferred with a stand lift. Failure to ensure staff received the necessary training placed the resident at risk for possible injury during transfers with a stand lift and resulted in Resident #9 experiencing discomfort during transfer. Findings include: Review of minutes from a nursing and nursing assistant meeting occurred on 05/13/10. The minutes dated, 04/15/10, stated "Lift jacket procedures discussed. Make sure the jacket is hooked before lifting. In-service was held with nursing assistants." A "Training Log" for the topic "Proper use of Jackets for Lifts" identified the facility held an in-service on 04/05/10, with nine certified nursing assistants (CNA) participating. - Review of the medical record for Resident #9 occurred on May 10-13, 2010. A nurses note, dated 03/19/10, identified a near miss for Resident #9: "Writer was notified by CNA [CNA's name], that when CNA was assisting Res. [resident] [with] HS [hour of sleep] care, CNA lifted Resident off the toilet [with] PAL [standing mechanical lift] [and] Res slipped out of the lift jacket falling 5 inches or so to the toilet seat. No c/o [complaints of] pain, AROM x 4 [active range of motion all four limbs]." A quarterly Minimum Data Set, dated 03/23/10, identified Resident #9 has long and short term memory problems and required extensive assistance of one staff for transfer, toileting,	F 323	2. Assess all residents currently using sit to stand lifts in the facility and change care plans accordingly. Continue to assess residents quarterly and PRN thereafter. Consult with physical therapy PRN. See exhibit J. 3. All residents will be evaluated by a nurse manager to ensure they are appropriate for sit to stand lift by 6/16/10/ All nursing staff will be educated on use of sit to stand lift and Hoyer lift on 6/9/10 & 6/10/10. Training videos reviewed. Lift competency checklist completed by all nursing assistants. This will be added to general orientation and annual all staff agenda. See exhibit K for training and exhibit L for orientation. 4. 6/10/10 5. Weekly audits completed x 3 months beginning 6/14/10 then monthly thereafter indefinately. See exhibit M. The DON or designee will be responsible to monitor the corrective action.	

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F 323	Continued From page 8 dressing and personal hygiene. This MDS did not identify Resident #9 used a mechanical lift during the assessment period. The current care plan for Resident #9, identified a revision on 03/19/10 added the approach "PAL Lift only [with] [one] to assist." Another revision on 04/30/10 discontinued this approach and identified transfer assistance as "1 person pivot in room [with] walker." Observation of care on 05/11/10 at 7:35 a.m. showed a CNA (#14) assisting Resident #9 with morning cares. The CNA (#14) assisted Resident #9 to sit on the edge of the bed, secured the lift jacket around Resident #9's abdomen and loosely attached the straps around the resident's abdomen. As the CNA (#14) engaged the lift, lifting Resident #9 to a standing position, the jacket slid up to her axillae (armpits), causing her shoulders to lift and her elbows to move up and away from her body, approximately level with her shoulders. Standing in this position, the CNA (#14) transferred Resident #9 into the bathroom and onto the toilet. After the CNA (#14) provided cares, the CNA (#14) stood Resident #9 again using the lift, the jacket slid up into Resident #9's axilla, lifting her shoulders and moving her elbows up and away from her body. As the lift reached it's maximum height, Resident #9 said "ouch." The CNA (#14) completed cares and arranged the resident's clothes, as Resident #9 stood as described in the lift. The CNA (#14) transferred Resident #9 to her wheelchair. The facility did not identify CNA (#14) as one of the CNAs attending the training on 04/05/10. The record lacked an assessment of Resident #9's use of the standing lift following the near	F 323		

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F 323	Continued From page 9 miss. Observation of use of the stand lift showed the facility failed to follow Resident #9's care plan which identified transfer assistance of one person pivot in room with walker. The positioning demonstrated by Resident #9 while in the standing lift showed this to be an unsafe lift for her and the resident experienced discomfort. During an interview, on 05/13/10 at 10:55 a.m., with two administrative nurse staff members (#2 and #13) they identified staff can use the mechanical lift when they feel the resident's condition requires more help. These staff members identified the lift was discontinued from the care plan due to an increase in the resident's strength, not due to the near miss incident identified in the nurses note. During an interview, on 05/13/10 at 1:08 p.m., an administrative nurse (#13) identified the facility failed to assess Resident #9 for the use of a stand lift.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional literature, review of manufacturer's instructions, and staff interview, the facility failed to ensure a medication error rate of less than 5% during medication pass on 2 of 2 days [May 11-12, 2010] of survey pertaining to administration of inhaled medication	F 332	1. Resident #18 education/ teaching record started 5/16/10. Directions placed in MAR on Advair Discus. See exhibit N and exhibit O. Resident #19 order clarified and completed on 5/12/10. New label placed on 5/21/10. See exhibit P. 2. All MAR's and labels checked for accuracy by nurses on med cart. 3. Revised medication administration policy. See exhibits B & C. 4. 6/10/10	(cont.)

