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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 11/29/10 and completed on 12/02/10, the sample included 5 residents for complete review, 18 residents for focused review, and 3 closed record for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000	- CNA registry checked re: staff #1 and #2. - Have reviewed files of recent hires to ensure checking CNA registry. Phone Call - D. Hanson & C. Swartland 01/04/11 KB	
F 226 SS=D	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 new employee files, and staff interview, the facility failed to implement their policy regarding checking the Certified Nurse Aide (CNA) abuse registry for 2 of 2 newly hired licensed staff members (#1 and #2) who had been CNAs. Failure to check the appropriate certification board has the potential for the facility to offer employment to a person with a work history of abuse and/or neglect, placing residents at risk. Findings include: Review of the facility policy titled, "All Employment" occurred on 11/30/10. This policy, dated 03/06/08, stated, "Criminal Background Checks . . . E. All applicants that have ever worked as a CNA will have their certification checked in each state that they have worked in to make sure there is no past history of abusing,	F 226	Director of Human Resources will educate Human Resources staff that completes the pre-employment screenings on Personnel Policy and Procedure #202.12 - All Employment - Criminal Background Checks. Education will be completed on December 29, 2010. The Human Resources Assistants will monitor to assure that all applicants that have ever worked as a Certified Nursing Assistant will have their certification checked in each state that they have worked in to make sure there is no past history of abusing, neglecting or mistreating individuals in a health care related setting. The audits of applications of newly hired individuals will be completed quarterly for the first six months and then at one (1) year by the Human Resources Assistants to assure completion Continued on page 2 of 20	

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

Greg Hanson | President/CEO | 12/28/10

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 226	Continued From page 1 neglecting or mistreating individuals in a health care related setting. If there is record of abuse, neglect or misappropriation of property, VMH [Valley Memorial Homes] will not employ them." On 11/29/10, the facility provided a list of staff hired in the last four months. Review of two recently hired staff files showed the facility failed to check the certified nurse aide abuse registry, for the staff members (#1 and #2) who had a history of working as CNAs. During an interview, on 11/30/10 at 3:13 p.m., an administrative staff member (#3) verified the CNA abuse registry should have been checked for the two staff members (#1 and #2).	F 226	Continued From page 1 of the Abuse Registry check. Results will be reported to the Director of Human Resources. If concerns are identified, immediate action will be implemented. The Director of Human Resources will submit a report of the monitoring results to the QA Committee as audits are completed.	01/06/11
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to	F 274	- Reg #20 has had an MDS including RAIS since survey. Plan Call, G. Hanson & C. Swartland 01/04/11 KG It is the policy of Valley Eldercare Center that each resident receive an accurate comprehensive assessment within 14 days after the facility or should have determined the resident (#20) experienced a significant change in condition. Resident #20 experienced a decline in Activities of daily living following a hospital stay. Staff felt resident would return to baseline but did not and a comprehensive assessment was missed. All residents have the potential to be affected by this deficient practice as result all staff will be educated at an in-service on January 5, 2011, during which the focus will be on completing Continued on page 3	

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F 274	Continued From page 2 conduct a comprehensive assessment of a resident within 14 days after the facility determined, or should have determined, the resident experienced a significant change in condition for 1 of 2 sampled residents (Resident #20) experiencing a decline in Activities of Daily Living (ADLs) following a hospital stay. Findings include: The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, revised September 2010, page 2-20 through 2-23 stated, "Significant Change In Status Assessment (SCSA) . . . A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. . . . Decline in two or more of the following: . . . Any decline in a ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment . . ." Review of Resident #20's record occurred on December 1-2, 2010. An annual Minimum Data Set (MDS), dated 06/11/10, identified Resident #20 as requiring limited assistance with bed mobility, transfers, walking in the room, and walking in the corridor. The record identified the physician admitted Resident #20 to the hospital for treatment of	F 274	Continued from page 2 necessary assessments based on the residents condition and significant change. Charts/MDS's will be audited for accuracy of significant change assessments by ADON/DON monthly times 6 months, then quarterly times 6 months. If no issues are noted we will do an annual audit for accuracy.	01/06/11

