

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

PRINTED: 04/26/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2007
NAME OF PROVIDER OR SUPPLIER GOSHEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2009 LARAMIE STREET TORRINGTON, WY 82240	
(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 080 F 356 SS- C	INITIAL COMMENTS F356 - 483.30(e) - POSTING STAFFING The facility must post the following information on a daily basis: - o Facility name. - o The current date. - o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. - o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: - o Clear and readable format. - o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. The Requirement is not met as evidenced by: Based on observation, the facility failed to post their nurse staffing information on a daily basis. The findings included: On 4/5/07 at 8:50 AM, observations made that the posted Resident Census and Nursing Staffing	F 080 F 356	The facility will ensure that we are posting nurse staffing data on a daily basis at the beginning of each shift in a clear, readable format and in a prominent place readily accessible to residents and visitors by: a) The facility staffing is now posted with up-to-date and current information. b) Nursing staff will be in-serviced on the expectations of posting staffing. Non-compliance will result in counseling with the RCD. c) Random monitors for posting will be done weekly by the RCD. Data will be collected monthly and reported quarterly to the PI Committee.	5/18/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Louise E. Patten CNO/AA

*

5/7/07

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 the 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.

MAY 23 2007

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F 000	Continued From page 1 was dated 04/03/07.	F 000			
F 164 SS=E	On 4/6/07 at 7:15 AM, observation revealed that the posted Nursing Staff list was dated 4/3/07. 483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY 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 by: Based on observation, record review, and staff	F 164	The facility will maintain the residents' right to personal privacy and confidentiality of his or her personal clinical records by: a) All potential new resident placements now take place in private areas. All shift reports now take place in private areas out of the presence of other residents. All of the letters from the physician's office with other resident names listed have been removed from all charts. b) Monitoring will be done on all potential resident placements by the SSD. She will collect the data monthly and report quarterly to the PI Committee. c) Random monitors of shift reports will be done weekly by the SSD with data collected monthly and reported quarterly to the PI Committee. d) Random monitoring will be done of personal resident cares on various shifts. Data will be collected monthly and reported quarterly to the PI Committee by nurse managers. e) Resident charts will be monitored randomly for privacy breaches on a monthly basis by the unit secretary. Reports will be given quarterly to the PI Committee.	5/18/07	

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F 164	Continued From page 2 interview, it was determined that the facility failed to provide privacy of medical information and/or to provide personal privacy while providing cares. The findings included: As an authoritative reference, the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule, December 3, 2002, Revised April 4, 2003 (45 Code of Federal Regulations 164.502(b), 164.514(d)), Minimum Necessary standard stated "The minimum necessary standard, a key protection of the HIPAA Privacy Rule, is derived from confidentiality codes and practices in common use today. It is based on sound current practice that protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguard as needed to limit unnecessary or inappropriate access to and disclosure of protected health information." 1. On 4/2/07 at 2:00 PM, an observation in the front lobby of the facility revealed a staff member (later identified by the Administrative staff to be the Social Service Director) discussing with family members the potential placement of a resident in the facility. The potential new resident's care issues were being discussed loudly enough that the survey team heard this information. There was a resident (later identified by the Administrative staff to be supplemental resident #34 and who was cognitively alert) seated adjacent to the area where the family members and staff members were seated. 2. On 4/5/07 at 2:15 PM, during an observation at the 200 Wing Nurses' station, supplemental	F 164	This Page Left Blank Intentionally		

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F 164	Continued From page 3 resident #28 was seated in his/her wheelchair approximately five feet from the Nurses' room where the charts were located. With the door open, the day shift nurse gave a verbal report to the evening nurse. This report included resident names and specifics of their care. The privacy of these residents' information was not protected as resident #28 and other people in the hallway could hear the information. 3. On 4/4/07 at 7:23 AM, during an observation of a medication pass on the 400 Wing, nurse A checked supplemental resident #25's blood sugar and administered insulin in the resident's abdomen. The resident was seated in the hallway outside of his/her room. There were other residents present in the area. 4. On 4/5/07 at 7:18 AM, during an observation of a medication pass on the 400 Wing, Nurse A checked supplemental resident #25's blood sugar and administered insulin in the resident's abdomen. The resident was seated in the hallway and was moved to the Certified Nurse Aide (CNA) desk. There were other residents present in the area. 5. Review of resident #4's medical record revealed a letter from a physician office dated 10/17/2006. The letter had listed Resident #4's name as well as the names of five other residents. a. On 4/3/07 at 2:00 PM in an interview with the RCD (Resident Care Director), she was shown the letter found in resident #4's chart. She reported that the letter should not be in resident	F 164	This Page Left Blank Intentionally		

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F 164	Continued From page 4 #4 's chart when it contained other residents' names. She further reported she would check the other residents' medical records and make sure the letter was not in their records. b. On 4/3/07 at 4:30 PM, in an interview with the Administrator and the Chief Nursing Officer (CNO), the CNO verified that the change of physician letter with six resident names on it should not have been in the residents' medical records.	F 164			
F 246 SS=E	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, family, and staff interview, it was determined that the facility failed to accommodate the needs of three of 15 sample residents (#5, #9, and #8) and three supplemental residents (#24, #30, and #35) by not ensuring that these residents had their call lights answered timely, had adequate staff to meet the residents' needs and/or had nutritional interventions implemented as planned for the residents. The findings included: MEAL OBSERVATIONS 1. On 4/2/07 from 5:50 PM to 6:53 PM, during an observation of the evening meal in the dining	F 246	The facility will ensure that the residents receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This will be accomplished by a). The staff have been educated on placing plate guards on the plates to ensure that the residents who need them have them at meals. Resident #5, #24, and #30 now have plate guards on their plates at meals. b). A computer program is being developed and staff will be in-serviced to ensure that all fluids are placed on the tray cards to eliminate any mistakes. This will ensure that residents get the fluid selections that they have chosen as well as those that have been ordered for them. Resident #5 is now getting her fluids at meals in 4 oz cups. c). Resident meals trays will be monitored monthly by the dietary manager to ensure the selections and needs are being met.	5/18/07	

