POC accepted 11/22/11 JC

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

(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 MAR- medication administration record TAR- treatment administration record Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	F 244 This Facility will follow our grievance policy that ensures we will return to Resident Council and talk to the actions taken to resolve call light issues. This will be accomplished by: 1. a) Staff will answer call lights promptly, and will not turn the call light off if the need is not met at that time. Resident #59 will not wait 45 minutes for staff to return; b) Staff will report Resident needs to the nurse, and the nurse will promptly address the Resident's issues with her/him. Resident #55 will not wait for 30-45 minutes to have his/her needs met; c) Resident #63 will not wait for 30-45 minutes to have her/his needs met whether the mechanical lift is / is not involved. d) The Executive Director and/or Designee will address the Resident council monthly to share actions to resolve the Resident's issues of concern.	
F 244 SS=E	483.15(a)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, review of resident council meeting minutes, review of grievance information, and staff interview, the facility failed to act upon one of one unresolved group concerns related to answering resident call lights. The unresolved concern affected 4 of 20 sample residents (#47, #55, #63, #66) and 7 non-sample residents (#23, #54, #59, #65, #67, #73, #95). The findings were: Review of the resident council meeting minutes for May, June, July, August and September 2011 showed the residents raised the issue of call	F 244	Continued on next page.	

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

Jaad on behalf of Tim Haley, ED — Director of Nursing — 11/10/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Wyoming Dept of Health
NOV 10 2011
Office of Healthcare Licensure and Surveys

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VG011 Facility ID: WY0010 If continuation sheet Page 1 of 17

POC accepted. Call to Tim Haley, ED on 11/22/11 JC
Jeanelle Conlin 10/22/12

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F 244	Continued From page 1 lights not being answered in a timely manner. The comments showed the residents were concerned because call lights were turned off with staff to return "soon" to complete the task requested. The residents thought the time it took for staff to return was too long. The issue continued to be documented in the minutes each month under the category of "nursing" and each months minutes showed the concern was referred to the DON and the status was "open." The following concerns were identified related to this unresolved grievance: a. Interview with the resident group on 10/18/11 at 1:30 PM revealed the 9 residents (#23, #47, #54, #59, #65, #66, #67, #73, #95) who were in attendance thought the process of answering call lights remained an unresolved issue. The residents complained that although it had gotten somewhat better, the staff would still come in and turn off the light, then leave saying they would be back soon. Resident #59 stated at times, s/he would have to wait 45 minutes for staff to return. b. Interview with resident #55 and his/her family member on 10/17/11 at 4:45 PM revealed call lights were an issue. The resident stated at times s/he had to wait 30-45 minutes for assistance. If the call light was answered by a CNA and they were unable to help the resident, the call light was then turned off. The CNA then referred the resident's need to the nurse, and the resident waited for the nurse to respond. Further, the resident stated s/he had to call for help more than once and the process was sometimes repeated. c. During an interview on 10/17/11 at 4 PM, resident #63 stated s/he had to wait up to 30 minutes for the call light to be answered. Further,	F 244	F 244 Continued: 2. A call light audit will be conducted every shift during the week days and week-end days to include response time and continuing until the Resident need is met, and return to Resident Council with resolution. Each Resident reporting a concern will be given an action plan as to how this Facility will resolve and respond to his/her concerns. 3. The Executive Director will provide an education to the Activities Director, the Social Services Director, department managers and Facility staff on call light rules and appropriate reporting of Resident concerns, and the importance of follow-up to resolve and respond to Resident concerns. 4. A quality improvement monitoring tool will be developed to track the appropriate reporting of Resident concerns, resolution and response to Residents. Social Services Director will report monthly for three (3) months to the PI committee meeting or until compliance is ascertained.	11/30/11

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F 244	Continued From page 2 s/he had waited 30-45 minutes for staff to return with a mechanical lift for transfers to the bathroom. d. Interview with the social service designee and the administrator on 10/20/11 8:40 AM revealed there was a system to address specific resident grievances. The administrator stated the issue of call lights was addressed by verbal education he had provided to the staff and discussed in most daily meetings. However, the administrator verified the residents were not always informed as to what actions were being taken to address specific concerns. Further, there was nothing documented to show what actions were being tried.	F 244	F 280 This Facility will ensure that Staff Review and revise Resident care plans periodically and as status' change. This will be accomplished by: 1. a) Resident #55's care plan has been updated to show D/C of PICC line, added oral antibiotic for prophylactic TKA infection, D/C of Cymbalta, and updated wound status; b) Resident #81's care plan has been updated to reflect Resident's immobilizer to right knee/leg (when in bed) and impaired skin care plan updated to reflect wound to left buttock is healed as of 11/09/2011; c) Resident #90's care plan has been updated to reflect Residents change in antidepressant from Prozac to Remeron. 2. Each Resident's care plans will be reviewed with any significant change of condition and/or following the RAI process. Continued on next page.	
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.	F 280		