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F 274	Continued From page 3 behaviors from July 12-21, 2010 and August 03-17, 2010. A Quarterly MDS, dated 08/30/10 identified a decline in Resident #20's ADL status with the resident requiring extensive assistance with bed mobility and walking in the room. The MDS identified walking in the corridor did not occur during the assessment period. A Resident Care Note, dated 08/23/10, stated ". . . This writter [sic] doesn't feel he will be a Sig [significant] Change would like to observe for now. I do expect to see flucutation [sic] in Resident's condition." A Quarterly MDS, dated 11/17/10, identified Resident #20 again declined in bed mobility - requiring total assistance; in transfers - requiring extensive assistance; and in walking in the corridor - requiring total assistance. The MDS further identified Resident #20 continued to require extensive assistance with walking in the room. The record lacked evidence staff considered completing a comprehensive assessment with the resident's significant change in condition. During an interview on 12/02/10 at 8:10 a.m., an administrative nurse (#9) agreed staff should have completed a Significant Change in Status Assessment for Resident #20 when he did not return to his previous level of functioning.	F 274		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	It is the policy of Valley Eldercare Center to provide or arrange services that meet professional standards of quality. Resident #14 continues on the Ativan to assist with sleep and anxiousness Continued on page 5	

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F 281	Continued From page 4 Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure the services provided met professional standards of quality for 1 of 2 sampled residents (Resident #14) on a scheduled anti-anxiety medication. Failure of facility staff to follow the nursing process and provide evidence to show the pattern and events leading up to the resumption of an anti-anxiety medication has the potential to result in the use of an unnecessary medication. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, dated 2008, page 192, stated, " . . . DOCUMENTING DATA: To complete the assessment phase, the nurse records client data. Accurate documentation is essential and should include all data collected about the client's health status. Data are recorded in a factual manner and not interpreted by the nurse . . . To increase accuracy, the nurse records subjective data in the client's own words, using quotation marks. Restating in other words what someone says increases the chance of changing the original meaning. . . ." Review of the facility procedure titled "Documentation, Resident Care Notes" occurred on 12/02/10. This policy, revised April 2007, stated, " . . . D. Standards: 1. Notes should reflect observations and observable facts including emotional and physical changes in the resident. Descriptions of observations, resident behaviors, changes, etc., should be clear, specific and objective . . . 5. The facts relating to variances should be noted, followed by a nurse's signature.	F 281	Continued from page 4 Care conference held on 12/20/2010, resident and family were satisfied with the care and with the medications resident is receiving. It is felt resident is fairly stable and wants no agressive treatment. We will continue to monitor resident health status. Because all residents can potentially be affected by the cited deficiency, Nursing staff will be educated during an in-service on January 5, 2011. The education will include accurate documentation of subjective data, data collected about the resident's health status. Descriptions of observations or changes should be clear, specific and objective. Any new medications or changes in medications, behavior or behavior changes related to resident's health needs. Chart audits will be completed by ADON/DON monthly times 6 months, quarterly times 6 months then annually to monitor effective charting of the resident overall condition but in particular related to medications that could be deemed unnecessary. Continued on page 6	01/06/11

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F 281	Continued From page 5 The focus should describe a resident's behavior or symptoms such as "dizziness", "laceration on right elbow", not "variance". 6. The time and notation is entered when a physician is notified regarding the resident's condition. Unsuccessful attempts and action taken . . . is also documented. The focus used should reflect the resident concern about which the physician is being notified . . . 7. By reading only the resident care notes, determination can be made of a general knowledge of the resident's diagnosis and problems . . . E. Specific Documentation Guidelines: . . . b. Medications: 1. New medication or change in medication: Make a notation in the chart at the time the order is obtained, including rationale (if known), new diagnosis, goals, etc. Include documentation of notification of family . . . d. Behavior Charting: *Describe mood and behaviors as they occur . . . *Describe both behaviors unusual for the resident and usual behaviors that need intervention. . . ." Review of Resident #14's medical record occurred on all days of survey. Medical diagnoses included anxiety, sleep disturbance, depression, dementia, congestive heart failure, emphysema, and chronic obstructive pulmonary disease. Review of the current quarterly Minimum Data Set (MDS), dated 08/28/10, identified the resident with short term memory problems and moderately impaired with daily decision making. The MDS showed Resident #14 exhibited mood and behavior symptoms which included: repetitive questions, repetitive verbalizations, repetitive health complaints, repetitive anxious complaints/concerns, and repetitive physical movements. The resident's annual MDS, dated 05/28/10, showed the resident displayed repetitive health complaints and repetitive	F 281	Continued from page 5 Audits will be reviewed by the QA Committee.	01/06/11