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F 246	Continued From page 5 room, the following observations were made: a. Supplemental resident #24's tray card noted that the resident was to have a plate guard. The resident's food was served without a plate guard on the plate. After approximately ten minutes, when the surveyor stood behind the resident, a staff member placed a plate guard on the resident's plate. b. Sample resident #5's tray card noted that the resident was to have liquids in four ounce cups. The resident was observed to have milk and water served in eight ounce glasses. The resident did not consume any of the water. c. Supplemental resident #30's tray card noted that the resident was to have a plate guard. The resident did not have a plate guard on his/her plate at any time during this meal. 2. On 4/3/07 from 7:35 AM to 8:50 AM, during an observation of the breakfast meal in the dining room, the following observations were made: a. Supplemental resident #24's tray card noted that the resident was to have a plate guard. The resident's food was served without a plate guard on the plate. b. Sample resident #5's tray card noted that the resident was to have liquids in four ounce cups. The resident was observed to have water served in an eight ounce glass. The resident did not consume any of the water. STAFFING 1. On 4/3/07 at 1:30 PM, during a Group Interview residents stated that meals are served	F 246	This page left blank intentionally		

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F 246	Continued From page 6 "late a lot of the time on the weekends", and that "responses to call lights is often delayed due to shortage of staff on evenings and nights." 2. On 4/4/07 at 1:30 PM, a staff member stated he/she "often works alone and as a result, resident care is delayed. I feel, I am put in the uncomfortable position of getting all the work done or caring for residents." 3. On 4/5/07 at 8:15 AM, a resident seated near the Sunset nurses' station desk, who wished to remain unidentified, initiated a conversation stating "when staff, returning to work, they do not always know what happened (with residents), it is scary to me." 4. During an interview with Staff C on 4/2/07 at 3:15 PM, the staff member voiced concerns with staffing. Staff C stated, "There has been a real issue here lately with being short of help. There are a lot of things that are not getting done. There are some residents that just need more time than they are getting." 5. During an interview with Staff E on 4/2/07 at 3:10 PM, the staff member voiced concerns with staffing. Staff E reported that the wing had an extra float person for a couple of hours. Staff E stated, "It's unusual to get a float. We have been having problems being short of help." 6. During an interview on 4/4/07 at 1:50 PM with a resident who wished to not be identified the following concerns were voiced. The resident reported having to wait a long time to get his/her call light answered. The resident stated, "It seems pretty routine to wait 20 - 30 minutes to get help. I know sometimes other people are	F 246	This page left blank intentionally		

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F 246	Continued From page 7 being helped but sometimes you just can't wait that long. When staff does answer, it seems that they are always in a hurry. There is just not enough help. It's not there fault if they don't have enough help. It can be pretty short around here on weekends." 7. During an interview on 4/5/07 at 4:00 PM, a resident stated, "I think they are short of help. It seems hard to get help when you need it. They seem to be rushed and in a hurry. I had a problem with one that was rude and I told her she would get old someday. I know that my roommate has waited a long time to get the call light answered. I would say at least a half an hour. It seems evenings and nights is worse." 8. On 4/3/07 at 9:30 AM, during a confidential resident interview, the resident commented that sometimes you have to wait for call lights to be answered or to get assistance when you want it. The resident related this to the facility being short of staff. 9. On 4/3/07 at 10:45 AM, during a confidential family interview, the family member revealed that his/her family member (resident) sometimes waits up to 15 minutes for call lights to be answered. This has been observed by the visiting family member. The person expressed concerns about the length of time the resident has sometimes been left in his/her wheelchair.	F 246			
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	Please see next page		

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F 248	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interview, it was determined that the facility failed to provide ongoing, individualized activities program for five of 15 sample residents (#1, #5, #4, #11, and #6) and one supplemental resident (#19) who were not involved in group activities. The findings included: 1. Review of a listing of the residents in the facility dated 4/2/2007 provided by activities staff identified residents needing activities. The bottom of the sheet stated, "One's that have (*) are 1:1's (one to one) 1 x (time) weekly and x 3 means 3 x (times) weekly. The list identified 13 residents who were to get activities on a one to one basis one time a week. This included 5 sample residents #13, #11, #12, #4 and #8. There were four residents marked as receiving one to ones three times a week which included sample resident #8. 2. The observations during survey included: a. Resident #11 and supplemental resident #19 spent most of the day, when not at meals, in recliners in the hallway on the 200 Wing. These residents were not observed to be taken to activities being held in the activity room or provided small group or one to one activities with staff involvement. Note: Resident #11 was listed as receiving 1:1's, 1 x (time) a week. Supplemental resident #19 was not listed as receiving one to one activities	F 248	The facility activities department will ensure the residents ongoing group and or individual participation with activities through initial and ongoing assessments by: a) The initial assessment completed by activities staff will identify resident's interests. The ongoing assessment will ensure their physical, mental, and psychological well-being is being addressed. b) Residents # 1,5,4,11,6, & 19's activity needs are being reviewed and provided with small group and or 1:1 activities depending on their desires and level of functioning along with documentation reflecting activities provided. Residents # 13,11,12,4,8 are receiving 1:1 at least 2-3x weekly and encouraged to attend small groups. Residents # 4,11,19 plan of care now reflect activity participation. Resident # 11's documentation reflects 1:1 activity or reasons why not attending or participating. Resident # 5's documentation on temporary care plan is completed. Daily encouragement to attend activities will be documented. c) The facility activities department will use a Therapeutic Recreation Assessment Tool. The tool will help indicate change in activity interests. That information will be used to make necessary changes in documentation. d) Documentation will be reviewed monthly by the activities supervisor. In-servicing will be done with activities staff to further educate documentation expectations.		

