STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____ APR 23 2010	04/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 04/05/10 and completed on 04/08/10, the sample included 2 residents for complete review, 9 residents for focused review, and 1 closed record for review.	F 000	The facility has prepared and submitted this Plan of correction because of the requirements Under state and federal law that mandate submission of a plan of correction to participate in the title 42 program. The submission of the plan of correction should in no way be considered or construed as an agreement with the allegations of non-compliance shall constitute this facility's credible allegation of compliance. This applies to tag's F164, F176, F278, F281, F323, F329, F428 F441	
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. This REQUIREMENT is not met as evidenced	F 164	Plan of Correction: 1) Education of all nursing staff regarding resident's personal privacy during cares will be completed at next Nursing meeting on May 11, 2010 and next CNA meeting on May 13, 2010. Education will include prevention of unnecessary exposure of body parts during cares/treatments (resident #5), the importance of knocking and introducing self before entering a resident's room or bathroom (resident #1, #11), and ensuring privacy curtains are pulled completely while cares are being performed (resident #11). Education will be provided by the Education/QA Nurse. 2) All residents have the potential to be affected by failure to ensure privacy. 3) A larger privacy curtain will be installed in the central bath area to ensure the curtain will provide sufficient coverage between wall spaces. All nursing staff will be educated regarding resident's rights to privacy, including preventing unnecessary exposure of body parts during cares/treatments, the importance of knocking and introducing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	4/22/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 by: Based on observation, record review and review of facility policy, the facility failed to ensure privacy for 3 of 8 sampled residents (Resident #1, #5, and #11) observed receiving personal cares. Failure to provide privacy to residents is a violation of resident's rights. Findings include: Review of the facility policy titled "Resident Rights Guidelines for All Nursing Procedures" occurred on 04/08/10. This policy, dated 11/18/09, stated "PURPOSE: To provide general guidelines for resident rights while caring for the resident . . . GENERAL GUIDELINES: 1. For any procedure that involves direct resident care, follow these steps: a. Knock and gain permission before entering the resident's room . . . f. Close the room entrance door and provide for the resident's privacy. . . ." - Review of Resident #5's medical record occurred on all days of survey. Resident #5's current quarterly Minimum Data Set (MDS), dated 02/17/10, identified the resident had no memory problems, independent in daily decision making, and able to understand others and make herself understood. Observation on 04/06/10 at 9:35 a.m., showed a certified nursing assistant (CNA) (#5) giving a bed bath to Resident #5. The CNA (#5) failed to place a cover over the resident after completing catheter/pericares, and the resident's periarea remained exposed for approximately five minutes while the CNA (#5) completed other tasks. Observation on 04/06/10 at approximately 10:00	F 164	self before entering a resident's room or bathroom, and ensuring privacy curtains are pulled completely while cares are being performed. Education will be provided by the Education/QA Nurse. 4) QA nurse will audit randomly on floor 3 times weekly for 1 month, then weekly for 2 months, then monthly times 3 months, then PRN to ensure the resident's right to personal privacy during cares. Any finding of failure to provide privacy as required will result in further education for the nursing staff responsible. Further monitoring will continue based on findings. QA nurse will track, trend, and report findings to the Director of Nursing for further evaluation and/or corrective action. 5) Completion date:	May 13, 2010

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F 164	Continued From page 2 a.m., showed two CNAs (#5 and #7) assisted a nursing staff member (#6) with repositioning of Resident #5 for a dressing change to her hip and coccyx. All three staff members turned the resident to her left side, which exposed her back and buttocks. The nursing staff member (#6) left the room to obtain additional supplies for the dressing change. The staff members failed to cover up the resident while the nurse left the room, which resulted in the resident having her back and buttocks completely exposed for approximately five minutes. - Observation on 04/06/10 at 10:45 a.m., showed a nursing staff member (#6) walked into Resident #1's room and failed to knock on the door before entering. Review of Resident #1's medical record occurred on all days of survey. Resident #1's current annual MDS, dated 01/22/10, identified the resident as having problems with short and long term memory, moderate impairment in daily decision making, and the ability to be understood and to understand others. - On 04/07/10 at 10:35 a.m., observation identified two Certified Nursing Assistants (#7 and #8) toileting Resident #11 in the central bath area. A sign on the door to the central bath stated "Please Knock." The area had spaces for shower and toilet facilities separated by curtains. Observation identified the curtain closed on one side of the toilet area and open on the other side. When the CNAs assisted Resident #11 to the toilet, one CNA (#7) partially closed the open curtain, leaving approximately one foot open to the hall/sink area.	F 164		

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F 164	Continued From page 3 The two CNAs (#7 and#8) remained with Resident #11 while she used the bathroom. At this point, another CNA (#5) entered the central bath hall area without knocking and walked directly to the toilet area. One CNA (#7) quickly closed the curtain as the other CNA (#5) attempted to enter. The CNA (#5) asked if a certain staff member was there. After determining the staff member was not present, the CNA (#5) then left the central bath. The medical record for Resident #11, reviewed on April 07-08, 2010, identified the resident as having short and long term memory problems, moderately impaired daily decision skills, and as understanding and being understood. Staffs' failure to completely close the privacy curtain before toileting the resident and to knock before entering the central bath or the toilet area placed Resident #11 at risk for having her privacy violated while seated on the toilet.	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, record review, and staff interview, the facility failed to determine resident's ability to self administer medications (SAM) for 3 of 4 sampled residents (Resident #3, #6, #7) identified able to self administer medications. Failure to determine	F 176	Plan of Correction: 1) Resident #3, #6, and #7 will have a new "Self-Administration of Meds after set up by nurse" form completed by Unit Manager and signature by resident's primary physician will be on resident's physician order sheet by April 30, 2010. The policy titled "Self-administration of meds at bedside or dining room table" will be reviewed. Upon completion of the assessments, we will verify the physician has signed the order, the order will be on the Physician order sheet to be reviewed monthly by the physician, and we will continue to update this policy per facility protocol.	