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and observations, the facility failed to ensure staff reviewed and revised the care plans as the status changed for 3 of 20 sample residents (#55, #81 and #90). The findings were: 1. Review of the medical record for resident #55 showed s/he had diagnoses to include diabetes, osteoarthritis, edema and muscle weakness. Review of the care plan for impaired skin integrity last dated 8/15/11 showed the resident had multiple pressure ulcers that were Stage II and Stage III. The treatments included applying calazime cream to the Stage II pressure ulcers. In addition, the care plan showed the resident had a PICC (peripherally inserted central catheter) line placed for antibiotic delivery. The following concerns were identified: a. Review of the 9/4/11-9/10/11 weekly pressure ulcer tracking report showed the resident now had one unstageable pressure ulcer on his/her coccyx. Interview with the wound care nurse on 10/20/11 at 1:10 PM verified the resident had one pressure ulcer. b. Review of the September 2011 MAR showed the PICC line was discontinued on 9/8/11 and the resident was started on oral antibiotics that same day. c. Review of the care plan for depression dated 8/15/11 showed the resident was on the antidepressant, Cymbalta. Review of the September and October 2011 MARs showed the resident was no longer on an antidepressant medication.	F 280	F 280 Continued: 3. The Director of Nursing (DON) and/or Designee will educate the nursing team to update care plans as Residents needs/cares change and/or when a Resident change of condition occurs. The DON and/or Designee will educate the Interdisciplinary Team (IDT) to review and revise periodically and/or with a change of condition to reflect the Resident current needs and cares. 4. The Resident Care Managers (RCM's) will audit Resident care plans quarterly to ascertain appropriateness to current needs, cares and status' of Resident care plans and report to the DON. DON will report the audit findings to the monthly PI committee for three (3) months or until compliance is ascertained.	11/30/11

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F 280	Continued From page 4 2. Review of the medical record for resident #81 showed s/he was re-admitted to the facility on 10/6/11 after being in the hospital for a displaced hip. The 10/6/11 nurse's note showed the resident returned with a leg immobilizer to avoid further dislocation. Random observations on 10/17/11 and 10/18/11 showed the resident wore the immobilizer on his/her right leg. Review of the resident care plan showed there was no mention of this devise. In addition, since returning to the facility on 10/6/11, review of a 10/11/11 wound assessment showed the resident had developed a stage II pressure ulcer on his/her left buttock. Review of the 9/12/11 care plan for impaired skin showed it was not updated to address this open area. During an interview with the DON on 10/20/11 at 11 AM she verified the care plan needed to be updated for this resident. 3. Review of the medical record for resident #90 showed s/he had diagnoses to include osteoarthritis, dementia and depression. The care plan last dated 9/20/11 showed the resident was on Prozac for depression. Review of the behavior monthly flow sheet for September and October 2011 showed s/he was on Remeron for depressive disorder. Review of the September and October 2011 MARs did not show an order for Prozac. The care plan failed to address the change of medication from Prozac to Remeron.	F 280	THIS PAGE HAS BEEN LEFT BLANK	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure staff followed the care plan for 3 of 20 sample residents (#55, #58, #111). The findings were: 1. Review of the 8/30/11 care plan for resident #58 showed s/he was at risk for pain. Further review of the care plan showed interventions included "anticipate and aggressively treat for pain before, during, and after prophylactic or painful treatments." Review of the nurses' notes on the reverse of the October 2011 MAR showed the resident received Tylenol 1000 mg on 10/16/11 at 2:30 AM and again at 11 PM with no evidence a re-assessment was performed to determine the effectiveness of the Tylenol. Continued review of this document showed the resident was administered Tylenol 1000 mg on 10/17/11 at 6:30 AM and again at 12:30 PM with the re-assessment both times noting the pain medication was not effective. Review of the medical record showed no evidence other interventions were implemented to address the resident's unrelieved pain at either of those times. 2. Review of the medical record for resident #55 showed s/he had diagnoses to include chronic kidney disease, edema, and septicemia (bacteria in the blood). Review of the care plan for impaired elimination last dated 8/15/11, showed the resident was to have his/her nephrostomy tube (tube that extends into the kidney) irrigated every four hours. Review of the TAR for August 2011 showed the treatment was not documented as	F 282	F 282 This Facility will ensure that services provided or arranged by the Facility will be in accordance with each Resident's written plan of care. This will be accomplished by: 1. a) Resident #58's needs for pain control has been reassessed, appropriately care planned and facility policy will be followed for reassessment following pain medication administration and appropriately documented on the MAR/pain flow sheet; Resident #55's nephrostomy tube will be irrigated according to Resident's care plan and documented appropriately on the TAR and/or MAR; b) Resident #111's care plan has been updated to reflect Resident's current need for pain management as well as reassessment per facility policy, and documented appropriately on MAR and/or pain flow sheet; Continued on next page.	