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F 281	Continued From page 6	F 281		

physical movements.

Current medications for Resident #14 included a Fentanyl (a medication for pain) patch 25 mcg/hr (micrograms per hour), Tylenol (a medication for pain) 650 mg (milligrams) at 7:00 a.m., 3:00 p.m., and 11:00 p.m., and Ativan (a medication for anxiety) 0.25 mg at HS (hour of sleep).

Review of the nurse practitioner's progress notes, dated 05/13/10, indicated an improvement in Resident #14's anxiety and sleeplessness. An order stated, "[Decrease] Ativan 0.25 mg at HS. If doing well on [decreased] dose then DC [discontinue] [after] 1 week. Dx [diagnosis]: anxiety." On 05/19/10, the resident's practitioner discontinued the scheduled bedtime dose of Ativan. On 07/08/10 a physician's order stated, "Ativan 0.25 mg Q [every] HS. Anxiety."

Review of the Resident Care Notes for the months of May - July 2010 lacked evidence the resident exhibited any symptoms requiring the resumption of the antianxiety medication - Ativan.

Resident #14's Social Services Review, dated 09/03/10, listed the following comment under the "MOOD" section on the review form, "Wasn't able to sleep (Ativan re-added 7/08/10)."

During an interview on 11/30/10 at 3:00 p.m., an administrative nursing staff member (#15) agreed Resident #14's medical record lacked evidence on the pattern of events which resulted in the resumption of the scheduled Ativan in July after being discontinued in May. She stated the nurses have received education on the importance of all steps in the nursing process, including documentation in the appropriate areas of the

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F 281	Continued From page 7 resident's chart to show the resident's current status and support the use of certain medications. The facility provided no additional information. During an interview on 11/30/10 at 4:30 p.m., a nursing staff member (#6) stated she recalled Resident #14 was quite anxious and hollering out a great deal at night after the Ativan was discontinued in May, so the nurse practitioner restarted the scheduled dose at HS in July. The staff member (#6) looked in the medical record for supporting documentation and was unable to find any additional information. During an interview on 12/01/10 at 2:00 p.m., an administrative nursing staff member (#7) stated the nurses received education in the past regarding the importance of documenting all steps completed throughout the nursing process. The administrative staff member stated the staff are educated to try other interventions first when a resident is anxious to address their basic needs before administering medications. The staff member agreed the chart lacked evidence of a nursing assessment on the mood and behavior symptoms the resident displayed leading to the resumption of the scheduled Ativan.	F 281		01/06/11
F 425 SS=D	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	F 425	It is the policy of Valley Eldercare Center to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biological) to meet the needs of each resident. Continued on page 9	