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F 176	Continued From page 4 if SAM is a safe practice places the resident at risk for improper use and/or, adverse reactions to the medication. Findings include: Review of the facility policy and procedure titled, "SELF ADMINISTRATION OF MEDS [medications] AT BEDSIDE OR DINING ROOM TABLE" occurred on 04/08/2010. This policy, dated 01/01/2009, stated, "The facility shall permit residents to self-administer their medications unless resident is deemed unsafe. . . . PROCEDURE: 1. The interdisciplinary team has determined it is safe for the resident to self-administer medications. 2. Physician order obtained. . . . 5. Resident's ability to self administer will be re-evaluated periodically." - Observation of medication administration occurred on 04/06/10 at 6:40 a.m. A licensed nurse (#9) prepared 11 oral medications for Resident #3. The nurse crushed some medications and mixed them in applesauce, but left others whole. After preparing the medications, the nurse took them to a table in the dining room, placed them on the table, and walked away. Observation showed Resident #3 seated near the table. The nurse stated Resident #3 would self-administer her medications. Review of Resident #3's medical record on all days of the survey, identified the facility admitted the resident on 02/04/2010. The medical record contained two forms entitled, "SELF ADMINISTRATION OF MEDICATIONS AFTER SET UP BY NURSE." The form dated 02/04/10, indicated "no," may self administer, and signed by a physician. A second form, dated 03/24/10,	F 176	2) All residents have the potential to be affected. 3) Charge nurses will be educated regarding self-administration of meds at next Nursing meeting on May 11, 2010. All residents will be reassessed by completing the "Self-administration of meds after set up by nurse" form. 4) Upon admission, a checklist is completed by the unit manager or charge nurse to ensure that the "self-administration" form is completed. After admission is completed, the QA nurse will verify all areas on the form are completed on all residents on every admission times 2 quarters, then randomly times 1 quarter, then PRN. 5) Completion date:	May 13, 2010

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F 176	Continued From page 5 indicated "yes," may self administer, and lacked a signature by a physician. Review of Resident #3's physician orders lacked an order for SAM. Resident #3's current care plan stated, ". . . nurse to give meds . . ." - Review of Resident #7's medical record on all days of the survey, identified the facility admitted the resident on 04/25/07. The medical record contained the form entitled, "SELF ADMINISTRATION OF MEDICATIONS AFTER SET UP BY NURSE." This form, dated 02/28/2008 indicated "yes," may self administer, and signed by a physician. Resident #7's care plan stated, . . . "nurse to give meds . . ." Review of Resident #7's Minimum Data Sets (MDSs), dated 01/21/09, and 10/23/09, indicated a decline in memory. Resident #7's monthly nurses note addressing SAM failed to identify this decline. - Review of Resident #6's medical record occurred on all days of the survey. A form in the medical record entitled "SELF ADMINISTRATION OF MEDICATIONS AFTER SET UP BY NURSE", dated 06/14/07, indicated a "yes" response to "May self-administer at dining room table." This form included signatures from the resident and a registered nurse, but lacked a physician's signature. Review of Resident #6's physician orders lacked an order for SAM. Resident #6's current care plan stated ". . . nurse to give meds . . ." In an interview on 04/08/10 at 8:40 a.m., a staff member (#1) stated the form represents a	F 176		

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F 176	Continued From page 6 physician's order and should be signed.	F 176		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/10/09. Based on record review, review of facility policy,	F 278	Plan of Correction: No.1 This corrective action will prevent any future errors noted on the submitted MDS regarding all residents. No. 2 All residents have the potential of being affected. No. 3. Addressing F-278 regarding accuracy on the MDS will reflect the true picture of the resident on the MDS. A flow sheet has been implemented to assist with the monitoring of data that is submitted on the MDS. The area of ulcers or skin concerns will be monitored as they occur. The skins and ulcers are reviewed daily by the management team and also bi-monthly at the falls and skin meeting. (Resident no. 5.) No. 3 The monitoring of diagnosis in correlation to the medications. The CPT codes will be updated with any changes in diagnosis noted in the history physical or progress notes. The new diagnosis will be submitted to medical records for input. The MDS nurse will correlate all antidepressant, ant anxiety, and antipsychotic meds with any new or old diagnoses. This will be monitored on the flow sheet also. (Resident no.11) The flow sheet will also include a three time check for information accuracy on the MDS prior to submission. This check will be done with another nurse or with the LSW. No. 4 These checks will ensure all	

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F 278	Continued From page 7 review of professional literature, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 2 of 11 sampled residents (Resident #5 and #11). Failure to accurately assess the residents for coding on the MDS may affect the appropriate level of care provided by staff in meeting the residents' needs and prevent the resident from attaining their highest level of physical, mental, and psychosocial functioning. Findings include: The Long-Term Care Facility Resident Assessment Instrument User's (RAI) Manual, Version 2.0, revised July 2008, page 1-25, stated "The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS information is the basis for the development of an individualized care plan . . . Medicare Prospective Payment System, State Medicaid reimbursement programs, quality monitoring activities . . . research, and policy development. Pages 3-159-3-165 of the RAI User's Manual, stated "M1. Ulcers (7-day look back) . . . Definition: . . . a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab or shallow crater . . . All skin ulcers present during the current observation period should be documented on the MDS assessment . . . M2. Type of Ulcer (7-day look back) . . . record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days . . . M3. History of Resolved/Cured Ulcers (90 days ago) . . .	F 278	information placed on the MDS will be accurate and will then be carried forward to the RAPS and CARE PLAN. This plan has been implemented by April 13th, and will continue for the next 2 quarters on all MDS's submitted. Then 2 MDS's per week for 1 qtr. This will be done by the MDS nurse. A revised MDS for resident no. 5 was completed and submitted. A revised MDS was revised for resident no. 11, raps were corrected regarding use of anti anxiety med and carried to care plan. No. 5. This corrective action will be in place by May 13. 2010.	