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F 282	Continued From page 6 being done 52 of 188 times (27.9%). The TAR for September 2011 showed the treatment was not documented as being done 42 of 180 times (23.3%) and from 10/1/11- 10/19/11, the TAR showed 6 of 111 times (5.3%) so far in the month where there was no documented evidence the treatment was done. 3. Review of the medical record for resident #111 showed s/he had diagnoses to include joint pain, neurogenic bladder, and multiple sclerosis. Review of the October 2011 MAR showed the resident received hydrocodone/APAP and Tylenol for pain as needed. Review of the care plan last dated 9/9/11 for alteration in comfort showed the staff was to monitor treatment effects within one hour of medication administration and at least every four hours. In addition, staff was to use non-pharmacological strategies to manage pain, such as massage and heat/cold. The following concerns were identified: a. Review of the pain flow sheet and MAR for August 2011 showed the resident was medicated 13 times for pain; however, seven times following the medication there was no documented reassessment to determine the effectiveness of the medication. Review of the MAR and pain flow sheet for September 2011 showed the resident was medicated 13 times, and 10 of those times there was no reassessment documented to the effectiveness of the medication. b. Review of the pain flowsheet for August and September 2011 showed there was no documentation that any non-pharmacological strategies to manage pain, such as massage and heat/cold had been attempted. 4. Interview with the DON 10/20/11 at 12:50 PM	F 282	F 282 Continued: b) Resident #111's non-pharmacological strategies for pain management will be reviewed and revised to meet Resident's current needs; 2. Each Resident's needs per their written plan of care will be provided by qualified persons. 3. The DON and/or Designee will educate Nursing department personnel to follow Resident's written care plans to meet the current needs of the Resident. 4. The RCM's will audit the MAR's, TAR's (including nephrostomy tubes), Pain Flow Sheet, etc. weekly and report monthly to the DON. The DON will report the audit findings to the monthly PI committee for three (3) months or until compliance is ascertained.	11/30/11

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F 282 F 309 SS=E	Continued From page 7 verified the care plans are to be followed and/or updated to meet the resident's current needs. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure monitoring and nursing measures were in place for preventive pain management for 3 of 11 sample residents (#30, #55, #58) who were treated for pain. In addition, the facility failed to assess and monitor a brace/immobilizer device, used for 1 (#81) of 2 sample residents who used a brace/immobilizer device. The findings were: 1. Review of the October 2011 TAR for resident #58 showed s/he had venous stasis ulcers on both heels, and the wound treatment included dressing changes every three days and as needed (PRN), whirlpool baths on bath days, and closed pulsating irrigation (CPI) Monday through Friday "if appropriate." Review of the nursing note dated 10/13/11 showed the resident had pain with wound treatments. Review of the 10/14/11 nursing note dated 10/14/11 showed the resident's heels also hurt when in the whirlpool even after Tylenol was given. Review of the	F 282 F 309	F 309 This Facility will ensure that each Resident will receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This will be accomplished by: 1. 1-a) The Facility IDT has assessed and addressed Resident #58's pain needs as they occur; 1-b) The Facility has care planned Resident #58's pain relief needs during CPI to include: a) administering pain medications within the hour of CPI treatments; b) Reassessing pain level during CPI treatment, and c) reassessing pain level after CPI is complete; 1-d) The Facility will proactively seek appropriate physician orders and medications from the pharmacy as reassessment prove needed for Resident #58. Continued on next page.	