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F 248	Continued From page 9 one or three times per week. A review of resident #19's activity log showed no one to one or small group involvement with staff for this resident. b. On 4/3/07 resident #4 spent the afternoon sitting in a recliner by the nursing station and then in a wheelchair. The resident was not taken to group activities in the main dining room or offered one to one activities with staff involvement. At 2:30 PM in an interview with staff D (nurse), she reported the resident had had a decline in his/her overall condition. Record Reviews: 1. Resident #4's medical record review revealed the resident was admitted to the facility on 7/28/06. The resident's diagnoses included: dementia other than Alzheimer's, CHF (congestive heart failure), HTN (Hypertension), arthritis, diabetes, diverticulosis, anemia, hypertension, recurrent UTIs (urinary tract infections), and history of trigeminal neuralgia (shooting pains in the facial area), and cancer of the colon. a. Review of sample resident #4's Minimum Data Set (MDS) dated 12/27/06 revealed the resident had moderate cognitive impairment. The resident required extensive assistance for Activities of Daily Living (ADLs), which included bed mobility, transferring, dressing, toilet use, personal hygiene and bathing. It identified that the resident was involved in activities some (1/3 to 2/3) of the time. b. Review of nurses notes from 1/15/07 to 4/1/07 showed the resident was having a decline in condition with included: increase in complaints of pain, edema requiring IV (intravenous) diuretic, recurrent UTIs (urinary tract infections),	F 248	e) Care plans and documentation will be reviewed and monitored by the activities supervisor. f) Data will be collected monthly and reviewed quarterly with the PI committee.		5/18/07

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F 248	Continued From page 10 significant weight loss and increase in confusion and lethargy. The notes also identified that the resident had been told about a family member's illness and was found at times crying and having concern with news. c. Review of the resident's activities log for 4/3/07 documented the resident was too tired for news and music. There was no documentation of one to one activities being provided. d. Review of resident #4's care plan with a status date of 12/01/06 identified that the resident needed encouragement to accept invitations to group programs. The outcome column stated, "Resident will develop daily routine to enhance mental stimulation E/B (?) Engaging in group and independent activities daily, will receive interactions 3-5 x (times) weekly." This care plan did not follow the documentation from the activity list that indicated the resident was to get activities on a one to one basis one time a week The interventions included: "Provide him/her with a monthly activities calendar. Inform him/her of group activities daily and encourage to attend. Escort as needed, Be aware he/she is more likely to attend if he/she is already out of his/her room and sitting in the common area or by the nurse's station, He/she likes to paint ceramics, He/she does have family and friends that do come into see him/her,	F 248	This page left blank intentionally		

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F 248	Continued From page 11 Offer to introduce to comparable peers, Provide him/her with 1:1 approaches 1 time weekly such as conversation, painting, manicure." The plan of care did not identify interventions to address this resident's needs based on a comprehensive assessment of his/her change in conation. There was no evidence the resident's psychosocial needs were being addressed with the resident's expressed concerns over a family member. 2. Review of sample resident #11's MDS significant change assessment dated 12/5/06 revealed the resident had moderate cognitive impairment. The resident required extensive assistance for Activities of Daily Living (ADLs), which included bed mobility, transferring, dressing, toilet use, personal hygiene and bathing. a. Review of resident #11's care plan with a print date of 2/28/07 identified activities. The care plan stated, "Not a joiner at groups prefers independent activities. Resident has a hard time making himself/herself understood. (Name) as socialization." The outcomes stated, "Resident will maintain satisfactory level of leisure pursuits on puzzles and has a history of crocheting. Ask him/her to come to group activities. (Name) will respond to 1:1 interactions.(Name) will be encouraged to participate in group activities of interest." The interventions included: "Offer (Name) activities 3-4 times per week. In	F 248	This page left blank intentionally		

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F 248	Continued From page 12 addition provide him/her a one to one interaction weekly... Encourage to accept invitations to programs... He/she prefers small groups or one to one interactions. (Name) at times has difficult time making self understood. Be aware that when (Name) is talking to you he/she will start talking in Yugoslavian. He/she enjoys visiting with people..." The plan of care did not reflect activities to address this resident's culture or history. The plan of care stated offering activities 3-4 times a week and the activity list only identified the resident needing one to one activities one time a week. b. Review of the resident activities log for 4/2/07 to 4/5/07 documented the resident was too tired or no reason given for not attending activities. There was no documentation of one to one activities being provided to this resident. The facility failed to provide for an ongoing program of activities designed to meet the needs, the interests and the physical, mental, and psychosocial well-being for this resident. 3. Record review for sample resident #1 revealed diagnoses that included hemiplegia, insomnia, malaise and fatigue, and osteoarthritis. Review of the resident's 3/8/07 significant change MDS assessment revealed that the resident required extensive to total assistance with all	F 248	This page left blank intentionally		

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F 248	Continued From page 13 Activities of Daily Living (ADLs). He/she was assessed to be involved in activities 1/3 to 2/3 of the time, preferring to be in activities in his/her room or day/activity room, and preferred cards, reading, religious activities, wheeling outdoors, watching TV, and talking. Review of the resident's Activities care plan had a review date of 12/13/06 and a target date of 3/8/07. The problem was listed as "Needs to remain active in independent pursuits, involved in independent activities of choice more than 2/3 of the time." The approaches included "Provide ____ (resident's name) with 1:1 approaches 2 - 3 time a month; Encourage to accept invitations to programs; Provide ____ (resident's name) with an monthly activity calendar posted in room. Invite ____ (him/her) daily to group activities..." Review of the resident's Resident Activities Logs for the months of January, February, March, and April, 2007 revealed the group activities were listed on each day. Further review evidenced that the resident seldom participated in these activities, as documented with the use of the facility codes. In 1/07, the resident was documented to have received 1:1s which consisted of assistance with his/her mail on 1/5, 1/11, 1/18, and 1/29. In 2/07, the resident was documented to have received 1:1s which consisted of talking with the resident (2/1), help with mail (2/8), talking (2/10), and meal assistance (2/24). In 3/07, the resident was documented to have received 1:1s which consisted of assistance with his/her mail on 3/22. In 4/07, the resident was noted to have received 1:1s which consisted of reading mail (4/2) and unspecified 1:1 (4/3).	F 248	This page left blank intentionally		

