STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN - registered nurse LPN - licensed practical nurse CNA - certified nursing assistant DON - director of nursing MDS - Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	F226 It is policy of DCC that each resident has right to be free from verbal, sexual, mental abuse; corporal punishment, and/or involuntary seclusion. DCC abuse policy has been revised to reflect the regulatory requirements. The administrator or designee will be responsible for investigating all	
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 policies and incident records and staff interview, the facility failed to develop and implement policies to ensure allegations of abuse, neglect, or theft were reported immediately to all required agencies for 1 of 2 allegations reviewed. The findings were: 1. Review of the facility's "Abuse Policy" (undated) revealed: "The administrator or designee will notify the required agencies for reporting alleged resident abuse and follow-up with results of the investigation." The following concerns related to reporting requirements were identified: a. The policy did not specify the timeframe for reporting allegations of abuse to the state survey agency and other agencies. Review of the facility's incident records showed an allegation of	F 226	reports of abuse or suspected abuse. The administrator or designee will notify DFS and/or law enforcement and the board of nursing immediately of facility investigation. Administrator or DON will assign a designee to report any abuse or allegations of abuse that occurs when either one is out of building. 7/23/10 incident has been reported to DFS. All residents are at risk. All staff was in serviced on September 24, 2010 on policy & procedures on abuse notification within 24hours; staff will be in serviced quarterly. Investigations and Any allegations of abuse and the reporting of such abuse will be monitored monthly as part of QA meetings until resolved, then quarterly.	9/25/10

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

11/8/10

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.

RECEIVED
Wyoming Dept of Health

This POC accepted on 11/8/10 at 1150 with all additions & correction per phone communication Kelli Rogge Adm & Betty Nelson, RN, Health Surveyor

NOV 08 2010
Office of Healthcare Licensing and Surveys

DOUGLAS CARE CENTER

11/08/2010 10:04 FAX 3078581881 002

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 1 resident-to-resident abuse occurred on 7/22/10, but was not reported to the SSA until 7/26/10. During an interview on 8/26/10 at 9:30 AM, the administrator stated she was aware allegations should be reported to the SSA within 24 hours. However, she stated she and the DON were both out of the facility during the time the 7/22/10 allegation should have been reported. b. The policy did not specify that the Department of Family Services (DFS) or law enforcement would be notified of allegations of abuse, neglect, or theft. Review of the facility's documentation for the 7/22/10 allegation of resident-to-resident abuse showed no evidence either DFS or law enforcement was notified. On 8/26/10 at 9:30 AM, the administrator stated she did not notify DFS or law enforcement for allegations of resident to resident abuse. According to Wyoming's Adult Protective Services Act, 35-20-103, "...Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited, or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the Department of Family Services."	F 226		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272		

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F 272	Continued From page 2 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed for 6 of 11 sample residents (#1, #3, #4, #11, #14, #16). The findings were: 1. Review of the 8/9/10 admission MDS assessment showed resident #1 required comprehensive assessments for mood and behavior patterns, bowel and bladder incontinence, and pain. The record review revealed these assessments were not included. Interview with the MDS coordinator on 8/24/10 at 4:20 PM confirmed the comprehensive assessments had not been completed.	F 272	F272 Comprehensive assessments have been completed on sample residents: #1: deceased #3:10/5/10-cognitive loss, activities of daily living, functional/rehabilitation potential, bowel incontinence, pressure ulcers and psychotropic medications. #4:10/5/10-cognitive communication, ADL's, urinary incontinence, mood, behavior, falls, nutrition, dehydration, dental, pressure ulcers, and psychoactive drugs. #11: 10/5/10-bowel assessment #14:10/5/10-cognition, communication, ADL's, Urinary incontinence, mood behavior, falls, nutrition, dehydration, dental, pressure ulcers and psychoactive medications. #16: 10/5/10-psychoactive medication All residents are at risk for not having updated and accurate comprehensive assessments. All residents will their assessments evaluated to ensure accuracy, ~~on a monthly basis.~~ have DON or designee will do random chart audits on a monthly basis to ensure comprehensive assessments are completed in the time frame indicated by MDS protocol. DON and MDS coordinator attended MDS 3.0 training the end of September. Comprehensive assessments will be monitored until all issues all resolved and brought to QA, ~~and then brought to QA after:~~ then quarterly thereafter 10/5/10	