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F 309	Continued From page 8 10/17/11 nurse's note timed 2 PM showed during wound treatments, the resident rated his/her pain an 8 on a scale of 1-10 with 10 being the worst. The following concerns were identified: a. On 11/17/11 a fax was sent to the physician requesting a stronger pain medication, four days after the resident was identified as having pain during whirlpool treatments. b. Observation on 10/18/11 at 11:20 AM showed the resident cried out in pain, grimaced, clenched his/her teeth and moaned frequently during the 50 minute CPI treatment to the resident's heels. The wound care nurse and the physical therapist performing the procedure discussed how painful it was for the resident. At one point they had to decrease the pulsating pressure due to his/her pain. Review of the October 2011 MAR showed the Tylenol 1000 mg was administered at 8:45 AM that morning, 2 hours and 35 minutes prior to the wound treatment. c. Interview with the DON at 10/21/11 at 2 PM via telephone revealed the physician's order for a stronger pain medication (Tramadol) was not received until 10/18/11. The order was then faxed to the pharmacy. The Tramadol was not received by the facility until 10/20/11 at 6 PM; seven days after it was determined the Tylenol did not control the resident's pain. 2. Review of the medical record for resident #30 showed s/he had diagnoses which included spinal stenosis and osteoporosis. Review of the physician's orders showed the resident had a 6/10/11 order for acetaminophen 325-650 mg orally every four hours PRN, and an 8/24/11 order for oxycodone 5/325 mg orally every six hours PRN for pain. Review of the resident's care plan	F 309	F 309 Continued: 2-a) The Facility will reassess Resident #30's pain level post medication administration per facility policy and document on the MAR / pain flow sheet. 3-a) The Facility will reassess Resident #55's pain level post medication administration per facility policy and document on the MAR / pain flow sheet; The Facility will review and revise Resident #55's care plan to reflect the non-medication interventions appropriate for Resident and document attempts on pain flow sheet; 3-b) Resident #55's pain will be addressed with appropriate non-medication and/or medication interventions when above "acceptable pain level" and reassessed and documented per facility policy; Continued on next page.	

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F 309	Continued From page 9 dated 8/9/11 revealed a plan to manage chronic back pain. The approaches showed assess for pain each shift, observe for non-verbal indicators of pain, and may need to use the Wong-Baker pain scale (a scale that depicts facial expressions associated with the number) to identify pain intensity due to impaired cognition. The care plan also showed the resident's acceptable level of pain was rated as 5 out of 10. The following concerns were noted concerning the facility's failure to adequately monitor pain intervention effectiveness: a. Review of the August, September, and October 2011 MARs and the associated pain flow sheets showed 22 times when pain medication was administered. Of those times medication was administered, there were 9 instances where the area for a post assessment to determine the effectiveness of the treatment was left blank. 3. Medical record review for resident #55 had diagnoses to include muscle weakness, osteoarthritis and kidney disease. Review of the October 2011 MAR showed the resident received acetaminophen 325 mg 1-2 tablets every 4 hours as needed for pain and acetaminophen 500 mg 2 tablets every 6-8 hours as needed for pain. The following concerns were identified: a. Review of the October 2011 MAR showed the resident received pain medication seven times from 10/1/11- 10/19/11. The pain flow sheet and MAR showed one time when the medication was assessed for effectiveness. Further, there was no evidence non-medication interventions were attempted. b. Review of the October 2011 MAR showed the resident's acceptable pain level was a 3 on a scale of 1-10. Review of the daily pain	F 309	F 309 Continued: 3-c) Resident #55 pain relief needs have been reassessed and Residents care plan has been revised to reflect current needs; 3-d) The Facility will follow it's policy for re-assessing and documenting Resident's pain relief needs as well as attempts to use non-medication interventions when appropriate. 4-a) The Facility team has assessed Resident #81, and reviewed and revised her/his care plan to reflect the Right knee immobilizer; 4-b) The Resident's right knee immobilizer has been added to the TAR to "observe every shift for proper placement" and "observe and intervene for possible skin breakdown due to immobilizer brace in place at all times"; 4-c) Resident #81's care plan has been updated to reflect Resident's current needs, cares and status. Continued on next page.	