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F 278	Continued From page 8 Identification of this condition is important because it places the resident at risk for development of subsequent ulcers. . . ." Pages 3-124-3-125 of the RAI User's Manual, stated "H3. Appliances and Programs (14-day look back) Definition: . . . d. Indwelling Catheter- A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision . . . Coding: Check all that apply. These items should be coded if a resident has, or has had any of the items during the 14-day observation period. . . ." Pages C-87-C-89 of the RAI User's Manual, stated "17. RESIDENT ASSESSMENT PROTOCOL (RAP): PSYCHOTROPIC DRUG USE. I. PROBLEM- . . . all psychotropic drugs have the potential for producing undesirable side effects or aggravating problematic signs and symptoms of existing conditions . . . In reviewing a psychotropic drug regimen there are several rules of thumb: * Evaluate the need for the drug (e.g., consider intensity and quality of distress, response to nonpharmacologic interventions, pros and cons of drug treatment vs. no drug treatment) . . . * Each drug has its own set of actions and side effects, some more serious than others; these should be evaluated in terms of each users' medical status profile, including interaction with other medications. * Consider symptoms or decline in functional status as a potential side effect of medication . . . II. TRIGGERS-TO BE TRIGGERED, RESIDENT MUST FIRST USE A PSYCHOTROPIC DRUG . . . If used, go to RAP review if one or more of following present: PSYCHOTROPIC TRIGGERS	F 278		

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F 278	Continued From page 9 A . . . Potential for drug-related cognitive/behavioral impairment if: . . . Depression [I1ee=checked]. . . ." Review of the facility policy titled "Resident Assessment Instrument (MDS 2.0)" occurred on 04/08/10. This policy, dated 11/18/09, stated " . . . 3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4. Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. . . ." Review of the facility policy titled "Care Plans-Comprehensive" occurred on 04/08/10. This policy, dated 03/30/10, stated " . . . 2. The Interdisciplinary Team documents in the RAP summary sheet and/or records in the clinical record: a. The resident's status in triggered RAP areas; b. The team's rationale for deciding whether or not to proceed with care planning; and c. Evidence that the team considered the development of care planning interventions for all RAPs triggered by the MDS . . . 7. The resident's Comprehensive Care Plan is developed within seven (7) days of the completion of the resident's comprehensive assessment by MDS Coordinator. In room Care Plans to be developed and or updated as indicated/needed by Unit Manager. . . ." - Review of Resident #5's medical record occurred on all days of survey. The facility originally admitted Resident #5 on 08/13/08. Current diagnoses for the resident included neurogenic bladder and a pressure ulcer. The	F 278		

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F 278	Continued From page 10 current quarterly MDS, dated 02/17/10, identified the resident as frequently incontinent of bowel, continent of bladder, and on a scheduled toileting plan with pads/briefs used. The facility identified Resident #5 as having no pressure ulcers in the last seven days and without a history of resolved ulcers in the last 90 days. Review of Resident #5's interdisciplinary notes, skin/wound documentation sheets, care plan, physician's orders, and physician's progress notes for the look back period used to complete the 02/17/10 MDS (Assessment Reference Date of 02/12/10), indicated a pressure ulcer existed and Resident #5 had an indwelling catheter during both the seven and 90 day time frames. During an interview on 04/07/10 at 9:50 a.m., an administrative nursing staff member (#3) stated Resident #5's current quarterly MDS, dated 02/17/10, should have identified an indwelling catheter rather than a scheduled toileting plan, and the resident should have been coded as having one stage two pressure ulcer in the assessment reference date period, as well as having a history of pressure ulcers in the last 90 days. The nursing staff member (#3) stated the MDS errors were an oversight on her part. - Resident #11's medical record, reviewed April 07-08, 2010, identified diagnoses including paranoia, dementia with behaviors, anxiety state, and depressive disorder. Physician's orders identified current medications at that time included Risperdal (an antipsychotic), Buspar (an antianxiety), and Cymbalta (an antidepressant). A licensed practitioner's progress note, dated 12/29/09, stated, ". . . I did decrease her	F 278		

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F 278	Continued From page 11 Cymbalta [an antidepressant] to 30 mg [milligrams] daily times one week and then I will discontinue. . . ." A note dated 12/31/09 stated, " . . . At this time, we will increase her Cymbalta back to 60 mg daily." An annual MDS, completed on 01/06/10, identified the resident as receiving the antipsychotic, antianxiety, and antidepressant medications seven of the last seven days, but failed to identify a current diagnosis of depression at I.1.ee. Failure to code depression as a current diagnosis resulted in the Antipsychotic RAP not triggered. Since the RAP did not trigger, staff did not perform the RAP assessment for Resident #11's use of the Risperdal, Buspar, and Cymbalta. During an interview on 04/07/10 at 4:30 p.m. an administrative nurse (#3) stated the failure to code the diagnosis was "an oversight."	F 278		
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: Based on observation, record review, review of facility standing orders, review of professional literature, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #10) observed receiving medications with transcription errors and 1 of 1 sampled resident (Resident #5) observed receiving a medication/treatment written as a nursing order. Failure to transcribe	F 281	Plan of Correction: 1) Resident #5 had a physician order written for Bacitracin. Resident #10 inaccuracies in MAR will be corrected by April 23, 2010. 2) All residents have the potential to be affected. 3) All residents will have a 1 month look back on MAR and Physician orders for comparison and accuracy by NOC charge nurse. The NOC charge nurse will continue to complete 24 hour chart checks. The medical records coordinator will be designated to be the only one to enter orders and verify they are correct with the physician order and the MAR. New	