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F 332	Continued From page 10 and eye drops. Failure to administer an inhaled medication in the proper manner has the potential to prevent the resident from receiving the full dose of medication, and failure to identify the correct dosage of a medication prior to administration has the potential to cause the incorrect dose to be administered. Three errors occurred resulting in a 7% medication error rate. Finding include: The Nursing 2009 Drug Handbook, 29th edition, Lippincott, Williams & Wilkins, pages 874 and 877, stated: ". . . Advair Diskus . . . Available forms . . . Inhalation powder: . . . 250 mcg [micrograms] fluticasone and 50 mcg salmeterol. . . . Patient teaching: Instruct patient on proper use of the prescribed inhaler to provide effective treatment. Tell patient to avoid exhaling into the dry-powder multidose inhaler . . . Instruct patient to keep the dry-powder multidose inhaler in a dry place, away from direct heat or sunlight, and to avoid washing the mouthpiece or other parts of the device." The manufacturer's prescribing information for Advair Diskus, dated October 2008, stated, ". . .Instructions for using Advair Diskus: . . . 3. Inhale. Before inhaling your dose from the Diskus, breathe out (exhale) fully while holding the Diskus level and away from your mouth. Remember, never breathe out into the Diskus mouthpiece. . . . Remember: Never breathe into the Diskus. . . . Never wash the mouthpiece or any part of the Discus. Keep it dry. . . ." Review of the facility policy titled "Inhalation Therapy Treatments" occurred on 05/13/10. This policy, not dated, stated "Purpose: To safely	F 332	5. Education 6/10/10. Audits beginning 6/14/10 of medication passes 1x/week x 3 months, then 1x/month indefinately. See exhibit F & G. Audits will be reviewed at the end of the month at IDT meetings and quarterly at QA meetings. The DON of designee will be responsible to monitor the corrective action.	

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F 332	Continued From page 11 administer medication inhalation therapy treatments to a resident while observing nursing considerations for minimizing possible adverse reactions. Procedure: . . . 3) If possible, the nurse shall teach the resident how to administer metered dose correctly. . . ." Review of the facility policy titled "Receiving Physician's Orders" occurred on 05/13/10. This policy, undated, stated "1. Document on pink sheet. Observe orders as written . . . INCLUDE: Medication, Dosage, Amount, Duration, Route, Frequency, Diagnosis. . . ." Review of the facility policy titled "Medication Administration/Oral" occurred on 05/13/10. This policy, undated, stated " . . . N) If there is any question in regard to dosage, the person in doubt should not give the drug until he/she has obtained information which clarifies drug dosage. . . ." Review of the facility policy titled "Eyedrop Administration for [sic] Procedure for Adults" occurred on 05/13/10. This policy, undated, stated " . . . PROCEDURE: 1. Check Medication Administration Record for order. 2. Read label 3 times before administering . . . 9. Instill medication as follows . . . instill required number of drops inside lower eyelid. . . ." The manufacturer's instructions for Systane eye drops stated, "Uses: For the temporary relief of burning and irritation due to dryness of the eye. Directions: Instill 1 or 2 drops in the affected eye(s) as needed." - Observation during medication pass on 05/12/10 at 7:35 a.m. showed the nurse (#11) assisted Resident #18 with the administration of Advair	F 332		

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	355069	A. BUILDING _____ B. WING _____	05/13/2010

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F 332	Continued From page 12 Diskus 250/50, an inhaled synthetic corticosteroid. The nurse (#11) handed the activated dispenser to the resident. Resident #18 inhaled though the Diskus, mouthpiece then exhaled out into the Diskus mouthpiece. Resident #18 inhaled and exhaled though the Diskus mouthpiece, approximately 10 times. The nurse (#11) did not intervene and instruct Resident #18 on the correct use of the Diskus. Failing to intervene and educate the resident on the proper use of the Advair Diskus has the potential to introduce moisture from exhalation into the mouthpiece chamber and cause the powder to cling to the inside of the Diskus and not allow inhalation of the full dose of medication. Repeated use of the Diskus, which contains 55 doses of medication, in this way, could cause less medication availability with each consecutive use. - Observation during medication pass on 05/11/10 at 9:25 a.m. revealed the label on Resident #19's bottle of Systane (lubricating drops for dry eyes) eye drops to read "Use in both eyes four times daily." The label failed to include the prescribed number of drops staff are to administer to the resident (Refer to F431). Review of Resident #19's physician's orders stated "Systane gtts [drops] OU [both eyes] QID [four times daily]," ordered on 11/19/09, lacked the number of drops also. Observation showed a nursing staff member (#3) administered one drop in each of Resident #19's eyes, even though the order was incomplete. - Observation during medication pass on 05/11/10 at 3:45 p.m. showed the nurse (#7) administered Systane eye drops, one drop to each eye, to Resident #19. Both the label on the bottle, and	F 332		