11/08/2010 10:04 FAX 3073581881 DOUGLAS CARE CENTER 004/019

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F 272	Continued From page 3 2. According to the 4/12/10 annual MDS assessment, resident #3 required comprehensive assessments for cognitive loss, activities of daily living (ADLs), functional/rehabilitation potential, bowel incontinence, pressure ulcers, and psychotropic medications. Review of the assessment documentation showed the assessment for cognitive loss was incomplete, and the others were missing. In addition, the assessment for urinary incontinence lacked the signature and date of completion. On 8/24/10 at 4:55 PM the MDS coordinator confirmed the problems with the cognitive loss and urinary incontinence assessments, and she reviewed the record and confirmed the other assessments were missing. On 8/25/10 at 8:10 AM, the MDS coordinator stated she was unable to find this resident's comprehensive assessments for ADLs, pressure ulcers, and psychotropic medication use. 3. Review of the annual MDS assessment dated 8/5/10 for resident #4 revealed the following areas triggered as requiring further assessment: vision, ADLs, urinary incontinence, psychosocial well-being, falls, dehydration, pressure ulcers, and psychoactive drugs. Further medical record review revealed there were no comprehensive assessments for those areas. There were blank Resident Assessment Protocol forms (RAP) attached to the 8/5/10 assessment. During an interview on 8/26/10 at 9:02 AM, the MDS coordinator stated the RAPs had not been completed for this resident's 8/5/10 assessment. 4. Review of the 8/4/10 annual MDS assessment for resident #14 showed the following areas were triggered, requiring further assessment: cognition, communication, ADLs, urinary incontinence,	F 272		

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F 272	Continued From page 4 mood, behavior, falls, nutrition, dehydration, dental, pressure ulcers, and psychoactive drugs. There were blank RAPs noted to be attached to the assessment documents. Review of the entire medical record showed no comprehensive assessments in those areas for the aforementioned. During an interview on 8/26/10 at 8:02 AM, the MDS coordinator confirmed the RAPs had not been completed for the 8/4/10 assessment. 6. Review of the 8/16/09 annual MDS assessment revealed resident #11 was incontinent of bowel. Review of the medical record showed no evidence a comprehensive assessment for bowel had been completed. During an interview on 8/26/10 at 9:45 AM, the administrator stated she was unable to find the required comprehensive bowel assessment for this resident. 8. According to the 1/7/10 annual MDS assessment for resident #16, the area of psychoactive drugs triggered as requiring further assessment. Section V referred to the "RAP 1/8/10" for assessment information. However, review of the 1/8/10 RAP assessment for psychoactive drugs showed it was incomplete. Interview on 8/26/10 at 4:30 PM with the MDS coordinator, failed to result in any additional assessment documentation for psychoactive medications for this particular resident.	F 272		
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	F 274		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 274	Continued From page 5 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 medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 1 of 2 sample residents (#3) who had experienced a significant change of condition. The findings were: According to the 4/12/10 annual MDS assessment, resident #3 had been independent with toileting and was usually continent of urine. Comparison of that assessment with the 7/15/10 quarterly MDS assessment showed the resident had declined in his/her ability to toilet independently and in urinary continence. The 7/15/10 documentation indicated the resident had become frequently incontinent of urine and had declined in his/her self-toileting ability. The July assessment documented the resident required extensive assistance with toileting. Interview with the MDS coordinator on 8/24/10 at 4:55 PM confirmed the decline. The coordinator acknowledged the decline required completion of a significant change assessment, which had not been done.	F 274	F274 DON or designee will do random chart audits on a monthly basis to ensure a significant change MDS assessment has been completed on those residents that experienced a significant change of condition. Significant change MDS was completed on sample residents #3 on 10/5/10 indicating that resident #3 is frequently incontinent of urine and requires extensive assistance to toilet. Sample resident #3 assessment has been completed. All residents are at risk for not having a compressive assessment done within 14 days after the DCC determines or should have determined that there has been a significant change in the residents physical or mental condition. All residents will be reviewed to see if significant changes assessments need to be completed. MDS coordinator and DON attended RAC-CT certification in Caster at the end of September. Change of condition assessments will be monitored in QA meetings until resolved, then on a quarterly basis.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		10/5/10