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F 281	Continued From page 12 physician's medication orders correctly has the potential to result in a medication error. Failure to consult the physician for appropriate medication/treatment orders has the potential to result in a negative resident outcome. Findings include: Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th Edition, 2008, page 840-841, stated "A physician usually determines the client's medication needs and orders medications, although in some settings nurse practitioners and physician's assistants now order some drugs . . . A drug order is written on the client's chart by a primary care provider or by a nurse receiving a telephone or verbal order from a primary care provider . . . The medication order is then copied by a nurse or clerk to a Kardex or medication administration record [MAR]. . . ." Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing, Concepts, Process, and Practice," 8th Edition, 2008, page 841, stated ". . . If your assigned client receives new medication orders, double-check the transcribed information with the primary care provider's order. This ensures client safety . . ." Page 849-850 stated " . . . Administer the drug. Read the MAR carefully and perform three checks with the labeled medications. Then administer the medication in the prescribed dosage, by the route ordered, at the correct time. There are aspects of medication administration that are important for the nurse to check each time a medication is administered. There are referred to as the "rights" . . . RIGHT DOSE . . . The dose ordered is appropriate for the client . . . Double-check calculations that appear	F 281	physician standing orders have been put in place and sent to the primary physicians for signatures. "Standing Order", "PRN", "Telephone", "Verbal", and "Physician Medication Orders" policies will be developed and reviewed with nursing staff by May 11, 2010. 4) DON will monitor 10% of medical records to ensure NOC nurse's accuracy of physician orders monthly times 2 quarters, then periodically thereafter. Education provided to charge nurses regarding new standing orders has been completed on April 13, 2010 by the Director of Nursing. Education will be provided to all nurses regarding the 5 rights of medication administration on May 13, 2010 by the Education/QA Nurse. QA nurse will audit medication pass for the 5 rights of medication administration monthly times 2 quarters, then PRN. 5) Completion date:	May 13, 2010

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F 281	Continued From page 13 questionable . . . Question a dose outside of the usual dosage range . . . Check Three Times for Safe Medication Administration. FIRST CHECK- Read the MAR and remove the medication(s) from the client's drawer . . . Compare the label of the medication against the MAR. If the dosage does not match the MAR, determine if you need to do a math calculation . . . SECOND CHECK- While preparing the medication (e.g., pouring, drawing up, or placing unopened package in a medication cup), look at the medication label and check against the MAR. THIRD CHECK- Recheck the label on the container (e.g., vial, bottle, or unused unit-dose medications) before returning to its storage place. . . ." - Observation on 04/06/10 at 10:15 a.m., showed a nursing staff member (#6) applied Bacitracin ointment to an area she referred to as a "tape burn" on Resident #5's lower left buttock. Review of Resident #5's record occurred on all days of survey. Resident #5's April 2010 treatment record and physician's orders lacked an order for the Bacitracin ointment the nursing staff member (#6) applied on the morning of 04/06/10. The facility's current standing orders, reviewed on 04/08/10, did not include Bacitracin. During an interview on 04/06/10 at 12:45 p.m., a nursing staff member (#6) stated she applied the Bacitracin to Resident #5 as a nursing order. She stated the morning of 04/06/10 was the first time she noticed the "tape burn" and stated she "will write the Bacitracin treatment as a nursing order and will put it in the treatment book." An interview with an administrative nursing staff member occurred on 04/07/10 at 11:10 a.m. The	F 281		

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F 281	Continued From page 14 staff member (#1) stated nurses are not to write orders for Bacitracin. He stated the nurse should have called the physician for orders on the tape burn, rather than applying Bacitracin and then writing it as a nursing order. The administrative nursing staff member (#1) agreed Bacitracin was not on the facility's current standing orders. - Random observations during the medication pass on the morning of 04/06/10 showed inconsistencies with Resident #10's Synthroid medication. Review of Resident #10's medical record occurred on April 06-08, 2010, and included the following: * Resident #10's April MAR showed "Synthroid 0.25 mcg [micrograms] (1 tab) by mouth one time daily" starting on 01/26/10. * The label on the current Synthroid cassette identified 25 mcg tabs of Synthroid. * The March 2010 Physician Order Sheet printout located in the resident's chart and signed by the physician each month, listed "Synthroid 0.25 mcg (1 tab) by mouth daily" starting on 01/26/10. * The original physician's order, dated 01/23/10, stated "Synthroid 0.025 mg [milligrams] 1 tab [by mouth] daily." Resident #10 received the appropriate dose of medication ordered by the physician, however inaccuracies with the MAR and Physician Order Sheet printout has the potential to result in medication errors. On the afternoon of 04/06/10, a nursing staff member (#6), stated in regards to Resident #10's Synthroid "I didn't catch the MAR being wrong when passing meds [medications] this morning." Facility staff failed to perform the necessary medication checks with the medication pass, and	F 281		

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F 281	Continued From page 15 failed to notice the MAR was incorrect and did not match the medication cassette or physician's order. After further review of Resident #10's medications, inconsistencies also existed with the Coumadin medication: * The original physician's order, dated 02/20/10, stated "Decrease Coumadin to 3 mg PO [by mouth] five days per week and 2 mg PO Monday and Thursday." * Resident #10's MAR and the label on the Coumadin cassette were consistent with the above order. * The March 2010 Physician Order Sheet printout located in the resident's chart differed from the physician's order, MAR, and cassette and stated "Coumadin tablets 3 mg (1 tab) by mouth five times weekly" and "Coumadin tablets 2.5 mg (1 tab) by mouth two times weekly" starting 02/20/10. Facility staff failed to accurately transcribe the physician's order for the twice weekly dose of Coumadin on the March 2010 Physician Order Sheet. During an interview on 04/08/10 at 8:00 a.m., a medical records staff member (#4) stated nursing staff enter the physician's orders into the computer, which generates the printouts for the medical record. She stated she double checks and compares the MAR and the computer information, but does not double check the information each month with the actual physician's orders. During an interview on 04/08/10 at 8:45 a.m., an administrative nursing staff member (#1) stated	F 281		