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	355069	A. BUILDING _____ B. WING _____	05/13/2010

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F 332	Continued From page 13 the physician's order, failed to identify the number of Systane eye drops Resident #19 should receive. When asked, the nurse (#7) agreed the medication administration record and the pharmacy label failed to identify how many drops of Systane to administer. During an interview on 05/13/10 at 8:20 a.m., an administrative nursing staff member (#2) stated she expected the nurse observing the physician's order and/or the nurse administering medications to notify the physician to clarify the dosage of all medications to be given, including the exact number of drops to administer.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy/procedure, review of professional reference, and staff interview, the facility failed to ensure residents remained free from significant medication errors for 1 of 13 sampled residents (Resident #3). Failure to prevent medication errors has the potential to cause significant harm to all residents. Findings include: Review of the facility policy titled "SUBJECT: Medication Administration/Oral" occurred on 05/13/10. This policy, undated, stated " . . . Preparing Dose Medication: . . . 2. Verify medication with medication sheets. 3. Read the	F 333	1. N/A 2. N/A 3. Revised receiving medication orders, see exhibit T. New policy written concerning crushed meds, see exhibit U. Med error reporting policy revised, see exhibit V. Implemented meds not given policy and documentation sheet, see exhibit W. 4. 6/14/10 5. Audits completed daily by medical records, see exhibit X. MAR's and TAR's checked weekly by unit managers. Audit records submitted to DON, reviewed at IDT meetings monthly and QA quarterly meetings. The DON or designee will be responsible to monitor corrective action.	

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	355069	A. BUILDING _____ B. WING _____	05/13/2010

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F 333	Continued From page 14 label on the container or card as it is removed from the drawer and check label with medication sheet. 4. Read the label again. 5. Pour prescribed amount into bottle cap prior to placing in medication cup. 6. Read label before returning container or card to the drawer. 7. Document on Medication Administration Record [MAR] appropriately . . . M) Any irregularity in pouring or administering must be reported to the doctor. N) If there is any question in regard to dosage, the person in doubt should not give the drug until he/she has obtained information which clarifies drug dosage. . . ." Review of the facility policy titled "Medication Incident/Error Reporting" occurred on 05/13/10. This policy, undated, stated "POLICY: An error or event, which departs from what is usual or expected which occurs through the pharmacy or in the administration of medications and treatments, will be documented on the Medication Incident/Error Report Form. 1) The Report Form will be completed by the person discovering the incident/error. 2) The incident/error will be reported to the Director of Nursing/Designee and appropriate action will be taken to correct the error. The Director of Nursing/Designee will contact the person that made the error, and review the incident with them. 3) The completed form will be given to the Designee who will follow up as necessary, within 72 hours. 4) The Director of Nursing/Designee, will compile a report on all medication incident/error reports submitted. These reports will be reviewed by QA & Medical director. 5) Medication/Incident report will be completed on all medication errors determined to be significant. PROCEDURE: Following a Medication Error: I. Provide for Resident Monitoring: a. Determine if the medication error	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 15	F 333		

has any potential for an immediate problem . . . b. If the above is a possibility, take the emergency action necessary and notify the attending physician as soon as possible. c. If it cannot be readily determined that the error will not result in an acute problem, check with the appropriate persona [sic] or agency for consultation. This may include the Director of Nursing/Designee, the attending physician, Medical Director, consultant pharmacist, poison control center, etc. d. Monitor the resident for as long as necessary. This may include finding out how rapidly a drug is excreted from the body, so that it can be determined when the effects should disappear. II. Notify the Appropriate Personnel: a. If the Director of Nursing/Designee has not already been notified, do so at this time. b. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee, and to the resident or the resident's legal guardian or designated representative, and an explanation must be made in the resident's clinical record . . . III. A. The medication error record should be completed in total so that regulations are complied with and more importantly, so that adequate follow up is possible. B. If Medication Error is significant utilizing the above criteria, a medication error report must be completed. C. Quality Assurance follow-up should be completed. D. Follow up with disciplinary action is required. E. Complete reporting to appropriate State agency(s) as required. . . ."