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F 248	Continued From page 14 On 4/5/07 at 3:00 PM, in an interview with an Activities Department staff member S, verified that sample resident #1 may have "slipped through the cracks" in relation to the provision of his/her 1:1 activities in March (2007). She indicated that they were working on establishing some small group activities and on improving the 1:1 program. She agreed that 1:1s two or three times a month and the lack of small group activities was not adequate for the residents who did not participate in large group activities. 4. Record review for sample resident #5 revealed that diagnoses that included angina, depressive disorder, hypoglycemia, sleep apnea, coronary atherosclerosis, diabetes, chronic airway obstruction, and trigeminal neuralgia (pain in the facial nerve areas). Review of the resident's 2/7/07 significant change MDS assessment revealed that the resident required extensive assistance with bed mobility, transfer, walking, and eating and total assistance with locomotion, dressing, personal hygiene, and bathing. He/she was assessed to be involved in activities 1/3 to 2/3 of the time, preferring to be in activities in his/her room, day/activity room, or inside nursing home/off unit and preferred music, reading, watching TV, and talking. Review of the Resident Assessment Protocol (RAP) Summary sheet evidenced that the resident triggered for all items except Delirium, Activities, Feeding Tubes, and Physical Restraints. Review of the resident's Activities care plan had a review date of 2/14/07 and a target date of 5/2/07. The problem was listed as "Needs encouragement to accept invitations to group programs." The approaches included "Provide	F 248	This page left blank intentionally		

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F 248	Continued From page 15 ____ (him/her) with 1:1 approaches 3 times weekly such as going for walks, massage and conversation; support ____ (his/her) family visits, provide ____ (him/her) with an monthly activity calendar. Inform ____ (him/her) daily of group activities daily and encourage ____ (him/her) to attend and escort if needed..." Review of the resident's Resident Activities Logs for the months of February, March, and April, 2007 revealed the group activities were listed on each day. Further review evidenced that the resident seldom participated in these activities, as documented with the use of the facility codes. In 2/07, the resident was documented to have received 1:1s which consisted of talking with the resident (2/14 and 2/17), walk around nursing home and up to hospital (2/17), talking (2/19), and hand massage (2/23). In 3/07, the resident was documented to have received 1:1s which consisted of talking on 3/2, 3/3, 3/6, 3/7, 3/8, 3/12, 3/14, 3/24 (ten days since the last 1:1), 3/29 (five days since the last 1:1), and 3/30 two times. In 4/07, there was no documentation that the resident received 1:1s. Observation throughout the survey time revealed that the resident sat in a recliner or his/her wheelchair, outside of his/her room. The resident was observed to talk to people who walked past him/her. The resident indicated that his/her hearing was too poor to attend group activities. 5. During daily observations on the 400 Wing, residents were often observed to be sitting in chairs in the hallway, sleeping in chairs in the hallway, wandering the halls, or sleeping in their or someone else's beds without staff interaction. Observation of staff interaction with residents was	F 248	This page left blank intentionally		

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F 248	Continued From page 16 related most often to the provision of care, i.e. feeding, toileting and medication administration. 6. Record review for cognitively impaired sample resident #6, revealed diagnoses that included dementia, atrial fibrillation, malignant neoplasm of prostate, chronic kidney disease. The resident's 1/25/07 significant change MDS assessment and the 11/23/06 Admission MDS assessment revealed that on the latest assessment, the resident required assistance to transfer. The assessments indicated that the resident was involved in activities more than 2/3 of the time, with assessed interests being music, walking/wheeling outdoors, watching television, and talking or conversing. The resident admitted on 11/16/06 had a Temporary Care plan, which did not address activities. a. The 12/7/07 Start Date, Active Care Plan Descriptor (Problem) stated: "not a joiner at groups prefers independent leisure pursuits." The Active Care Plan Outcome included "will receive activity approaches 1 to 3 times weekly." The Active Care Plan Interventions included "Encourage to try part of an activity", "Offer to introduce to comparable peers", "provide 1 to 1 approaches such as visiting in his room 1 time weekly", "prefers to sleep in ___ (his/her) room and not attend group activities." b. During all the survey observations, the resident was observed to sit in hallway alone or to lie on his/her bed not engaged in any activity. c. On 4/5/07 at 3:00 PM resident #6 approached the surveyor to engage in a conversation, relating memories of work related experiences in Wyoming and Oklahoma. The resident	F 248	This page left blank intentionally		

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F 248	Continued From page 17 expressed enthusiasm, cheerfulness and enjoyment during this interaction.	F 248			
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to develop care plan interventions to address facility assessed needs of two of 15 sample residents (#6 and #7) and one supplemental resident (#18) and failed to have residents' care plans accessible for staff use. The findings included: 1. During an interview with Staff B (nurse) on 4/4/07 at 1:15 PM the access to care plans was	F 279	The facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment by: a) The care plans for residents #6, 7, and 18 now have care plans that are accessible for staff use. All pain assessment forms for new residents are being done within the 24 hours of admission. All temporary care plans for new residents have been improved to include specific interventions for diagnoses, pain, assistance with ADL's, and other resident needs requiring ongoing interventions. All care plans being reviewed will be updated and returned to their halls within 24 hours of their review date. b) All staff involved in the care plan review and updating will be in-serviced on care plan expectations. c) Care plans, pain assessment forms, and temporary care plans will be monitored monthly for timeliness by the unit secretary. Quarterly reporting will be done to the PI Committee.		5/18/07