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

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	535049	A. BUILDING _____ B. WING _____	10/20/2011

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F 309	Continued From page 10 assessment initialed as done from 6 PM-6 AM showed the resident rated his pain a 4 or above on 16 days from 10/1/11- 10/19/11. When the daily pain assessments and the MAR were compared, the documentation showed the resident was medicated for pain on 6 of those 16 days s/he reported pain 4 or above. c. Interview with the resident on 10/20/11 at 1:30 PM when asked if his pain medications were effective, s/he stated they help "some." d. Interview with the DON on 10/20/11 at 12:50 PM verified the process for assessing pain needed to be re-evaluated. Further, staff was encouraged to attempt the use of non-medication interventions to relieve pain. The nursing staff were to reassess the resident's level of pain using the 1-10 scale with 10 being the worst. 4. Review of the facility policy and procedure for pain management dated August 1, 2011 showed, "Reassess the resident's pain level after medication or treatments have been administered and document the resident's response to treatment. Plan pain management strategies for rehabilitation therapy so that the resident will have optimum success with therapy interventions with a minimum level of pain." Care related to an immobilizer device: Review of the 10/6/11 timed at 3:45 PM nurse's note showed resident #91 was re-admitted to the facility after going to the hospital for a dislocation of the right hip. On 10/6/11 when the resident returned to the facility s/he wore an immobilizer device on the right leg. Review of the medical record showed an order for this device was lacking. Interview with the DON and unit 1	F 309	F309 Continued: 2. Each Resident's care plans will be reviewed with any significant change of condition and/or following the RAI process by a team of qualified persons after each. 3. The Director of Nursing (DON) and/or Designee will educate the nursing team to ensure that each Resident will receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance the comprehensive assessment and plan of care; and to update care plans as Residents needs/cares change and/or when a Resident change of condition occurs. The DON and/or Designee will educate the Interdisciplinary Team (IDT) to review and revise periodically and/or with a change of condition to reflect the Resident current needs and cares. Continued on next page.	

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F 309	Continued From page 11 resident care manager (RCM) on 10/20/11 at 10:20 AM revealed the immobilizer device was ordered and applied while the resident was in the hospital. The RCM revealed a copy of the order was not in the medical record. At 10:35 AM the DON provided a copy of the hospital order dated 10/4/11 which showed, "right leg to be in knee immobilizer." There were no other orders in the medical record showing more clear directions for the use of this immobilizer device. Review of the skin assessment done on 10/6/11 showed a diagram with a surgical wound on the right hip, two blisters, one on the interior of the right groin, and one on the outside of the left hip. The diagram assessment also showed there was a bruise on the resident's right arm, and the right knee and lower right leg was circled with the word "immobilizer." Review of the 10/6/11 risk assessment for skin breakdown showed the resident was at high risk for developing pressure ulcers. The following concerns were identified related to the use of this device: a. Review of the medical record failed to show an assessment was done to determine the proper positioning/fitting and functional aspects of the device. Review of the TAR for October 2011 showed there was no mention of the immobilizer device being checked or monitored. Interview with the DON on 10/20/11 at 11:20 AM revealed there was not an assessment completed on the immobilizer device that was worn continuously by the resident. The physical therapy department mentioned the immobilizer in a 10/6/11 note; however, there was no documentation an assessment was completed. b. Observation on 10/13/11 at 10 AM revealed the resident had developed an open area on the back of the right calf and a soft red	F 309	F 309 Continued: 4. The Resident Care Managers (RCM's) will audit Resident care plans quarterly to ascertain appropriateness to current needs, cares and status' of Resident care plans and will report to their findings to the DON. DON will report the audit findings to the monthly PI committee for three (3) months or until compliance is ascertained.	11/30/11

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F 309	Continued From page 12 area on the back of the right ankle. Review of the 10/16/11 wound assessment faxed to the physician showed "...sore soft area noted just above back of R [right] ankle, which appears to be caused from knee immobilizer currently in place at all time-will apply sheep skin to area and to bottom of knee immobilizer for healing and preventative measures unless otherwise advised." A 10/19/11 physician communication showed "...open blister to R [right] posterior calf under knee immobilizer..." b. Review of the 9/12/11 impaired skin/pressure ulcer care plan showed it was not updated to include the immobilizer device. Review of the resident's entire care plan failed to mention the device until 10/18/11. Interview with the wound care nurse on 10/20/11 at 11:30 AM verified the immobilizer contributed to skin issues for this resident, and it should have been assessed initially and addressed in the care plan.	F 309	F 315 This Facility will ensure that a Resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections. 1. a) The Facility will ensure Resident #33 will have his / her nephrostomy tube irrigated per physician order and appropriately documented; b) The Facility has reviewed and revised Resident #111's care plan to reflect the daily "reminders" for the Resident to perform his/her own catheter care (as this is the request of the Resident). And, have offered education to Resident for days he/she feels the procedure cannot be self-initiated, the Facility will provide said cares. c) The Facility DON reported "the TAR had been changed to reflect Resident #111's daily catheter care was changed to be an "FYI" for the Facility to remind the Resident to perform catheter care and if unable the Facility was to complete the task".	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 315	Continued on next page.	