Record review for Resident #3 occurred on all days of survey. Diagnoses for Resident #3 included osteoarthritis, coronary artery disease, hypertension, and chronic ischemic heart disease. Review of Resident #3's physician's orders sheets showed the resident received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	05/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 333	Continued From page 16 Prednisone therapy for osteoarthritis, and Imdur for coronary artery disease, both initiated on 05/27/09. Lippincott, Williams & Wilkins, The Nursing 2009 Drug Handbook, 29th edition, pages 316-317 defined Imdur (isosorbide mononitrate) as an antianginal (used for chest pain), listed isosorbide dinitrate and isosorbide mononitrate as available forms, and stated "Action: Thought to reduce cardiac oxygen demand by decreasing preload and afterload. Drug also may increase blood flow through the collateral coronary vessels . . . Caution patient to take drug regularly, as prescribed . . . Alert: Advise patient that stopping drug abruptly may cause spasm of the coronary arteries with increased angina symptoms and potential risk of heart attack . . . Advise patient taking P.O. [by mouth] form . . . to swallow oral tablets whole. . . ." Review of a communication sheet faxed to the physician on 09/06/09 stated "[Resident #3] takes Imdur which says not to crush be [sic] we do crush her meds. Is this ok to crush it?" The physician responded "May change to equivalent dose to [sic] Isosorbide Dinitrate and may crush." The facility failed to follow the order to switch to the equivalent crushable medication and wrote on the MAR "May crush- 09/08/09," incorrectly indicating the physician approved crushing the Imdur (isosorbide mononitrate). Review of a Pharmacy Review form for Resident #3, dated by the consulting pharmacist on 01/29/10, stated "Imdur 30 mg daily (isosorbide mononitrate)- Request was made to crush on 09/06/09. [Name of physician] said it would be OK to switch to isosorbide dinitrate (an equivalent	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	05/13/2010

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F 333	Continued From page 17	F 333		

dose) and then crush. This didn't happen- the mononitrate is still being given and it is being crushed. Could the order be changed to isosorbide dinitrate 10 mg TID [three times daily] with the last dose no later than 7:00 p.m. to allow a nitrate free period. It is OK to crush." Resident #3's physician responded "OK to above" on 02/01/10. The resident started on Isosorbide Dinitrate 10 mg TID on 02/02/10. This resident's medication (isosorbide mononitrate) was incorrectly crushed (should not be given crushed) from 09/06/09 until 02/01/10 without facility staff identifying and correcting these medication administration errors.

Lippincott, Williams & Wilkins, The Nursing 2009 Drug Handbook, 29th edition, pages 1088-1090 defined Prednisone as a steroidal anti-inflammatory and stated "Action: Not clearly defined. Decreases inflammation . . . suppresses immune response . . . Nursing Considerations: . . . Always adjust to lowest effective dose. Most adverse reactions to corticosteroids are dose or duration dependent . . . Watch for depression or psychotic episodes, especially during high-dose therapy. . . ."

Resident #3's physician's order, dated 02/12/10, stated "[decrease] Prednisone to 5 mg [milligrams] PO [by mouth] daily X [for] [one] week then f/u [follow up] [with] [name of physician]. . . ." Resident #3 had received 10 mg of Prednisone daily prior to the order change to decrease the Prednisone.

Review of Resident #3's Physician Progress Notes identified "02/15/10- Received a call from [name of long term care facility] stating that her Prednisone dose was mixed up over the weekend

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 18 and she received 15 mg instead of 5 mg so informed to take 10 mg X 3 days then 5 mg for 1 week and then contact [name of physician] regarding stopping. . . ." A physician's order, dated 02/15/10 stated "[change] Prednisone to 10 mg PO daily X 3 days then 5 mg X [one] week Prednisone PO then f/u [with] [name of physician]. . . ." Review of Resident #3's February 2010 MAR and nurses notes provided no information regarding the Prednisone dose medication error. During an interview on 05/13/10 at 8:00 a.m., an administrative nursing staff member (#2) explained the staff member who discovers a medication error fills out a medication error report form, notifies the physician, and gives the error form to the unit manager. The unit manager reviews the medication error form, educates the staff member(s) involved, and then gives the medication error report form to the Director of Nursing (DON). The facility provided no further explanation regarding the medication errors for Resident #3.	F 333		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425	1. N/A 2. N/A 3. Revised policy on obtaining medication, see exhibit Q. Educate nursing staff on 6/9/10 & 6/10/10. 4. 6/10/10 5. Charge nurses do QA checklist; see exhibit R. Education given and unit managers will do weekly MAR and TAR checks indefinately. See exhibit S. Checklists will be reviewed → Completed every Friday K Sieh 6/15/10	(cont.)