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F 425	Continued From page 8 (including procedures that assure the accurate 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: Based on observation, review of professional literature, review of facility guidelines, record review and staff interview, the facility failed to discard an expired medication for 1 of 4 residents (Resident #~~28~~ 27) observed receiving an insulin injection during the medication pass task. Failure to discard an opened insulin vial allowed usage beyond the manufacturer's recommended discard time frames. This practice may affect the potency and sterility of the insulin, with the potential to decrease the medications effect of controlling the resident's blood glucose levels. Findings include: Diabetic Care, Volume 26, Number 9, September, 2003, pages 2666-2667, "How Long Should Insulin Be Used Once a Vial Is Started?" stated, ". . . Although an expiration date is stamped on each vial of insulin, a loss of potency may occur after the bottle has been used for >1 [more than 1] month . . . Insulin products are sterile until the first dose is withdrawn by syringe . . . After first use, the contents of the vial . . . are technically no	F 425	Continued From page 8 Resident #27 (instead of #26 which is listed as that resident was part of the closed record) did receive insulin after the expiration date. The resident did not have any adverse effect from the practice and has discharged home since this occurred in stable condition. All residents have the potential to be affected by this deficient practice. All nursing staff will be educated at an in-service on January 5, 2011. Areas that will be covered will be the importance of dating a medication when it is opened, know the time limit that a medication is good/effective. We will also cover the importance of discarding an expired medication as this may affect the potency/ effectiveness of the medication. There is a laminated copy of the time limits of medications after opening placed on each MAR on all units so the nurses have easy access for reference when unsure. We will audit weekly the dating and discarding of medications. This audit will be completed by the day nurse on each unit every week-end. The ADON will Continued on page 10	

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F 425	Continued From page 9 longer sterile . . . Sterile products should be used in as short a time as possible to minimize concerns about microbiological contamination once the container has been punctured. The CPMP [Committee for Proprietary Medicinal Products] has proposed a maximum-use period of 28 days for sterile products . . . including insulin products . . . changes in insulin action can lead to significant changes in blood glucose control." Review of the facility guideline "Medication with Shortened Expiration Dates", not dated, occurred on 11/30/10. This guideline stated " (Supply) Insulin 10 ml [milliliter] Multi-dose vial; (Insulin) All other insulins; (Refrig.? [refrigerate]) Yes, until opened; (Expiration) 28 days; (Notes) Vial expires 28 days after opening or after removal from refrigerator. Which ever comes first." During an observation on 11/30/10 at 5:37 p.m. a licensed nurse (#13) prepared a dose of Novolog insulin to administer to Resident #26. Facility staff labeled the multi-dose vial as opened on 10/28/10. This surveyor stopped the nurse (#13) prior to administration and requested the policy be reviewed. This nurse (#13) went to the nurses station and consulted a procedure manual, he/she did not find the information on expiration of insulin. When the nurse (#13) questioned his/her co-worker as to the expiration date of the insulin, the nurse (#14) stated 28 days. The multi-dose vial of insulin expired five days earlier on 11/25/10. During an interview, at the time of the above observation, both nurses (#13 and #14) stated facility staff complete an audit of medications every weekend and remove expired medications from use. The audit documentation showed staff	F 425	Continued from page 9 track the audit weekly for compliance. Our consulting pharmacy also does monthly audits of the medications carts and storage areas for expired medications and dates on medications. 01/06/11	

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F 425	Continued From page 10 completed the audit for the transitional care unit on 11/27/10. Staff completing the audit failed to discard the expired Novolog insulin for Resident ~~#26~~ #27 KS Record review showed facility staff administered 14 doses of the expired Novolog insulin to ~~Resident #26~~ from 11/26/10 thru 11/30/10. ~~Resident #26's~~ vial of Novolog insulin is stored in a locked drawer in his room. Observation showed the expired multi-dose vial to be the only vial of Novolog insulin available for administration to ~~Resident #26.~~ During an interview, on 12/01/10 at 5:25 p.m. an administrative nursing staff member (#16) stated, during the audit, any stock medication, eye drops, and multidose vials used for residents should be reviewed. This staff member (#16) confirmed nursing staff who administered the Novolog insulin should have known the medication had expired by facility guidelines.	F 425		01/06/11
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 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	F 441	It is the policy of Valley Eldercare Center to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and prevent the development and transmission of disease and infection. The care-giver's of Resident #11 have been observed for proper technique regarding isolation and have been noted to be wearing gowns and gloves and following hand-washing technique. Continued on page 12	