11/08/2010 10:04 FAX 8073581881 DOUGLAS CARE CENTER 007/019

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F 278	Continued From page 6 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: Based on medical record review and staff interview, the facility failed to ensure the accuracy of the MDS assessments, including required time frames for signatures and completion of Resident Assessment Protocols (RAPs), for 6 of 11 sample residents (#1, #3, #11, #16, #24). The findings were:	F 278	F278 It is policy of DCC that each individual who completes portion of MDS assessment must sign and certify the accuracy of that portion of the assessment. DON or designee will de random chart audits to ensure that their specific section of MDS and face sheet per instructions in RAI manual. Are completed. All resients are at risk and their assessmen are being reviewed for accuracy All entities will be in-serviced as to the section they are to sign on MDS and face sheet. Accuracy ~~Signatures~~ will be assessed for 6 months as part of QA then quarterly.	10/1/10 11/8/10

11/08/2010 10:06 FAX 8078681881 DOUGLAS CARE CENTER 008/018

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F 278	Continued From page 7 1. According to the Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, Revised December 2008, page 1-24, "...An RN coordinator must also sign and date the RAP Summary form at VB1 and VB2, the RAPs Completion Date, to signify completion of the RAI assessment." Review of the following RAIs revealed some of the RAPs were signed and dated after the VB2 date: a. The 1/7/10 annual RAI for resident #16. b. The annual MDS assessment dated 6/30/10 for resident #24. c. The RAPs for the 4/12/10 annual RAI for resident #3, in addition, Sections VB1 and VB3 were unsigned. d. Interview with the MDS coordinator on 8/26/10 at 9:02 AM verified the RAPs should be completed prior to the date signed as complete. 2. Review of the MDS assessments for resident #11 showed a quarterly assessment dated 2/27/10. There was another assessment dated 5/17/10 that had been completed after the resident was re-admitted from the hospital. However, it was only coded as a Medicare PPS assessment (at section AA, line 8b). During an interview on 8/26/10 at 9:02 AM, the MDS coordinator acknowledged the 5/17/10 assessment should also have been coded as an admission assessment (at section AA, line 8a). 3. Review of the admission MDS assessment dated 3/9/10 for resident #1 showed the attestation statements in Section AA9 and Section AD had not been signed. Per the instructions in the RAI manual, these statements are to be signed by each person who completes a portion of the assessment (Section AA9) and the	F 278		

11/08/2010 10:05 FAX 3073581891 DOUGLAS CARE CENTER 009/019

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F 278	Continued From page 8 person completing the face sheet (Section AD); the signatures attest to the accuracy of the information contained in the document. On 8/24/10 at 4:55 PM, the administrator stated the facility did not have an MDS coordinator in March 2010. During the same interview, the administrator confirmed the attestation statements were unsigned.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the care plan for 1 of 10 sample residents (#24) was updated. The findings were:	F 280	F280 It is policy of DCC that a comprehensive care plan for each resident is developed within 7 days of completion of MDS. Resident #24 deceased. A monthly care plan review will be held by IDT to ensure residents care and services are being maintained at the highest practicable physical mental and psychosocial well being. IDT will be in-serviced as to importance of updating care plan as to individual needs of each resident as it arises. All residents are at risk, and care plans will be reviewed for accuracy. Care plan updates will be monitored until resolved & taken to QA meetings monthly and then to QA quarterly after that.	10/1/10