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	355069	A. BUILDING _____ B. WING _____	05/13/2010

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F 425	Continued From page 19 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/28/09. Based on record review, review of policy and procedure, review of professional reference, and staff interview, the facility failed to ensure 2 of 13 sampled residents (Resident #3 and #9) received medications as prescribed. Failure to ensure availability of medications resulted in missed doses, and placed the residents at risk for increased pain and overall discomfort. Findings include: Review of the facility policy titled "Medication-Emergency-How to Obtain" occurred on 05/13/10. This policy, revised 10/19/09, stated "According to F425 'Pharmacy Services' the facility must provide routine and emergency drugs and biologicals to its residents or obtain them under agreement . . . Under the referred section is the issue of timelessness falling under the facility's responsibility. Hence, the facility and the contracting pharmacy need to think about and plan ahead for a situation where the back-up	F 425	monthly at the end of the month at IDT meetings and quarterly at QA meetings. DON or designee will be responsible to monitor corrective action.	

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	355069	A. BUILDING _____ B. WING _____	05/13/2010

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F 425	Continued From page 20	F 425		

supply and emergency kit are not to be considered for all 24 hours of the day. Under the Interpretive Guidelines for pharmacy it state [sic]: 'If one drug is not available for the resident at its scheduled time of administration and the omission of that drug can cause the resident discomfort or endanger his/her health and safety, a negative finding (by the surveyors) shall be recorded' . . . For this facility, in the event of regularly scheduled delivery of the pharmacy will not provide the medication in a timely fashion and the Contingency Supply and Emergency Medication Box do not hold the drug, the licensed nurse is to: 1. Contact the [name of pharmacy], if unable to reach Pharmacy contact the Pharmacist available . . . 2. If medication is not available or approved from Pharmacy a doctor must be notified and a telephone order obtained to hold medication or change medication to a different one. 3. Charge nurses are responsible to ensure that medications are ordered in a timely fashion to ensure that medication is available. 4. Any re-orders are to be sent by fax to the Pharmacy [name of pharmacy] by 3 pm or specify, NEED IMMEDIATELY. . . ." This policy does not address/define at what point a medication is low and should be ordered so that medications are available on a continuous, uninterrupted basis.

- Review of Resident #3's medical record occurred on all days of survey. Current diagnoses included history of hip fractures, osteoarthritis, and generalized pain. Past medications for Resident #3 included "Lorcet 10/325 mg [milligrams] PO [by mouth] QID [four times daily] for pain," initiated on 02/12/10. The Nursing 2009 Drug Handbook, 29th edition, Lippincott, Williams & Wilkins, page 1411, identified this medication is

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	355069	A. BUILDING _____ B. WING _____	05/13/2010

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F 425	Continued From page 21 used to relieve moderate to moderately severe pain. Resident #3's Medication Administration Record (MAR) for March 4, 2010, identified "1800 [6:00 p.m.] Lorcet 10/325 did not come [with] Rx [medication] exchange- [name of pharmacy] closed- called [different name of pharmacy] they will bring later. Called [name of physician] to report no Rx for 1800. [Name of physician] stated ok," written on the back side of the MAR. The MAR showed the 6:00 p.m. dose of Lorcet initialed and circled on the 4th. Review of Resident #3's physicians orders showed a telephone order, later signed off by the physician, which stated "03/04/10 Reported to [name of physician] no Lorcet available for 1800 Rx pass- Stated 'ok'." During an interview on 05/13/10 at 8:00 a.m., an administrative nursing staff member (#2) stated the charge nurses are responsible for ordering the residents' medications so they are available at all times. If a medication is unavailable and not in the emergency medication kit, staff members are instructed to call the pharmacy, and then notify the physician for further orders. - Review of the medical record for Resident #9 occurred May 10-13, 2010. The record contained a fax to the resident's physician, identified as "FYI [for your information] which stated, "Res [resident] was not given Fexofenadine HCl [hydrochloride] 60 mg [one] tab. [tablet] 2000 [8:00 p.m.] dose on 2/18/10." The date/time identified on the fax was 02/18/10 at 8:15 p.m. The fax failed to explain why the resident did not receive the identified dose.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	05/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 425	Continued From page 22 The Nursing 2009 Drug Handbook, 29th edition, Lippincott, Williams & Wilkins, page 835, identified this medication is used to relieve seasonal allergies and chronic idiopathic urticaria, a type of hives. Diagnosis for Resident #9 included eczema, neurodermatitis, and an unspecified pruritic disorder, all which can cause itchy and/or irritated skin. Review of the February 2010 "Medication Administration Record" (MAR) for Resident #9, showed the medication signed off by the nurse as given. The entry is not circled or otherwise identified as not administered to the resident. The "Nursing Notes" for the month of February reviewed showed no entires made on 02/18/10. During an interview, on 05/13/10 at 8:05 a.m., with an administrative staff nurse (#13) the nurse agree the documentation recorded on the MAR conflicted with the fax sent to the physician. This nurse (#13) stated the nurse who sent the fax to the doctor should have identified, on the MAR or a nurse's note, why the resident missed the medication. The facility failed to develop a proactive system to address medication supply and the need to have medications on a continuously basis.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	05/13/2010