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F 281	Continued From page 16 the facility does not have a policy on transcribing and entering physician's orders and stated he realized their current process "has holes in the system and needs improvement."	F 281		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 03/15/07, 04/02/08, 04/15/09, 09/10/09. Based on observation, review of facility policy and procedure, record review, and staff interview, the facility failed to ensure 1 of 6 sampled residents (Resident #7) who experienced falls, received adequate supervision and assistance devices to prevent accidents. Failure to provide assistance devices puts the resident at risk for injury. Findings include: Review of facility policy titled "Assessing Falls and their Causes" occurred on 04/08/10. This policy, dated 11/18/09, stated, " . . . The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. 1. Review the resident's care plan to assess for any special	F 323	Plan of Correction: 1) For Resident #7, education was provided to nursing staff regarding safe transfer techniques on April 15, 2010. 2) All residents have the potential to be affected. 3) Education will be completed at next Nurse meeting on May 11, 2010 and next CNA meeting on May 13, 2010 regarding gait belt usage and locking wheelchairs with transfers. All "Fall Risk Assessments" will continue to be addressed as dictated by the MDS system. All care plan changes will be dated and initialed by Unit Manager in the resident's medical record. Nurse management will conduct a daily "Incident/Accident" report meeting to review the incidents/accidents as they occur. 4) QA nurse will audit randomly on floor for gait belt usage and safe transfer technique 3 times weekly for 1 month, then weekly for 2 months, then monthly times 3 months, then PRN. 5) Completion date:	May 13, 2010

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F 323	Continued From page 17 needs of the resident. . . . General Guidelines . . . 4. Falling may be related to underlying clinical conditions and functional decline, medication side effects, and/or environment risk factors. . . ." - Review of Resident #7's medical record occurred on all days of the survey, and identified the facility admitted the resident in April 2007. Resident #7's current care plan dated 04/25/07, listed a problem area of fall potential with recent falls. The care plan interventions included, see Activities of Daily Living (ADL) care plan, and bed alarm hooked to bed/chair so it goes off on call board at nurses station. The care plan lacked dates to identify when specific interventions started. Review of the facility's "Falls Incidents" tracking form, indicated that Resident #7 experienced four falls during the time frame of December 2009 to March 2010. Review of Resident #7's nurses notes indicated the following: * 02/18/10, 2:00 p.m., "Loud noise heard in rm [room] by staff res [resident] found lying on back [with] blood on floor, laceration noted to back of head approx [approximately] 2cm [centimeters] long . . ." * 02/18/10, 3:45 p.m., "Returned from clinic 5 stitches to back of head . . ." * 03/19/10, 11:30 p.m., "Resident on floor [at] 1845 [6:45 p.m.] ROM - WNL [range of motion within normal limits] discoloration noted L [left] elbow et [and] to of [sic] L hand on 2nd finger. Ice applied to hand, Aide reported she was walking resident to bed from the bathroom, Aide let go to pull bedding back resident yelled but aide stated ' It was too late I couldn't catch her.' Resident	F 323		

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F 323	Continued From page 18 assisted [up] [with] gait belt et assist x [times] [three] [without] difficulty, resident c/o [complained of] achiness [sic], Apap [acetaminophen] 650 mg [milligrams] adm [administered] [with] good results. . . ." Review of information sent to physician, dated 03/19/10, regarding Resident #7's fall, stated, " . . . c/o [complained of] pain to L hand et elbow. 2 1/2 cm bruise to L elbow. 3-4 cm bruise et hematoma to top L hand, 2nd finger, ice applied 2x [times], [decreased] swelling. [No] other injuries noted. . . ." During an observation at 12:20 p.m. on 04/06/10, a Certified Nursing Assistant (CNA) (#8) pushed Resident #7 in her wheelchair to the bathroom door. The CNA (#8) failed to apply a gait belt or lock the wheelchair brakes before assisting the resident to stand and transfer onto the toilet. When Resident #7 indicated she had finished, the CNA (#8) failed to apply a gait belt, locked only the left brake on the wheelchair and assisted the resident to stand and turn to sit in the wheelchair. Observation showed a gait belt around the CNA's waist, however, she did not use the gait belt during the transfer. Review of Resident #7's "My Daily Living Needs" form, located in the resident's chart and posted on the resident's bathroom door, indicated a safety device to be used, as "gait belt." This form, dated 02/24/10 and updated 03/22/10, stated "when working with resident keep hands on her gait belt for fall prevention." During an interview at 5:00 p.m. on 04/07/10, an administrative staff member (#1), identified the use of a gait belt as the current intervention for	F 323		

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F 323	Continued From page 19 Resident #7.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/10/09. Based on record review, review of facility policy, and professional reference review, the facility failed to ensure a medication regimen free from unnecessary drugs for 1 of 3 residents (Resident	F 329	Plan of Correction: 1) Resident #7 and #9 will have a review of medications in citation by Rose Bergquist, PA on April 27, 2010. 2) All residents have the potential to be affected. 3) At time of the survey, a change was already implemented for the pharmacy review. Pharmacy consultant received all F tag regulations in February and again on April 21, 2010. Drug Regimen Review form reviewed with Pharmacy consultant, Director of Nursing, and QA committee on April 21, 2010. 4) Audit will be completed weekly at the Mental Health meeting to include resident name, medication, dose, route, and frequency, date of order, date of projected attempt for reduction, and date of reduction. The Licensed Social Worker will track and report findings weekly at the Mental Health meeting. 5) Completion date:	May 13, 2010

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F 329	Continued From page 20 #9) receiving an antipsychotic medication and for 1 of 5 residents (Resident #7) receiving an antianxiety medication. Failure of the facility to monitor the need for these drugs and to attempt gradual dose reductions may result in residents receiving unnecessary medications. Findings include: The Centers for Medicare & Medicaid has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction (GDR) which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization or decline. For antipsychotic medication, within the first year the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. For hypnotic medication, as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated. Review of the facility policy entitled "TAPERING MEDICATIONS AND GRADUAL DRUG DOSE REDUCTION" occurred on 04/07/10. This policy, dated 09/01/07, stated ". . . Policy Interpretation	F 329		