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F 441	Continued From page 11 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: NON-COMPLIANCE WITH CONTACT ISOLATION PRECAUTIONS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/18/09. 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow isolation precautions for 1 of 2 sampled residents (Resident #11) requiring contact isolation. Failure to follow infection control procedures placed residents, visitors, and staff at risk of contacting an infection. Findings include:	F 441	Continued from page 11 The Lemon Q product will no longer be used for cleaning any surfaces except for the floors where the surface can remain wet. The containers of Lemon Q have been permanently removed from the housekeeping carts and replaced by Oxivir Tb. It is a general virucide, bactericide, Tuberculocide, fungicide sanitizer. It has a 30 second contact surface time and contains properties to eliminat eht MDROs, MRSA and VRE. Dining tables will continue to be cleaned with a solution of Dawn dish soap and water, followed by an application of Oasis, a disinfectant sanitizer that is left on the dining surface. All resident's can potentially be affected by this dificient practice and all staff will be re-educated at the in-service on January 5, 2011. The infection control nurse will discuss infection control policies regarding: contact isolation practices for residents with MRSA and VRE, hand-washing protective equipment (gloves, gowns). The staff will be informed as to the importance of following policies for the protection of the resident and also protecting themselves Continued on page 13.	

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F 441	Continued From page 12 Review of the facility policy titled "Isolation Precautions, Categories of" occurred on 12/01/10. The policy, dated 8/2010, stated, "Transmission-based isolation precautions will be used for residents who are documented or suspected to have infections or communicable diseases that can be transmitted . . . by contact with dry skin or contaminated surfaces. Policy Interpretation and Implementation . . . 4. In addition to Standard Precautions, Contact Precautions must be implemented for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. a. Examples of infections requiring Contact Precautions include . . . 1. Gastrointestinal, respiratory, skin, or wound infections or colonization with multi-drug resistant bacteria (with culture results at 100,000 col/ml [colonies per milliliter] or greater). . . . c. Gloves and Handwashing 1. In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, nonsterile) when entering the room. 2. During the course of caring for a resident, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage.) 3. Remove gloves before leaving the room and wash hands immediately with soap and water. 4. After glove removal and handwashing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident's room. d. Gown 1. In addition to wearing a gown as outlined under Standard Precautions, wear a gown (clean, Nonsterile) when entering the room if you anticipate that your clothing will have substantial	F 441	Continued from page 12 against disease. The Infection Control Nurse will conduct audits to monitor compliance monthly for 6 months, quarterly time 6 months and then annually. Audits will be reviewed by the QA Committee.	01/06/11

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contact with the resident, environmental surfaces, or items in the patient's room, or if the resident is incontinent, has diarrhea, an illeostomy [sic], a colostomy, or wound drainage not contained by a dressing. . . . g. Signs - A contact Isolation Notice will be used to alert staff of the implementation of isolation precautions, while protecting the privacy of the resident. . . ."

Review of Resident #11's medical record occurred on November 30 - December 02, 2010. Diagnoses included end-stage renal disease, methicillin-resistant staphylococcus aureus (MRSA), and history of infection with a drug-resistant microorganism. A Vancomycin Resistant Enterococcus (VRE) screen collected from Resident #11's anus on 10/23/09 showed, "Result: Vancomycin Resistant Enterococcus (VRE) detected . . ." Resident #11's final blood culture report, dated 10/22/10, stated, "Result: Staphylococcus Aureus (MRSA)." Resident #11's annual Minimum Data Set (MDS), dated 10/28/10, identified an active diagnosis of multidrug-resistant organism (MDRO).

Resident #11's discharge orders from the hospital on 10/22/10 identified: "Discharge Diagnosis: MRSA Bacteremia" and "Infection Control to indicate MRSA [positive] blood and VRE [positive] urine." Resident #11's discharge orders from the hospital on 11/19/10 identified: "Isolation type - Contact." Resident #11's certified nurse aide (CNA) plan of care included cards on contact precautions. One card stated, "[Resident #11's name] . . . has a MRSA infection per blood culture. Use contact precautions when providing direct care for her such as dialysis and assisting with incontinence ares [sic], dressing, partial baths, or linen changes. Contact precautions

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includes wearing a gown and gloves, and if splattering is anticipated, a mask should be worn. . . ." The other card stated, "[Resident #11's name] . . . has VRE in her Urine. Use Contact Precautions when providing direct care for her, such as assisting with toileting, partial baths, emptying her bedpan/commode or soiled linen changes. These precautions include wearing gloves, and if splashing is anticipated eye protection. . . ."