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F 279	Continued From page 18 discussed. Staff B reported that staff was to start an initial/temporary plan of care when the resident was admitted. The staff identified supplemental resident #18 as being a recent admission of 3/14/07. The care plan book was checked and had an initial care plan identifying three focus problems but no specific interventions for care to meet the resident's needs. Staff B reported that care plans including initial care plans are often taken off the unit and do not return until they are completed. At times they are off the floor for a month or more. The date for the comprehensive care plan was due was 4/3/07. Staff B confirmed that staff did not have access to care plans to ensure care needs identified on the initial care plan were being provided. 2. Review of supplemental resident #18's medical record revealed the resident was admitted to the facility 3/14/07 with diagnosis including: dementia, debility, and pneumonia. a. Review of the "Pain Assessment Form" was dated 3/16/07. Staff B reported that the pain assessment was supposed to be completed within 24 hours of admission however had not been done timely. The form identified the pain as intermittent and shooting, and the pain intensity as zero. The area under comments had documentation that stated the resident had a blister on right heel and cause of pain most likely pressure and swelling. The plan was to elevate feet as much as possible and heel pads while in bed. b. Review of resident #18's "Temporary Care Plan" listed: Problem 1) Rt (right heel) ulcer. -"Expected	F 279	This page left blank intentionally		

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F 279	Continued From page 19 resident outcome- Rec. Tx (receiving treatment) to R (right) ulcer + (plus) other ulcers." (The care plan did not identify the use of heel pads as stated on the pain form.) Problem 2) Pneumonia -"Expected resident outcome- resolve pneumonia without complications." Problem 3) Notable Sundowners- -"Expected resident outcome-reinforce - orient (orientate), rm (room), DR (dining room), etc." The care plan did not address specific interventions which included but not limited to: to treat the resident's pressure ulcer or interventions to prevent other skin breakdown, interventions to address pain management, assistance the resident may need with ADL's (activities of daily living), interventions to address monitoring of oxygen saturation and issues of infection with pneumonia. 3. Record reviews on 4/3/07, for sample residents #6 and #7 revealed that there were no Care Plans for these residents available to the floor staff on the Sunset wing. a. On 4/4/07 at 8:00 AM, an interview with Staff A revealed that Care Plans are often taken off the unit and do not return for periods of a month or more. The Care Plans are not available to floor staff during that period. "It has been this way the entire time here" b. On 4/3/07 at 5:15 PM, an interview with the MDS Coordinator revealed that Care Plans were not completed for residents #6 and #7 and the current MDS (Minimum Data Set) was on her	F 279	This page left blank intentionally		

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F 279	Continued From page 20 desk. c. On 4/04/07 at 9:30 AM, a second interview with the MDS Coordinator confirmed that Care Plans for residents #6 and #7 had not been completed and that they were on her desk. d. On 4/4/07 at 2:00 PM, a copy of the Active Care Plan printed at 04/04/07 13:16 (1:16 PM) for resident #6 was provided by MDS Coordinator. The Active Care Plan identified several dates. The Start Date, Status Date and Next Review Date and Target Date. MDS Coordinator explained that the Start Date is the date the problem is identified. The Status Date is the date the system is most recently updated. The Review Date is the projected quarterly review. i) On 4/4/07 at 1:30 PM, the Active Care Plan printed 4/4/07 by the MDS Coordinator for the Descriptor (Problem) MRSA POSITIVE identified a start date of 2/08/07, the Status Date was identified as 4/4/07, the Review Date was identified as 2/8/07. ii) On 4/4/07 at 8:15 AM, revealed that resident #6 was identified on the 3/26/07 Lab Bacteriology Final Report as MRSA Positive.	F 279			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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	F 280	The facility will ensure that a comprehensive care plan will be developed with 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, 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		

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F 280	Continued From page 21 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, record review, and staff interview, it was determined that the facility failed to update the care plans in a timely manner for four of 15 sample residents (#1, #13, #11, and #8) as their individual needs changed. Additionally, the care plans were not available for staff to use as guidance when providing cares based on individual resident assessments. The findings included: 1. On 4/4/07 at 4:05 PM, in an interview with the Resident Care Director (RCD) and the MDS coordinator, the MDS coordinator indicated that the staff were not updating the care plans (CP). She commented that the staff have been told about the need to update the care plans. The Coordinator revealed that the Minimum Data Set (MDS) assessments have been completed timely, but the CP updates had not been inputted. During the interview with the RCD and MDS coordinator, they confirmed that the facility did not have or use any type of Certified Nurse Aide (CNA) care plan, which listed the cares needed by individual residents. The RCD indicated that	F 280	assessment by: a) Care plans for residents #1, 8, 11, and 13 are now updated and available to staff on their units. b) Nursing staff will be in-serviced about how and when to update care plans to address and keep current with resident needs and CNA care plans—which are being developed. c) Care plan status date, next review date, review date and target date will be changed for clarification and to reflect actual review dates. d) Care plans will be checked to see if they are updated and relevant to the residents' needs by the MDS Coordinator on a monthly basis. She will report quarterly to the PI Committee.	5/18/07	

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F 280	Continued From page 22 the CNAs who are starting their shifts get report from the CNAs who are going off shift and from the nurses. 2. Record review of sample resident #1's 3/8/07 and 12/7/06 MDS assessments evidenced that he/she had been assessed as having significant changes in condition. On both of these MDS assessments the resident was assessed to require extensive or total assistance with all Activities of Daily Living (ADLs). The surveyor was unable to locate the resident's CP on the unit where he/she resided. During the interview with the MDS Coordinator, she verified that sample resident #1's CP was not currently at the nurses' station, but in her office. She confirmed that this resident's CP was last updated in 12/06. The CP was not kept updated and it was not available for the staff to use to provide consistent care to this dependent resident. 3. Record review of sample resident #13's 3/6/07 significant change MDS assessment evidenced that he/she had experienced a decline in bladder continence, a significant weight loss, and an overall deterioration in care needs. On the MDS assessment the resident was assessed to require extensive assistance with all Activities of Daily Living (ADLs), except locomotion on and off the unit. The surveyor was unable to locate the resident's CP on the unit where he/she resided. On 4/5/07 at 6:00 PM, in an interview with the MDS Coordinator, she verified that sample resident #13's CP was not currently at the nurses' station, but in her office. She confirmed that this	F 280	This page left blank intentionally		