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F 329	Continued From page 21 and Implementation . . . 4. The staff and practitioner will consider tapering under certain circumstances, including when: a. The resident's clinical condition has improved or stabilized; b. The underlying causes of the original target symptoms have resolved; c. Non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms; . . . 5. The physician will review periodically whether current medications are still necessary in their current doses; for example . . . whether those conditions and risks could potentially be equally well managed or controlled without certain medications, or with a lower dose. . . . 11. Within the first year . . . after the resident has been started on an antipsychotic medication, the staff and practitioner shall attempt a GDR [gradual dose reduction] in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. . . . 14. Attempted tapering of sedatives and hypnotics shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. Tapering shall be done consistent with the following: a. For as long as a resident remains on a sedative/hypnotic . . . the physician shall attempt to taper the medication at least quarterly unless clinically contraindicated. . . ." The Nursing 2009 Drug Handbook, 29th Edition, pp. 669-670, identified indications for Seroquel include Schizophrenia, Short-term treatment of acute manic episodes associated with bipolar I disorder, and Depression associated with bipolar disorder. The Handbook further states, ". . . NURSING CONSIDERATIONS . . . Alert: Drug isn't indicated for use in elderly patients with	F 329		

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F 329	Continued From page 22 dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection. . . ." - Review of Resident #9's medical record occurred on April 07-08, 2010. The facility admitted the resident in March 2009. The resident's diagnoses included Alzheimer's dementia and depression. Current medications included Aricept (a medication used for Alzheimer's disease) 5 milligrams (mg) every day, Remeron (an antidepressant) 15 mg every night (started 06/23/09), and Seroquel (an antipsychotic) 25 mg twice a day (started 07/07/09). Records indicated the initiation of Seroquel on 07/01/09 at a dose of 25 mg every night. Review of Resident #9's Minimum Data Set (MDS) revealed the following: * 03/13/09 (Admission MDS) Section E: (Mood and Behavior Patterns): Repetitive questions and repetitive physical movements seen up to five days a week. No behavioral symptoms (such as wandering, physically/verbally abusive, socially inappropriate/disruptive, resistant to cares) noted in this assessment period. *06/08/09 (Quarterly MDS) Section E: Repetitive questions and persistent anger with self or others present daily or almost daily, and sad, pained, worried facial expressions present up to 5 days a week. No behavioral symptoms noted in this assessment period. *09/07/09 (Quarterly MDS) Section E: Persistent anger with self or others; repetitive health complaints; sad, pained, worried facial expression; and repetitive physical movements noted up to five days a week. No behavioral symptoms noted in this assessment period.	F 329		

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F 329	Continued From page 23 *12/07/09 (Quarterly MDS) Section E: No mood or behavior patterns indicated. *03/03/10 (Annual MDS) Section E: No mood or behavior patterns indicated. Review of Resident #9's health care provider progress notes revealed the following: *04/15/09: ". . . [Resident #9] would like to return home. She feels that it is spring time and she needs to get back to take care of her house. She states that she enjoys doing housework. . . . does not appear to be in any distress. She was friendly and cordial. She used humor. She smiles frequently. Her affect was bright. . . . AXIS I. Dementia. She has a mild dementia. . . ." *05/13/09: ". . . She is quite alert and cheerful today. She still talked only about leaving and going back to [Resident #9's hometown] to live. . . ." *06/23/09: ". . . [Resident #9] has Alzheimer's dementia. She currently is having an increase in behaviors. She is becoming very demanding that she wants to go home but her home has been sold. . . . She has become more resistant also with her cares. . . . it is becoming more difficult to redirect her. . . . [Resident #9] does not appear to be in any acute distress. Her voice tones did range from anger to being calm. She did not become aggressive physically. She always came back to the topic of going home. . . . Axis I: Alzheimer's dementia. Depression. . . . PLAN: I started her on Remeron 15 mg every bedtime. . . ." *07/07/09: ". . . Currently she is wanting to go home. She states that she is not happy here. She refuses to participate in any activities, such as gardening outside. She states that she want [sic] to go home to garden in her own garden. . . . She does not have any physical behaviors. She does	F 329		

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F 329	Continued From page 24 become agitated and she gets very upset. She was started on Seroquel 25 mg every bedtime in addition to Aricept 5 mg daily and Remeron 15 mg at bedtime. . . . AXIS I. Dementia with depression. . . . PLAN: . . . At this time we will continue her Remeron and Aricept as is. Increase the Seroquel to 25 mg b.i.d. [twice a day] for confusion reaction; she does become quite agitated and upset. . . ." *08/12/09: ". . . We had a long talk today. . . . I don't think they [Resident #9's family] did notify her they were selling her house and things. She evidently found out from somebody in [Resident #9's hometown] who read in [sic] the paper. . . . I will decrease or withdraw the medications somewhat. . . . I don't think her dementia is all that bad. I think depression was a part of it too and that will continue to be treated. . . ." Progress notes (written by a different provider) from 10/26/09, 12/14/09, and 01/26/10 indicated the Seroquel dose was 25 mg daily, not twice a day as indicated by Resident #9's physician's orders since 07/07/09. The progress note from 12/14/09 also stated, ". . . As well as she is doing, we may be able to cut back on some of her medications here in a while also. Her confusion does seem to be disappearing. She is settling in a lot better and doing quite a bit better. . . ." A "PHARMACIST CONSULTANT REPORT: DOCUMENTATION OF RECOMMENDATIONS" form, dated 09/29/09 indicated the pharmacist questioned the use of Seroquel for "confusion reaction." The record failed to indicate that any action had been taken by the health care provider in regard to the pharmacist's note. Resident #9's medical record contained forms	F 329		