On 11/30/10 at 8:25 a.m., observation showed an isolation cart with a contact precautions sign on top of the cart outside Resident #11's room. Observation showed a CNA (#17) placed a gait belt on Resident #11, put her arm under resident's arm and held onto the gaitbelt on one side and a nurse (#18) held onto Resident #11's other side in the same manner. The staff members assisted Resident #11 to stand up from her wheelchair, pivoted, and transferred her to the bed. The staff members had direct contact with Resident #11's clothes, skin, and linens. The staff members failed to wear gloves or gowns as required per contact isolation.

On 11/30/10 at 9:04 a.m., observation showed a CNA (#17) and a nurse (#18) assisted Resident #11 to sit on the edge of the bed and stand by holding onto the gait belt and holding Resident #11 under the arms. The staff members assisted Resident #11 to stand on a scale, obtained her weight, assisted her back into bed, and lifted her legs to place a pillow under her knees. The staff members failed to wear gloves or gowns as required per contact isolation. The nurse (#18) then gloved, but failed to gown, before performing a dressing change to the peritoneal dialysis catheter site on Resident #11's abdomen. The

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staff members had direct contact with Resident #11's clothes, skin, and linens.

On 11/30/10 at 9:45 a.m., observation showed a nurse (#18) gloved and masked, clamped and removed the peritoneal dialysis solution tubing from Resident #11's dialysis catheter tubing, placed a new sterile cap on the catheter tubing, and emptied the contents of the urine bag into the toilet. The nurse failed to wear a gown as required per contact isolation.

On 12/01/10 at 12:50 p.m., during an interview an administrative nurse (#19) stated, "[Resident #11's name] was kept on isolation since her infection of VRE in April and continued on isolation with the MRSA in October. I would expect staff to wear a gown and gloves with cares, and a mask if they think may have a splash."

2. Based on observation, review of manufacturer's recommendations, review of facility policy, and staff interview, the facility failed to follow manufacturer's recommendations for cleaning areas used by residents, visitors and staff during 2 of 4 days of survey (November 30, 2010 and December 01, 2010). Failure to follow the recommendations has the potential to adversely affect the health of all residents, visitors and staff who utilize these areas.

Findings include:

The manufacturer's label for "Lemon Q," a cleaning product used by staff to clean multiple items, stated, "Directions For Use: It is a violation of federal law to use this product in a manner inconsistent with its labeling. For use on

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precleaned, hard, inanimate surfaces. For heavy soil or organic matter, a precleaning step is required. Rinse with clear water. Apply disinfectant solution of two ounces per gallon of water with cloth or mop to toilets, restroom floors, shower stalls, diaper pails, and garbage cans. Wet all surfaces thoroughly. Use four ounces per gallon of water for sick rooms, hospitals, or clinics. Keep surfaces wet for at least 10 minutes. . . "

Review of the facility policy titled "Cleaning of Common Areas" occurred on 12/02/10. This policy, dated 07/20/10, stated, " . . . V. Steps in the Procedure . . . B. Manufacturer's instructions will be followed for the proper use of disinfecting and cleaning products, including the recommended use-dilution, material compatibility, storage, shelf-life and its safe use and disposal."

- On 11/301/0 at 1:05 p.m., observation identified a housekeeper (#10) cleaning tables in the 500 unit parlor dining room. Observation showed the housekeeper sprayed the tables and immediately wiped the solution off with a cloth. When asked, the housekeeper (#10) stated her practice is to spray and immediately wipe the tables. Observation of the label on the container identified the product as Lemon Q, but failed to identify any contact time required prior to wiping the solution from the surface.

- A random observation, on the afternoon of 11/30/10, showed a housekeeping staff member (#11) sprayed Lemon Q on the game tables in the main corridor between the northeast and southeast courtyards and immediately wiped off the surfaces.