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F 431	Continued From page 23 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. 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, record review, 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 3 of 9 sampled residents (Resident #16, #19, and #20) observed receiving medications. Failure to ensure correct medication labels has the potential	F 431	1. Resident #16 order clarified, see exhibit Y. Resident #19 order clarified, see exhibit P. Resident #20 passed away 5/12/10. 2. All MAR's and labels will be checked for accuracy by licensed nurse on medication cart. 3. Education on revised policy & procedures 6/9/10 & 6/10/10. Revised medication administration policy, see exhibit B. Revised eye drop/ointment policy, see exhibit C. Implemented labeling of medication policy and procedure. See exhibit Z. 4. 6/10/10 5. Education 6/10/10. Audits beginning 6/14/10. See exhibit F & G. Audits will be conducted 1x/week x 3 months, then 1x/month indefinately. Audits will be reviewed at the end of the month at IDT meetings and quarterly at QA meetings. The DON or designee will be responsible to monitor the corrective action.	

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F 431	Continued From page 24 to result in significant medication errors potentially harmful to residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the 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 . . . The facility ensures that medication labeling in response to order changes is accurate and consistent with applicable state requirements. . . ." Review of the facility policy titled "Receiving Physician's Orders" occurred on 05/13/10. This policy, undated, stated "1. Document on pink sheet. Observe orders as written . . . INCLUDE: Medication, Dosage, Amount, Duration, Route, Frequency, Diagnosis. . . ." Review of the facility policy titled "Medication Administration/Oral" occurred on 05/13/10. This policy, undated, stated "PURPOSE: To accurately prepare, administer and document oral medications . . . PROCEDURE: . . . 3. Read the label on the container or card as it is removed from the drawer and check label with medication sheet. 4. Read the label again . . . 6. Read label before returning container or card to the drawer. .	F 431		

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F 431	Continued From page 25 . ." - Observation during medication pass occurred on 05/11/10 at 7:45 a.m. This observation showed discrepancies between the Medication Administration Record (MAR)/Physician's Order and the label on Resident #20's Roxanol (form of morphine for moderate to severe pain) medication. Review of Resident #20's record indicated the resident is currently receiving hospice services. The label on the Roxanol stated "5 mg [milligrams] sublingual [under tongue] every 4 hours as needed for pain," ordered on 04/30/10. The label lacked the current physician's orders which included: Roxanol 5 mg by mouth or sublingual every morning before cares, ordered on 05/03/10, and Roxanol 5-10 mg sublingual every 2 hours as needed, ordered on 05/10/10. The resident's MAR reflected the current physician's orders. - Observation during medication pass on 05/11/10 at 7:50 a.m., identified an incorrect label on Resident #16's Tobradex eye ointment (antibiotic/anti-inflammatory medication for eye inflammation). The label on the bottle containing the tube of Tobradex ointment stated "Apply to [left] eye BID [twice daily]. The MAR/current physician's order, started on 12/19/09, stated "Tobradex eye ointment- small amount on q-tip to both lateral lashline BID indefinitely." The label failed to identify application to both lashlines. - Observation during medication pass on 05/11/10 at 9:25 a.m. revealed the label on Resident #19's	F 431		

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F 431	Continued From page 26 bottle of Systane (lubricating drops for dry eyes) eye drops to read "Use in both eyes four times daily." The label failed to include the number of drops to be administered to the resident. Review of Resident #19's MAR/physician's orders stated "Systane gtts [drops] OU [both eyes] QID [four times daily]," ordered on 11/19/09, also lacking the exact dose to give. During an interview on 05/11/10 at 3:44 p.m., a nursing staff member (#7) agreed the Systane eye drop label failed to identify the number of drops to give. She stated she gives one drop to each eye because she remembers the original order. During an interview on 05/13/10 at 8:20 a.m., an administrative nursing staff member (#2) stated the nurse administering medications should notify the pharmacist if a label is incorrect and the pharmacy will then deliver a correct label. If a nurse notices a label is incorrect for a resident on hospice, he/she notifies the hospice nurse who obtains a correct label. The staff member (#2) stated a nurse should notify the physician and clarify an order if the physician failed to indicate the exact dosage of medication ordered. The facility provided no further information or any additional policies/procedures.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441		