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F 329	Continued From page 25 entitled "CNA (certified nursing assistant) Daily Documentation." CNAs complete this documentation on each shift (3 times per day) to indicate the presence of mood and behavior patterns. Forms from November 2009 (the beginning of their implementation) through April 7, 2010 revealed no behavior patterns and two incidents of mood patterns (an unpleasant mood in the morning) on February 9 and March 18. Except for these two days, the forms were blank (indicating no mood/behavior patterns occurred). Review of nurses notes written from the day of admission through 04/07/10 indicated incidents on 15 days of the nearly 15 months reviewed. These incidents involved Resident #9 stating she wants to go home, asking staff when she was going home, and asking visitors to take her home. Quarterly social services notes from 06/08/09, 09/08/09, and 12/03/09 stated "No behaviors indicated." The resident's current care plan did not address any behavior problems and therefore did not provide any nonpharmacological interventions to attempt with the resident before initiation of antipsychotic medication. The facility's initiation of an antipsychotic without an adequate indication and continuing the medication without attempts at a dose reduction has resulted in the resident receiving an unnecessary medication. The resident may also experience complications from side effects and fail to achieve her highest level of well-being. - Review of Resident #7's medical record occurred on all days of the survey and indicated the facility admitted the resident on 04/25/07. Review of the current physician orders indicated Xanax (an antianxiety medication) 0.25 milligrams	F 329		

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F 329	Continued From page 26 (mg) two times daily with a start date of 04/25/07. A quarterly Minimum Data Set (MDS), dated 01/21/10, identified short and long term memory problems, an unsteady gait, and no mood or behavior symptoms. Review of the facility's "Falls Incidents" tracking form, indicated that Resident #7 experienced four falls during the time frame of December 2009 to March 2010. The record indicated on 02/18/10 the resident fell and sustained a laceration to the head which required stiches. The Nursing 2009 Drug Handbook, 29th Edition, pp 681-682 identified adverse reactions of Xanax, include dizziness, confusion, light-headedness, and sedation. Review of Resident #7's "PHARMACIST CONSULTANT REPORT DOCUMENTATION OF RECOMMENDATIONS," dated 03/30/08, 04/18/08, and 01/30/09 recommended a reduction and/or review of the Xanax dose. The medical record for Resident #7 lacked evidence the physician addressed the recommendations made by the pharmacist regarding the scheduled Xanax. Failure of facility staff to evaluate the appropriateness of a antianxiety medication creates the potential for a resident to receive an unnecessary medication and has the potential to affect residents' highest level of functioning.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428	Plan of Correction: 1) Resident #7 and #9 will have a review of medications in citation by Licensed Pharmacist before May 1, 2010. The pharmacist will report any irregularities to the attending physician and the Director of	

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F 428	Continued From page 27 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, professional reference, review of facility policy and procedure, and staff interview, the facility failed to act on recommendations made by the pharmacist for 1 of 5 sampled residents (Resident #7) receiving an antianxiety medication and 1 of 3 sampled residents (Resident #9) receiving an antipsychotic medication. Failure of the facility to act on the recommendations of the pharmacist may result in residents receiving unnecessary medications and has the potential to affect residents' highest level of functioning. Findings include: The Centers for Medicare and Medicaid Services (CMS) outlined the "Medication Regimen Review" (MRR) as a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team." Review of facility policy titled "TAPERING	F 428	Nursing and these reports will be acted upon. 2) All residents have the potential to be affected. 3) Medication review will be completed by the licensed pharmacist monthly and reported to the DON. The DON will forward the recommendations to the physician or physician assistant for a response to licensed pharmacist's recommendations. Copies of the recommendations will go to the Medical records for order entry to the physician order and a copy will go to the charge nurse for verification of recommendations/physician orders to the current physician order in the chart, the medication administration record, and the treatment record. The original copy of the pharmacist recommendations will be filed in the resident's medical record. 4) DON Nurse will audit 10% of resident's medical records monthly times 2 quarters, then periodically thereafter. 5) Completion date:	May 13, 2010.

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MEDICATIONS AND GRADUAL DRUG DOSE REDUCTION" occurred on 04/08/10. This policy, dated 09/01/2007, stated, " . . . After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. . . . 1. Periodically, the staff and practitioner will review the continued relevance of each resident's medications. . . . 5. The physician will review periodically whether current medications are still necessary in their current doses . . . "

- Review of Resident #7's medical record occurred on all days of the survey, and identified the facility admitted the resident on 04/25/07. Review of the current physician orders indicated Xanax (an antianxiety medication) 0.25 milligrams (mg) two times daily with a start date of 04/25/07.

Review of Resident #7's "PHARMACIST CONSULTANT REPORT DOCUMENTATION OF RECOMMENDATIONS," stated, the following:
* 03/30/2008, ". . . Possible [decrease] [decrease] Xanax [question mark] Response: [blank empty]"
* 04/18/2008, ". . . or Xanax [decrease] ? Response: [blank empty]"
* 01/30/2009, "On Xanax x [times] 1yr [year] any attempt to [decrease] dose? Response: [staff initials]"

The medical record for Resident #7 lacked evidence the physician addressed the recommendations made by the pharmacist regarding the scheduled Xanax the resident had been on since 04/25/2007.