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F 280	Continued From page 23 resident's CP was last updated in 12/06. The CP was not kept updated and it was not available for the staff to use to provide consistent care to this dependent resident. 4. Review of sample residents' Active Care Plans revealed that the stated Interventions were often justifications for the stated Descriptors (Problems) i.e. under Descriptor Activities: "Declines all activity invitations prefers to remain in own room." Intervention included "prefers to sleep in his room and not attend group activities." 5. On 4/3/07 at 9:00 AM, record review revealed that the Active Care Plan for resident #8, printed on 3/1/07, and located in the Resident Care Plan Book was not current or updated. The Active Care Plan identified various dates for the Start Date, Status Date, Next Review Dates, Review Date and Target Dates that were confusing: a. The Active Care Plan for the Descriptor (Problem) Activities identified a start date of 10/26/07, the Status Date was identified as 3/1/07, Next Review Date was identified as 11/30/06, Review Date was identified as 12/21/06, Target Date was identified as 3/15/07. b. The Active Care Plan for the Descriptor (Problem) Advanced Directives identified a start date of 8/18/03, Status Date was identified as 5/26/06, Next Review Date was identified as 11/30/06, Review Date was identified as 12/21/06, Target Date was identified as 3/15/07. c. The Active Care Plan for the Descriptor (Problem) Cognitive identified a Start date of 8/18/07, Status Date was identified as 3/1/07, Next Review Date was identified as 11/30/06,	F 280	This page left blank intentionally		

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F 280	Continued From page 24 Review Date was identified as 12/21/06, Target Date was identified as 3/15/07. d. The Active Care Plan for the Descriptor (Problem) Continence identified a Start date of 7/28/07, Status Date was identified as 3/1/07, Next Review Date was identified as 11/30/06, Review Date was identified as 12/21/06, Target Date was identified as 3/15/07. e. The confusing pattern of dates continued for all Active Care Plan Descriptors (Problems) including; Communication, Constipation, Dental Care, Delirium, Dehydration, Discharge, Falls Activities of Daily Living, Mood, Nutritional Status, Pain, Psychotropic Medications, Restorative Care, Vision and Psychosocial. 6. On 4/5/07 at 6: 30 PM, MDS Coordinator explained that the Active Care Plan Start Date is the date the problem (Descriptor) is identified. The Status Date is the date the care plan is most recently updated in the system. The Review Date is the projected quarterly review, the Target Date is a date of a problem (Descriptor) may be resolved. The explanation included the admission that many dates are inconsistent, confusing and have not been updated. 7. Review of resident #11's medical record identified the resident had multiple falls. The resident's plan of care was not updated to show alternate or changes in care in an attempt to prevent further falls. Cross refer to F324. 8. The facility failed to ensure that resident care plans were updated to address resident needs for activities. The residents identified as needing one to one activities or small group activities did not have specific interventions to meet their needs.	F 280	This page left blank intentionally		

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F 280	Continued From page 25	F 280			
	Cross refer to F248.				
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS 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, it was determined that the facility failed to follow professional standards when administering medications to one of 15 sample residents (#1) and one supplemental resident (#17). The findings included: STANDARD OF PRACTICE: ADMINISTRATION OF MEDICATIONS: Standards for nursing practice for administration of medication provide, in pertinent part that: The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients. Medications must be accurately administered and documented. Accurate administration includes, in the first instance, a physician order authorizing the administration of the medication; if an order is not clear, the nurse should communicate with the physician to seek clarification. Thereafter, accurate administration includes transcribing the drug order correctly, delivering the correct drug, to the correct resident, by the correct route, in the correct dose. Accurate documentation involves recording information on the drug administered, including the client's response to the medication. The physician may order a drug on a PRN basis (when a client requires it). The nurse uses objective assessments, subjective assessments,	F 281	The facility will ensure that the services provided or arranged by the facility will meet professional standards of quality. a) All nurses now verify resident #17's medications with the resident's MAR before administering. All residents' medications are verified with their MAR by the nurse before administration. b) All nurses will be in-serviced in the nursing standard of practice with medication administration. Random checks of medication administration practice will be done by the RCD monthly and reported on a quarterly basis to the PI Committee.	5/18/07	

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F 281	Continued From page 26 and discretion in determining the client's need. When medications are administered, the nurse documents the assessment made and the time of drug administration. The nurse should make frequent evaluation of the effectiveness of the drug and record findings in the appropriate place. See generally: Lippincott, Nursing Drug Guide, 1998 (Lippincott) and Perry & Potter, Clinical Nursing Skills & Techniques; 1998, (Perry & Potter). 1. On 4/5/07 at 8:00 AM, during an observation of a medication pass, Nurse D administered supplemental resident #17's medications. The nurse was observed to prepare the medications by taking the medication cassettes out of the drawer, removing the tablets, and taking the medications to the resident in the dining room. The nurse did not verify these medications with the resident's Medication Administration Record (MAR). 2. On 4/5/07 at 10:55 AM, during an observation of a medication pass, Nurse A administered eye drops to sample resident #1. The nurse was not observed to check the resident's MAR before administering this medication.	F 281			
F 309 SS=D	483.25 QUALITY OF CARE 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:	F 309	The facility will ensure that each resident receives 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 by: a) Resident #11's prn pain meds are changed to routine with prn meds for		