11/08/2010 10:05 FAX 8073581881 DOUGLAS CARE CENTER 010/018

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F 280	Continued From page 9 According to the nutrition care plan dated 7/16/10, resident #24 was to have food items served in individual bowls. Observation of the 8/24/10 noon meal at 12:16 PM and the breakfast meal on 8/26/10 at 8:05 AM showed individual bowls were not used for the resident's food items. Interview with CNA #5 who was assisting the resident on 8/26/10 revealed the CNA had never seen the resident's food served in individual bowls. During an interview on 8/26/10 at 8:43 AM, the dietary manager verified the resident did not use individual bowls. She stated the resident refused to eat when served in that manner. The manager confirmed the care plan needed to be updated to reflect the change.	F 280	F314 It is policy of Douglas Care Center to do a risk assessment on all new admissions within 4 hours of admission by licensed staff. DON or designee will monitor all new admissions to ensure risk assessments have been completed within 4 hours of admissions.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to establish and implement a wound care program that provided consistent, accurate documentation related to wound appearance, the effectiveness of treatment interventions, and changes in the treatment plan for 1 of 2 sample	F 314	All residents are at risk and will have weekly skin assessment. If wounds or skin issue are found steps will 1. determine type of wound, EI: pressure, venous, arterial, diabetic/neuropathic 2. Measure, length, width, and depth of wound. 3. Note nay odor, drainage, slough eschar and character of surrounding tissue and document. 4. Consult wound care flow sheet for proper wound dressing 5. Completed "notice of significant change" form and notify MD. 6. If infection is suspected notify MD within two hours. 7. Notify DNS or RCC of wound and type of dressing used. 8. Add treatment to the TAR. and appropriate documentation will be done There will be appropriate steps to follow for wounds: 1. Abrasion: cleanse with wound cleanser, leave open to air, check every shift.	

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F 314	Continued From page 10 residents (#1) who had pressure sores. The findings were: According to the admission nursing note dated 9/18/10, resident #3 was admitted with two small scabbed areas on the buttocks. Observation and interview with the resident on 8/25/10 at 11:40 AM revealed s/he slept in a recliner. The resident stated staff encouraged him/her to move and explained the importance of staying off the sores. However, the resident further stated s/he "...wasn't going to [move]" or lie down on the bed. Observation of the sores on 8/25/10 at 3:22 PM showed no evidence of infection in either. The wound on the left buttock was approximately 0.3 centimeters (cm) in diameter with healed skin surrounding the scab. The right wound was approximately 0.4 cm in diameter with pink edges around the scab. Prior to the observation, the resident was leaning to the left while sitting in the recliner. Review of wound documentation revealed the following concerns: a. Although the form provided space for accurate documentation, staff failed to describe the appearance of the wounds, provide exact measurements, or indicate what treatments were being followed. b. There was no documentation indicating the effectiveness of previous treatments. During the observation on 8/25/10 at 3:22 PM, RN #4 stated dressings over the wounds just rolled up and left red marks which took over 24 hours to resolve. c. There was minimal documentation related to the resident's non-compliance with offloading or what alternatives had been attempted.	F 314	2. Skin tear: cleans area with wound cleanser, approximate edges, apply steri-strips as indicated cover with non-stick telfa & secure in place with hyper fix or sockinette. Check for s/s infection every shift, change dressing every day until are is resolved. 3. Stage II: ~~cleanse with wound cleanser apply non-stick telfa & secure in place with hyperfix or sockinette. Check for s/s infection every shift, change dressing every day & PRN~~, Notify Dr. Wound care team to assess for appropriate treatment plan 4. Stage III: wound care team to assess for appropriate treatment notify Dr. 5. Stage IV: wound care team to assess for appropriate treatment notify Dr. Licensed nursing staff will be in-serviced on 9/24/10 on DCC's policy of risk assessment being completed within 4 hours of admission. Risk assessments & skin issues will be until resolved and taken to monthly QA meetings and then quarterly. monitored	~~9/25/10~~ 11/8/10
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 6% OR MORE The facility must ensure that it is free of	F 332		

11/08/2010 10:05 FAX 3073588881 DOUGLAS CARE CENTER 012/019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____ 11/8/10 DC	C 08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 11 medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain a medication error rate below five (5) percent (%). Staff committed 11 errors out of 47 opportunities for error, resulting in an error rate of 23.4 %. The findings were: 1. Observation on 8/24/10 at 7:17 AM showed RN #4 administered Calcium 500 milligrams (mg) with Vitamin D 200 mg for resident #6. Comparison of the medication pass with the physician's orders revealed the order was for Calcium with Vitamin D 500 mg. At 9:35 AM that day, the RN confirmed the medication had not been administered as ordered. 2. Observation showed RN #6 was orienting with LPN #10. The RN prepared and administered medications, including Cogentin 0.5 mg, for resident #28 on 8/24/10 at 7:30 AM. Although the medication was on the medication administration record (MAR), reconciliation of the medication pass with the current orders revealed Cogentin was not included on the physician's signed recapitulation (recap) of orders, which became effective 8/1/10. On 8/24/10 at 9:10 AM, LPN #10 confirmed the medication was given without an order. 3. On 8/24/10 RN #6 was observed preparing and administering medications for resident #27 at 12:33 PM. The medications included acetaminophen 650 mg. Reconciliation of the	F 332	F332 It is DCC's policy ~~of DCC~~ that medications will be administered in a timely manner and as prescribed by resident's physician or facility's medical director. Resident #6 calcium 500 mg with Vitamin D 200 mg order was clarified on 8/23/10 by nurse #4. Resident #28 physician was notified that medication was given to resident without an order; and we did receive an order for Cogentin. Resident #27 MD order for Tylenol Miralax and vitamin C have all been corrected and clarified. Resident #20, the order for Caltrate was corrected and clarified. Resident #34, the order for Amaryl Metoprolol has been corrected and clarified. Medications have been corrected for resident #s. All residents are at risk; however no residents were at harm. Medication administration records have been compared to orders and are accurate. This issue will be monitored monthly until resolved.	