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- Observation in the dining room on 11/30/10 at 1:30 p.m. showed Resident #29 sitting at the table. A housekeeping staff member (#8) sprayed the table surface with Lemon Q disinfectant and left the area without wiping the table.

- Observation on 12/01/10 at 8:00 a.m. showed a housekeeping staff member (#8) used Lemon Q spray to clean the surfaces in Resident #28's room including, the bedside table top and stand. The housekeeping staff member sprayed the surfaces with Lemon Q and immediately wiped the surface off with a cloth.

During an interview on 12/01/10 at 8:30 a.m. a housekeeping staff member (#8) stated she uses the Lemon Q solution to clean all surfaces and was not aware of any surface contact time.

- During a random observation, at the transitional care unit, on the morning of 12/01/10, a housekeeper sprayed a cleaning product on the table by the nurses' station and immediately wiped the table. Random observations showed residents and staff used the table. When asked, the housekeeper provided the bottle for review. The label identified the product as "Lemon Q". The label lacked the contact time for the product, but stated to refer to the directions for use provided with the primary container.

During an interview on 12/02/10 at 10:45 a.m., an administrative staff member (#12) stated the proper procedure for cleaning the dining table is to use a solution of Dawn dish soap and water, followed by Oasis, and not "Lemon Q". This same staff member (#12) stated the "Lemon Q" is not meant to be used as an all-purpose cleaner and housekeeping staff are using the "Lemon Q" as

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F 441	Continued From page 18 an all-purpose cleaner.	F 441	Continued from page 18	01/06/11
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to comply with Life Safety Code requirement NFPA 99 for Health Care Facilities to protect the health and safety of residents, personnel, and the public, regarding oxygen storage in 1 of 5 medication rooms (200 unit). This failure could result in an oxygen tank falling and becoming a projectile, placing residents, staff, and visitors in the area at risk of injury. Findings include: Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with National Fire Protection Association (NFPA) 99, 13-5.1, 7-1.2, NFPA 70." Standard for the Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 state "Securing Compressed Gas Containers, Cylinders and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart,	F 454	It is the policy of Valley Eldercare Center to be designed, constructed,equipped and maintained to protect the health and safety of residents, personnel and the public. There was no intent for any resident, staff or general public to be hurt. The storage of oxygen tanks in holders was corrected before the end of the survey process. The oxygen/portable emergency policy 0.3.1c was reviewed and revised to address the storage issues. There will be two (2) tanks stored in the clean utility room on each unit. One (1) tank for Valley Eldercare Center, One (1) tank for Hospice, emergency use only. And these must be in holders. Staff will be in-serviced on January 5, 2011 of these changes to policy and procedure. There will be an audit completed weekly by the two (2) bath aides. There is a new form developed on which this will be documented. This will be an on-going audit for compliance. Continued on page 20	01/06/11

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F 454	Continued From page 19 framework, or fixed object by use of a restraint . . ." - During review of the medication room on the 200 unit, on 12/01/10 at 5:45 p.m., observation showed an empty oxygen tank standing unsecured in the medication room. The tank stood away from the cupboards and wall next to an individual wheeled oxygen tank cart with a tank of oxygen in place. Observation showed no available storage rack/area for the unsecured oxygen tank in the medication room. When interviewed, during the above review of the medication room, a nursing staff member (#6) confirmed staff failed to store the oxygen properly. This staff member (#6) moved the unsecured oxygen tank to the facility designated oxygen storage room. During an interview on 12/02/10, at 08:00 a.m., an administrative staff member (#7) the identified the facility does not have a policy on oxygen storage. This same staff member (#7) stated the staff have been trained, and know the facility standard to secure oxygen tanks in a two wheeled cart and place them in the clean utility room when stored on the units.	F 454	Continued from page 19 Attachment A (Procedure #0.3.1c) Attachment B (Emergency Portable Oxygen Storage Log (VEC)). Audits will be reviewed by the QA Committee.	01/06/11