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F 309	Continued From page 27 Based on observation, record review, and staff interview, it was determined that the facility failed to provide care in a manner to ensure adequate pain relief and provide appropriate neurological monitoring for residents who experienced head trauma. This failure affected three of 15 sample residents' (#5, #11, and #1) and one supplemental resident's (#18) ability to reach their highest practicable level of physical, mental, and/or psychosocial functioning. The findings included: 1. Review of sample resident #11's medical record revealed that the resident was admitted to the facility on 2/18/05 with diagnoses which included: CVA (cerebral vascular accident), osteoarthritis, DJD (degenerative joint disease), osteoporosis and arthritis of the right shoulder. The resident was also identified as having a history of multiple fractures and falls with right elbow fracture (7/12/06) and a right tibia and fibula fracture (10/17/06). a. Review of sample resident #11's Minimum Data Set (MDS) significant change assessment dated 12/5/06 revealed the resident had moderate cognitive impairment. The resident required extensive assistance for Activities of Daily Living (ADLs), which included bed mobility, transferring, dressing, toilet use, personal hygiene and bathing. Additionally, the resident was coded as being frequently incontinent of bladder and having a limitation in ROM (range of motion). The area under accidents identified falls in the past 31-180 days and other fracture in the last 180 days. b. Review of the "Nurses Notes" identified the resident as having repeated falls. The notes	F 309	breakthrough pain. Resident #11 is not left in her wheelchair or in the bathroom without supervision. Resident #5's arm brace has been d/c'd with no evidence of skin problems. b) A new policy is being implemented regarding neurological assessments using recommended nursing standards. c) Nursing staff will be in-serviced on the recommended nursing standards for neurological assessments, including frequency of assessments, and on pain assessments; including when indicated, continued evaluation of prn meds, when to change to routine meds, and the assessment of pain for cognitively impaired residents. Temporary care plan in-servicing will also occur. d) Neurological assessments will be monitored on all head injuries. The data will be collected by the RCD monthly and report to the PI Committee quarterly. Pain Assessments and pain medication administration will be randomly monitored on all residents on a monthly basis. PI Committee reporting will occur quarterly.	5/18/07	

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F 309	Continued From page 28 included: 9/29/06 "Resident helped self off toilet, fell to floor denies any injuries-non observed..." 10/12/06 "Called to Activities by CNA found Res (resident) lying on the floor. Asked the resident if he/she hurts; he/she pointed to forehead. Res. has sustained a bruise with scrape to mid forehead and front of scalp, also has a very small skin tear to bridge of nose..." 10/17/06 "1415 (2:15 PM) CNA found Res on floor in BR (bathroom). Took 3 CNA's to get him/her into the W/C (wheelchair). Res c/o (complained of) pain R (ankle) ankle. VS (vital signs) 177/88 (blood pressure) 106 (pulse), O2 (oxygen) 95% RA (room air). PROM (passive range of motion) WNL (within normal limits) ex (except) R (right) ankle. Sent res to Xray. Dr. (____name) will splint in ER (emergency room)." 1/18/07 "Had been taken into supper at about 1720 (5:20 PM) left dining room and was found on floor lying on R side down by double doors entering the dining room. [Symbol for no] sx (symptom) of injury X (except) for reddened area upper right cheek..." 2/7/07 "Res in recliner - verbal with discomfort - loud and high pitched tones. Questioned as to pain." 2/9/07 noted resident whimpering and signs of increased pain. The resident was taken to have right foot and ankle re-xrayed and seen by the physician. c. Review of the "Nurses Notes" identified the	F 309	This page left blank intentionally		

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F 309	Continued From page 29 resident having repeated falls. The notes included: 2/23/07 "06-14 -1110 - Resident found on floor in shower room BR (bathroom). Resident denies discomfort-although has hematoma on head-moves all extremities as well as usual, assisted off floor with assist of 2; placed in w/c (wheelchair) please see neuro [symbol for check] sheet physician notified and residents [family]. d. Review of the "Neurological Assessment" sheet dated 2/23/07 had entries for 11:15 AM, 11:20, 11:30, 11:45, 12:00, 13:00 (1:00 PM), 1500 (3:00 PM) and 1630 (4:30 PM) and then stopped. The "Nurses Notes" showed one entry for 2/24/06 which stated, "No other effects from the previous fall." There was no further neurological assessments or vital signs documented. The recommended nursing standards for neurological assessments every fifteen minutes for the first hour, then every thirty minutes for the second hour, then every hour for the next four hours, then every two hours for the first 24 hours, and then every shift for the second and third day was not followed. PAIN: e. Review of the nurses notes identified ongoing signs and symptoms of pain as noted above on 2/9/07. Review of the "PRN (as needed) Medication FORM" identified the resident received Vicodin and Tylenol Extra Strength for pain. The resident had received 36 doses of Vicodin and 23 doses of Tylenol from 2/6/07 to 3/28/07.	F 309	This page left blank intentionally		

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F 309	Continued From page 30 f. Review of resident #11's medication records for March 2007 and April 2007 identified that the resident was not on a routine medication for pain control. g. Review of "Pain Assessment Form" 7/15/06 stated, "Resident denies having pain." The back of this form had periodic reviews. The next entry was dated 9/5/06. It stated, "Even with surgical repair of elbow resident consistently denies discomfort. There was no evidence that a pain assessment for a resident with cognitive impairment was completed. The next entry was 3/6/07 it marked "Pain goal is being met." It stated, "Resident's pain is controlled with prn Vicodin - complains mostly of RT leg discomfort and has been going to PT (Physical Therapy) 2-3 times per week for ROM (range of motion) strengthening at times with discomfort is relieved. Resident is encouraged to help adjust self when in recliner chair." There was no evidence that a reassessment of this resident's pain was completed when the resident had a change of condition 12/5/06, after falls, or with increase signs and symptoms of pain. The facility failed to assess the need for routine pain medication with medication for breakthrough pain for this resident who had ongoing use of PRN pain medications and increased pain. 2. Review of supplemental resident #18's medical record revealed the resident was admitted to the facility 3/14/07 with diagnosis including: dementia, debility, and pneumonia. a. Review of the "Pain Assessment Form" was dated 3/16/07. Staff B reported that the pain assessment was supposed to be completed	F 309	This page left blank intentionally		

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F 309	Continued From page 31 within 24 hours of admission however had not been done timely. The form identified the pain as intermittent and shooting, and the pain intensity as zero. The area under comments documentation stated that the resident had a blister on right heel and cause of pain most likely pressure and swelling. The plan was to elevate feet as much as possible and heel pads while in bed. The facility failed to do the pain assessment timely to ensure adequate pain management. b. Review of resident #18's "Temporary Care Plan" listed: Problem 1) Rt (right heel) ulcer. -"Expected resident outcome- Rec. Tx (receiving treatment) to R (right) ulcer + (plus) other ulcers." (The care plan did not identify the use of heel pads as stated on the pain form.) Problem 2) Pneumonia -"Expected resident outcome- resolve pneumonia without complications." Problem 3) Notable Sundowners- -"Expected resident outcome-reinforce - orient (orientate), rm (room), DR (dining room), etc." The plan of care did not address pain management for this resident with dementia who had a pressure sore. Reference: PROFESSIONAL STANDARDS FOR ASSESSMENT OF KNOWN OR SUSPECTED HEAD INJURIES: 1. Scope of Assessment: Pursuant to the Lippincott Manual of Nursing Practice, sixth edition, 1996 (Lippincott), in the event of a possible head injury a nurse should do the following assessment:	F 309	This page left blank intentionally		