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F 441	Continued From page 27 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 by: Based on observation, review of facility policy and procedures, and staff interview, facility staff failed to implement infection control practices consistent with facility policy/procedure for 3 of 9 sampled residents (Resident #1, #6, and #9) observed receiving personal cares, and 2 supplemental residents (Resident #16 and #19) observed	F 441	1. N/A 2. N/A 3. Education 6/9/10 and 6/10/10 on hand hygiene infection control, see exhibit AA. Revised applying eye drops/ ointment procedure, see exhibit C. Implemented hand hygiene / glove use audit tool, see exibit BB. Medication administration audit, see exhibit F. 4. 6/10/10 5. Education 6/10/10 audits beginning 6/14/10, see exhibits F & G. Audits will be conducted 1x/week x 3 months, then 1x/month indefinately. Audits will be reviewed at the end of the month IDT and quarterly QA meetings. The DON or designee will be responsible to monitor corrective action.	

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F 441	Continued From page 28	F 441		

receiving eye medications. Failure to follow infection control practices has the potential to affect the health and safety of all facility residents, visitors, and staff.

Findings include:

Review of the facility policy titled "Infection Control/Resident Care: Work Activity Guidelines for Infection Control" occurred on 05/13/10. This policy, undated, stated, "Caring for Incontinent Residents: It is difficult to clean an incontinent resident without getting urine and/or stool on the hands . . . Major risks include getting stool under the fingernails. Gloves reduce that risk and make hand washing after completion of the task easier and more effective . . . Always remove the soiled gloves and wash your hands before moving on to the next task . . ."

Review of the facility policy titled "Heartland Care Center Handwashing" occurred on 05/13/10. This policy, undated, stated, "Because handwashing is generally considered the most important single procedure for preventing nosocomial infections, it is important that proper procedures be followed. All personnel are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by accepted professional practice . . . personnel should always wash their hands [even when gloves are worn]: . . . After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood and body fluids, secretions, or excretions, or items contaminated with these substances . . . After removing gloves . . . Gloves should be worn when contact with blood and all body fluids, secretions, and excretions. However,

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F 441	Continued From page 29 gloves are not a substitute for handwashing. Hands should be washed as indicated above even when gloves are worn . . . Antiseptics will inhibit or kill many microorganisms that may not be completely removed by normal handwashing . . . Such antiseptics should not be used as a substitute for adequate handwashing, however . . ." Review of the facility policy titled "Eyedrop Administration for [sic] Procedure for Adults" occurred on 05/13/10. This policy, undated, stated " . . . 4. Wash hands (examination gloves may be worn) . . . 9. Instill medication as follows: Place hand against patient's forehead to steady, and instill required number of drops inside lower eyelid close to outer corner of eye . . . 12. Recap Bottle. 13. Wash hands. . . ." - Observation of medication pass on 05/11/10 at 8:00 a.m. showed a nursing staff member (#3) administering eye ointment to Resident #16. The staff member (#3) failed to wash her hands prior to donning gloves and administering the eye ointment, and after removing the gloves. - Observation of medication pass on 05/11/10 at 9:25 a.m. showed a nursing staff member (#3) administering eye drops to Resident #19. The nursing staff member (#3) failed to wash her hands prior to donning gloves and administering the eye drops, and after removing the gloves. - Observation of medication pass on 05/11/10 at 3:45 p.m. showed a licensed nurse (#7) administered eye drops to Resident #19. The nurse (#7) failed to wash her hands after administering the eye drops and removing her gloves.	F 441		

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F 441	Continued From page 30 During an interview on 05/13/10 at 8:00 a.m., an administrative nursing staff member (#2) stated staff have received education on the importance of washing hands with soap and water before and after the administration of eye drops or ointments. - Observation on 05/11/10 at 10:45 a.m., showed two certified nursing assistants (CNAs) (#8 and #10) toileted Resident #1. One CNA (#8) performed pericares with gloved hands following the resident's bowel movement, removed her gloves, and sanitized her hands. The CNA (#8) failed to wash her hands with soap and water following completion of pericares. - Observation on 05/11/10 at 3:15 p.m., showed a CNA (#9) wore gloves and prepared to assist Resident #6 with toileting. When the CNA (#9) stood the resident from her wheelchair and upon removal of her brief, observation showed a moderate amount of smeared feces on the resident's buttocks. Before toileting her, the CNA wiped the feces from her buttocks using wet wipes. She then assisted the resident onto the toilet, removed her gloves, exited the bathroom, and retrieved clean pants from the resident's closet. The CNA (#9) returned to the resident's bathroom, washed her hands, and donned gloves before proceeding to dress the resident. The CNA (#9) failed to wash her hands with soap and water following the removal of her gloves prior to exiting the bathroom, and before proceeding to touch the resident's closet handles and clean pants. An interview occurred on 05/13/10 at 8:40 a.m. with an administrative staff member (#2). The staff member confirmed she expected staff to remove gloves and wash their hands with soap	F 441		