11/08/2010 10:08 FAX 3073581891 DOUGLAS CARE CENTER 013/019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____ 11/8/10	C 08/26/2010

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F 332	Continued From page 12 medication pass with the physician's orders revealed acetaminophen was ordered on an as needed (prn) basis. Further, the physician also ordered Miralax and vitamin C at noon; however, these medications were not administered. Review of the August 2010 MAR showed acetaminophen was scheduled four times a day and was administered per that schedule. The MAR showed the Miralax and vitamin C were also scheduled incorrectly. After reviewing the orders and MAR at 1:30 PM that day, LPN #10 confirmed the medications were administered incorrectly and that the resident did not request acetaminophen. Three errors occurred during this medication pass. 4. Observation showed LPN #1 prepared and administered Caltrate 600 mg + Vitamin D 400 mg for resident #20 on 8/24/10 at 6:35 PM. Reconciliation of the medication pass with the orders showed the resident should have received Calcium Carbonate 600/200 mg [Calcium 600 mg /Vit D 200 mg]. 5. Observation on 8/24/10 at 5:44 PM showed LPN #1 administered Neurontin 300 mg, Coumadin 3 mg, and Colace 100 mg to resident #4. Reconciliation of the medications with the physician's recap of orders, signed 8/16/2010, revealed the orders were for Neurontin 100 mg, Coumadin 6 mg, and Colace 100 mg pm. Review of the August 2010 MAR showed Colace was given routinely. Three errors occurred with administration of these medications. 6. At 8:47 AM on 8/25/10 RN #8 was observed administering medications after breakfast was finished to resident #34. The medications included Amaryl 1 mg. Reconciliation of the	F 332	All licensed staff will be in-serviced on 9/24/10, that medications must be administered as ordered. Each medication needs to be verified with MARS and physician orders.	11/8/10

11/08/2010 10:06 FAX 3073681881 DOUGLAS CARE CENTER 014/019

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F 332	Continued From page 13 observed medication pass with the physician's orders revealed Amaryl was specifically ordered before breakfast, and it was scheduled for administration at 7 AM. Reconciliation of the medications also revealed the resident did not receive Metoprolol 25 mg which was ordered twice daily. At 9:58 AM that morning the LPN stated the medication was not available and she had ordered it from the pharmacy. The LPN stated the medication was last administered around 5 PM the night before, and she was aware it should be given every twelve hours. Two errors occurred during this medication pass. 7. On 8/26/10 at 8 AM the DON acknowledged all medication errors.	F 332	F371 All dietary staff will be in-serviced on the sanitizer solution that is going to be used for sanitizing surfaces. The DM and RD will in-service staff and keep a log of the results of their random audits It will be monitored by current DM twice monthly and reported to QA until resolved and then quarterly. All residents are at risk for food born pathogens and illnesses. 11/8/10	
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of inservice education materials, the facility failed to ensure a sanitizer solution was properly prepared for sanitizing surfaces during two of two observations. The findings were: 1. Observation on 8/23/10 at 4:05 PM revealed	F 371		

11/08/2010 10:08 FAX 3078581891 DOUGLAS CARE CENTER 016/018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536040	A. BUILDING _____ B. WING _____ 11/8/10	C 08/26/2010