The facility failed to provide additional information, upon request, regarding the

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F 428	Continued From page 29 physician addressing pharmacy recommendations for Resident #7. - Review of Resident #9's medical record occurred on April 07-08, 2010. The resident's diagnoses included depression and Alzheimer's dementia. Current medications included Seroquel (an antipsychotic) 25 mg twice a day. The resident began taking Seroquel twice a day on 07/07/09. A "PHARMACIST CONSULTANT REPORT: DOCUMENTATION OF RECOMMENDATIONS" form, dated 09/29/09 indicated the pharmacist questioned the use of Seroquel for "confusion reaction." The record failed to indicate that any action had been taken in regard to the pharmacist's note. Nurses notes indicated a health care provider visited Resident #9 on 10/06/09 to review the medication administration record (MAR). The health care provider failed to address the pharmacist's recommendations. During an interview on 04/08/10 at 10:30 a.m., a staff member (#3) stated that if there are no recommendations or changes, the health care provider does not always make a note in the chart.	F 428		
F 441 SS=D	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	F 441	Plan of Correction: 1) Education of all nursing staff regarding hand hygiene and infection control practices will be completed at next Nursing meeting on May 11, 2010 and next CNA meeting on May 13, 2010. Education will include re-training on the policy titled "Hand Hygiene" which includes guidelines from section 483.65 from F 441: Infection Control regarding when soap and water are	

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F 441	Continued From page 30 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 policies/procedures, review of professional literature, and staff interview, the facility staff failed to wash hands consistent with acceptable professional standards of practice for 2 of 8 sampled residents observed receiving personal cares (Resident #1 and #5). Failure to perform proper hand hygiene has the potential to affect	F 441	required under certain conditions, including before and after assisting a resident with toileting, after completion of personal hygiene, and after emptying urine from a Foley catheter (resident #1, #5). 2) All residents have the potential to be affected from failure to perform proper hand hygiene. 3) Hand hygiene posters will be made available near areas where hand washing will occur; such as by sinks and soiled utility rooms. All nursing staff will be educated regarding hand hygiene and the importance in preventing the spread of infection. 4) QA nurse will audit randomly on floor 3 times weekly for 1 month, then weekly for 2 months, then monthly times 3 months, then PRN to ensure consistent and acceptable professional standards of practice regarding infection control, including hand washing after each direct resident contact for which hand hygiene is indicated. Any finding of failure to perform proper hand hygiene as required will result in further education for the nursing staff responsible. Further monitoring will continue based on findings. QA nurse will track, trend, and report findings to the Director of Nursing for further evaluation and/or corrective action. 5) Completion date: May 13, 2010	

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F 441	Continued From page 31 the health and safety of facility residents, staff, and visitors. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 04/08/10. This policy, dated 12/14/09, stated " . . . the following is a list of some situations that require hand hygiene: When to wash your hands with soap and water: . . . 4. Before and after assisting a resident with toileting . . . When to use hand sanitizer: . . . 11. After contact with a resident's mucous membranes and body fluids or excretions. 12. After handling soiled or used linens, dressings, bedpans, catheters, and urinals. 13. After handling soiled equipment or utensils. 14. After removing gloves or aprons. 15. After completing duty. . . ." Review of the facility policy titled "Perineal Care" occurred on 04/08/10. This policy, dated 11/18/09, stated "PURPOSE: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition . . . For a female resident: . . . Wash perineal area, wiping from front to back . . . Remove gloves and discard into designated container. Wash and dry your hands thoroughly. . . ." Review of the facility policy titled "Procedure for Cleaning and Disinfecting of Bedpans, Urinals, and Graduated Cylinders" occurred on 04/08/10. This policy, dated 03/03/10, stated "1. Wash hands and apply gloves. PPE [personal protective equipment] will be donned as appropriate when handling body fluids. 2. Empty the equipment into the resident's toilet and place dirty equipment into	F 441		

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F 441	Continued From page 32 a clean bag. 3. Remove gloves and wash your hands . . . 6. Take bag containing the equipment to the soiled utility room. 7. Place an orange chux pad down over the countertop to ensure a clean surface area and to prevent contamination of the countertop . . . 9. Use the spray bottle to disinfect the equipment and leave the disinfectant on the equipment for 10 minutes. 10. Remove gloves and wash your hands. . . ." The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice regarding infection control which states hand hygiene (washing hands with water & soap or applying an alcohol-based hand rub) is the primary means of preventing the transmission of infection. Hand washing with soap and water is required under certain conditions, including before and after assisting a resident with toileting. - Observation on 04/06/10 at 8:45 a.m., showed a nursing staff member (#6) and a certified nursing assistant (CNA) (#5) transferred Resident #1 into bed. The staff member (#6) removed the brief, wet with urine, and placed a bedpan under the resident. The staff member (#6) then removed her gloves, but failed to wash or sanitize her hands and proceeded to go to the nurse's station to chart. - At 9:35 a.m. on 04/06/10, observation showed a CNA (#5) assisted Resident #5 with a bed bath. After completing peri/catheter cares, the CNA (#5) changed gloves, but failed to wash or sanitize his/her hands. The CNA (#5) proceeded to lotion Resident #5's face, removed gloves, offered the resident a drink of water, applied lip balm to the resident's lips with his/her finger, and then applied a new pair of gloves. The CNA (#5)	F 441		

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F 441	Continued From page 33 assisted with positioning the resident for a dressing change, removed gloves, offered the resident a drink of water, cleaned the wash basin, and then left the room to go on break. The CNA (#5) failed to wash their hands at any point in providing cares for Resident #5. Observation on 04/06/10 at 1:50 p.m., showed a CNA (#5) provided catheter cares to Resident #5 and then emptied the urine in the foley catheter bag into a graduated cylinder. After emptying the urine into the resident's toilet, the staff member (#5), who kept the gloves from the catheter cares on, took the graduated cylinder to the soiled utility room to disinfect. The CNA (#5) failed to remove the soiled gloves, and wash or sanitize his/her hands before leaving Resident #5's room. After disinfecting the graduated cylinder in the soiled utility room, the staff member (#5) removed their gloves and failed to wash or sanitize his/her hands after completing the task. The CNA (#5) then went directly into another resident's room to answer a call light. During an interview on 04/08/10 at 7:40 a.m., an administrative nursing staff member (#2) stated she trained and expected the staff to use soap and water to wash their hands after handling body fluids, including after emptying a catheter, and she expected staff to also wash their hands with soap and water directly after performing pericares.	F 441		