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F 315	Continued From page 13 interview, the facility failed to provide appropriate care to prevent urinary tract infections for 2 of 4 sample residents (#55, #111) who had either a catheters or a nephrostomy tube. The findings were: 1. Review of the medical record for resident # 55 showed s/he had diagnoses to include chronic kidney disease and diabetes. Review of the admission Minimum Data Set care area assessment (CAA) dated 8/4/11 showed the resident had a right nephrectomy (removal of the right kidney) and urostomy (channel for urine). The skin became macerated (soft white tissue) around the urostomy site and a nephrostomy tube (catheter tubing that is inserted into the kidney to drain urine) was then placed. The CAA also showed the resident had a history of recurrent urinary tract infections and urosepsis in June 2011. Review of the care plan last dated 8/15/11 showed the resident was to have the nephrostomy tube irrigated every four hours. Review of the TAR for August 2011 showed it was not documented the resident received the irrigations 52 out of 186 times (27.9%). Review of the September 2011 TAR showed it was not documented the resident received the irrigations 42 out of 180 times (23.3%). 2. Review of the medical record for resident #111 showed s/he had diagnoses to include neurogenic bladder and urinary retention. Review of the care plan last dated 9/9/11 showed an alteration in elimination and self care deficit. The care plan included information that the resident had a suprapubic catheter, chronic urinary tract infection, and the catheter had urine leakage from the suprapubic catheter site that caused skin	F 315	F 315 Continued: 2. This Facility will audit catheter care weekly for one month, then randomly for another two months to ensure each Resident receives appropriate treatment and services to prevent urinary tract infections. 3. The DON and/or Designee will educate Nursing department personnel to follow Resident's written care plans to meet the current urinary needs of the Resident. 4. The RCM's will audit the TAR's weekly for three months, then monthly and report their findings to the DON. DON will report the audit findings to the monthly PI committee for three (3) months or until compliance is ascertained.	11/30/11

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F 315	Continued From page 14 irritation. According to the care plan approaches, the resident was to receive catheter care per protocol. Review of the August 2011 TAR showed suprapubic catheter care was to be provided daily; however, it was not documented the resident received the care 13 of 30 days. Review of the September 2011 TAR showed the care was not documented as provided 7 of 31 days. Review of the October 2011 MAR showed a urinalysis was obtained on 10/17/11 and the resident was started on Diflucan 200 mg daily (a medication used to treat yeast infections). 3. Interview with the DON on 10/20/11 at 12:50 PM verified the treatments for these residents were to be provided as indicated, and needed to be documented.	F 315	F 441 This Facility will ensure the Infection Control Program designed to provide a safe, sanitary, and comfortable environment is maintained to help prevent the development and transmission of disease and infection. 1. This Facility will provide wound care per Facility Infection Control policy. 2. This Facility will audit wound nurses for hand washing and infection control practices weekly for one month, then randomly for another two months to ensure proper technique to prevent possible transmission of disease and infection of our Residents. 3. The DON and/or Designee, and Infection Control Nurse will educate Nursing department staff and other personnel to follow Facility Infection Control policies. Continued on next page.	
F 441 S3=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 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	F 441		

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F 441	Continued From page 15 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 and staff interview, the facility failed to ensure staff followed appropriate infection control practices regarding hand hygiene and contact precautions during 1 random observation. The findings were: Observation on 10/17/11 at 4:45 PM showed LPN #1 change the dressing of sample resident #56. The nurse cleansed her hands and put on gloves, then removed the old dressing from the wound. Without first removing the soiled gloves, and washing her hands, she proceeded to cleanse the wound and apply clean dressings. Interview with the DON on 10/19/11 at 2 PM verified the nurse was to remove her gloves and cleanse her hands before putting on new gloves to clean and dress the wound.	F 441	F 441 Continued: 4. The RCM's and/or Wound Nurse will randomly audit the Resident wound care treatments for three months and report their findings to the DON. DON will report the audit findings to the monthly PI committee for three (3) months or until compliance is ascertained.	11/30/11

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