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F 371	Continued From page 14 two buckets on the counter in the kitchen. Interview with cook #1 at that time revealed the red bucket contained bleach and water, and the green bucket had only dish soap and water. Both buckets contained wet wiping cloths. When tested at 4:05 PM, the solution in the red bucket did not show any bleach content. At that time the cook stated it was tested when prepared; however, there was no log kept. She verified the test strip showed no concentration of chlorine bleach. She also revealed she was unaware that wet wiping cloths could not be stored in the soapy water. According to Food Code 2009, U.S. Public Health Service: 3-304.14, "...(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" 2. On 8/26/10 at 11:10 AM the solution in the red bucket showed no chlorine bleach content when tested. Interview with cook #1 at that time revealed it was prepared and tested at 8:30 AM that morning. She was unsure why it was not showing any bleach concentration. In addition, the green bucket with soap and water was on the counter next to the red sanitizer bucket and contained a wet wiping cloth. At 11:15 AM cook #2 came into the kitchen, got a clean dry wiping cloth, soaked it in the green bucket of soapy water and proceeded to wipe the counter surface. At no time did she sanitize the counter surface before she prepared sandwiches. According to Food Code 2009, U.S. Public Health Service: 4-702.11, "Utensils and food-contact surfaces of equipment shall be sanitized before use after cleaning." 3. Interview with the dietary manager on 8/26/10	F 371		

11/08/2010 10:08 FAX 3073581881 DOUGLAS CARE CENTER 018/019

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	535040	A. BUILDING _____ B. WING _____	C 09/26/2010

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F 371	Continued From page 15 at 2 PM revealed she was unaware that wet wiping cloths were to be held in a sanitizer solution. She also stated a recent inservice was conducted related to sanitizing food preparation surfaces. She stated staff should be aware of the need to ensure the concentration of the sanitizing solution and of the need to appropriately use the solution on counter surfaces. Review of the inservice materials showed education on the "Red sanitation bucket" was provided to the dietary staff on 7/31/10. The sign in sheet for the education showed cook #1 was in attendance; however, cook #2 was not listed.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431		

11/08/2010 10:08 FAX 3073581881 DOUGLAS CARE CENTER 017/019

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F 431	Continued From page 16 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure all medication labels included expiration dates in 2 of 2 medication carts. The findings were: Observation on 8/26/10 at 8:15 AM revealed both medication carts contained bottles of medications without expiration dates on the labels. The residents involved were #1, #3, #9, #10, #22, and #38. These medications included narcotics, and all came from the pharmacy identified by LPNs #10 and #3 as the "back-up pharmacy." Both LPNs confirmed the medications were currently being administered to the residents.	F 431	F431 It is DCC's policy to that all medications have expiration dates on them. This was corrected by Emissary Pharmacy who contracts through Safeway Pharmacy. All medications will have expiration dates on them. All residents are at risk & meds have been changed and have expiration dates on them. Resident #1: deceased. Resident #3: expiration dates added. Resident #9: expiration dates added. Resident #10: expiration dates added. Resident #22: deceased. Resident #38: expiration dates added There will be monthly audits of this done and reported to QA until resolved, then quarterly. DON or designee will monitor this.	11/8/10
F 507 S9=D	483.75(l)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 507		

11/08/2010 10:08 FAX 3073581891 DOUGLAS CARE CENTER 018/019

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F 507	Continued From page 17 Interview, the facility failed to ensure laboratory (lab) test results were filed in the medical record for 1 of 10 sample residents (#1). The findings were: Medical record review showed resident #1 had a urinary tract infection on 8/2/10. The record contained an order dated 8/3/10 for the lab to perform a culture and sensitive test on the resident's urine. Review of the medical record failed to show evidence of the test results. On 8/24/10 at 12:20 PM, RN #4 confirmed with the lab that the test had been done. However, she was unable to locate the lab test results.	F 507	F507 The facility will file the resident's lab result. RN#4 received faxed copy from lab on resident #1. It was given to surveyors during survey process. DON or designee will monitor labs weekly to ensure lab results are filed in medial records of resident charts in a timely manner. Licensed staff was in-serviced on the need to file labs when received into the patients chart on 9/25/10/ All residents are at risk for failure to file lab results in medical records. Lab results will be monitored until resolved and brought to QA then quarterly after that.	9/25/10

11/08/2010 10:06 FAX 3073581881 DOUGLAS CARE CENTER 018/019