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F 441	Continued From page 31 and water after providing pericare to residents. - Observation of cares for Resident #9 occurred on 05/11/10 at 10:05 a.m. Two CNAs (#14 and #15) donned gloves and assisted Resident #9 onto the toilet after pulling down her pants and brief. Observation showed the pants and brief soiled with loose/watery stool. When Resident #9 sat on the toilet, both CNAs (#14 and #15) removed their gloves. One CNA (#14) left the bathroom without washing her hands with soap/water, and went into the resident's closet and dresser to obtain clean clothes. The other CNA (#15) continued to assist Resident #9 with incontinence cares after donning a new pair of gloves. A nurse (#7) came in to assist Resident #9. The CNA (#15) removed her gloves and left the Resident #9 with the nurse (#7) in the bathroom, and without washing her hands with soap and water, went into the resident's room to obtain a clean brief. Both CNAs (#14 and #15) failed to wash their hands with soap and water following the provision of incontinence cares before they exited the bathroom and touched other items. During an interview, on 05/13/10 at 9:15 a.m., with an administrative nurse (#2), this nurse identified staff should wash their hands with soap and water, if the resident is safe, and they are moving from dirty to clean.	F 441		
F 520 SS=E	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	F 520		

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F 520	Continued From page 32 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 State Agency (SA) provider file, review of the facility's Quality Assurance (QA) policy/procedure, and staff interview, the facility failed to maintain a QA committee which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct identified quality deficiencies. Failure of the facility to have quality assurance activities in place may have contributed to: the repeat deficient practice of not having medications available for residents and medication errors; including significant medication errors and placed residents at risk of injury due to improper use of a lift. Findings include:	F 520	1. N/A 2. N/A 3. Revised the entire QA agenda and added current month action plans. See exhibit H. 4. 7/27/10 is our next scheduled QA meeting. Will hold earlier meeting on June 28th per t.c. w Karissa Olson, DON at 1pm on 6/17/10 5. Will follow QA agenda and monitor all deficient practices to acheive and sustain processes in place. See exibit H. The QA Committee Coordinator will be responsible to monitor corrective action.	

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F 520	Continued From page 33 Review of the facility policy/procedure titled, Quality Assurance and Assessment Committee, occurred on 05/13/10. This policy, undated, identified the goal "To oversee the quality & effectiveness of facility operations & systems to meet the needs of our customers." The policy does not identify the process the QA committee will utilize to identify issues in which quality assessment and assurance activities are necessary. The policy also did not identify the process the QA committee will utilize to develop and implement appropriate plans of action to correct identified quality deficiencies. Review of the provider file as part of preparatory activity prior to the survey, revealed a deficiency cited at F425 (Pharmaceutical services that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident), during the previous standard survey completed 05/28/09, requiring QA monitoring as part of the facility's plan of correction. The facility has not maintained compliance with this requirement. Refer to F425. In addition, the survey team identified the following Quality of Care and Pharmacy Services citations during the current survey: * F323 - Failed to adequately train staff on lifting residents. Refer to F323 * F332 - Medication error rate of 7%. Refer to F332 * F333 - Significant medication errors. Refer to F333 * F431 - Labeling of Medications. Refer to F431 An interview occurred with an administrative staff	F 520		

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F 520	Continued From page 34 member (#1) responsible for QA on 05/13/10 at 9:30 a.m. This staff member indicated the QA committee utilizes the Quality Indicators (QIs) as their main QA tool; reviewing any area >75% and sentinel events. When asked if the committee identified concerns/conducted audits in the areas of medication errors/labeling of medications or proper use of lifts, this staff member indicated no QA activity had occurred. This staff member was not able to identify a specific process (other than use of the QIs, which contain very specific information and do not address many areas concerning resident care) used by the QA committee to determine areas the QA committee should review. This staff member also was not able to identify a specific process the QA committee utilized to develop and implement appropriate plans of action to correct identified quality deficiencies.	F 520		