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F 309	Continued From page 32 Monitor for signs of increased ICP (intracranial pressure) such as altered level of consciousness, slowing of the pulse, rising systolic pressure, increasing pulse pressure, changes in pattern of respiration, dilating, non-reacting pupils, projectile vomiting; Observe for CSF (cerebrospinal fluid) leakage; Note contusions, lacerations or abrasions around head, face, eyes or ears; Perform cranial nerve, motor, sensory, and reflex assessment by noting motor responses, reflexes, movement and strength of extremities, purposeful or abnormal flexor or extensor posturing. 2. Frequency of assessment: According to Mosby's "Patient Care Standards: Collaborative Practice Planning Guide" 6th Edition published in 1996 the neurologic status needs to be initially assessed every 15-30 minutes on those residents with possible craniocerebral trauma, decreasing the frequency of the checks as the resident 's condition stabilizes. Reference for Professional Standards of Practice regarding head injuries assessments: Lippincott Manual of Nursing Practice (6th edition, 1991): The standard of nursing practice dictates that following a head injury, the resident should be monitored for sign of increased intracranial pressure-altered level of consciousness, observed for cerebrospinal fluid leakage, assessed for contusions about the eyes and ears and assessed for neurological changes - pupils, reflexes, and motor ability. A thorough assessment including neurological status checks will be done and documented for 72 hours following the incident. The recommended nursing standards for neurological assessments are: every fifteen minutes for the first hour, then every	F 309	This page left blank intentionally		

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F 309	Continued From page 33 thirty minutes for the second hour, then every hour for the next four hours, then every two hours for the first 24 hours, and then every shift for the second and third day. These assessments should be continued if the person is not stable or is showing evidence of a change in status. 3. Record review for sample resident #5 revealed that diagnoses that included angina, depressive disorder, hypoglycemia, sleep apnea, coronary atherosclerosis, diabetes, chronic airway obstruction, and trigeminal neuralgia (pain in the facial nerve areas). a. Review of the resident's 2/7/07 significant change MDS assessment revealed that the resident required extensive assistance with bed mobility, transfer, walking, and eating and total assistance with locomotion, dressing, personal hygiene, and bathing. The resident was assessed to have fallen in the last 30 days and in the last 31 - 180 days. Review of the Resident Assessment Protocol (RAP) Summary sheet evidenced that the resident triggered for all items except Delirium, Activities, Feeding Tubes, and Physical Restraints. The triggered and care planned items were Cognitive Loss, Visual Function, Communication, ADL (Activities of Daily Living)/Rehab (rehabilitation), Urinary Incontinence, Psych/Social, Mood State, Behavioral, Falls, Nutritional Status, Dehydration, Dental Care, Pressure Ulcers, and Psychotropic (medications). b. Review of resident's Nursing Notes evidenced that the resident had experienced multiple falls, including two falls with fractures to the right arm. These occurred on 9/10/06 at 3:30 AM and 12/31/06 at 6:30 AM.	F 309	This page left blank intentionally		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 53A049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2007
NAME OF PROVIDER OR SUPPLIER GOSHEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2009 LARAMIE STREET TORRINGTON, WY 82240		
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F 309	Continued From page 34 c. On 4/3/07 at 2:38 PM, during an observation of the resident receiving a shower, Certified Nurse Aide (CNA) (staff O) removed the splinting device from the resident's arm. The surveyor observed that there was a bright red mark (approximately two inches long) with a small open area on the inside of the right arm, extending vertically. The CNA indicated that she would tell the nurse about the mark and that it was probably from the cast pinching the arm. When the shower was completed, the CNA turned the call light on for the nurse to check the resident's skin. While the CNA waited for the nurse to arrive, she dressed the resident. She put the resident's bra over the resident's breasts, fastened it, and then pulled it down into place. The bra was observed to be very tight. The resident complained of pain during this procedure and especially when the left breast was touched. After 12 minutes, the nurse (P) came into the shower room. When the nurse checked the resident's right arm and under the resident's breasts, the resident complained of pain and requested a pain pill. The nurse verified that there was a red mark on the resident's right arm, a red area under the right breast, a red mark (three to four inches long) under the left breast, and the resident's buttocks were red. The nurse indicated that she was not aware of these skin issues. d. On 4/3/07 at 3:25 PM, nurse P commented that she had called the Physical Therapist (PT) about the red mark on the resident's right arm. The PT planned to see the resident again on Friday (4/6/07) and she would check the arm at that time.	F 309	This page left blank intentionally		

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F 309	Continued From page 35 e. Review of the resident's Nursing Notes and PT notes confirmed that there was no documentation related to the sore on the resident's arm until after the surveyor questioned the staff about this mark. f. Review of the resident's April Medication Administration Record (MAR) revealed that the resident was not medicated for pain until 4:00 PM. g. On 4/4/07 at 9:20 AM, in an interview with the PT, she stated that "the wound looked better than last Friday." She indicated that the device should have had a sleeve placed under it, but when she originally observed the brace on the resident's arm, the sleeve was not there. She commented that she padded the brace more. h. On 4/4/07 at 9:33 AM, in an interview with the Resident Care Director (RCD), she revealed that the PT said that the device was put on upside down last week. She said that the PT marked arrows on the device and indicated that there should always have a stockinette under it. During the shower observation on 4/3/07, no stockinette was on the resident's arm when the device was removed prior to the shower. The RCD indicated that the information was written in the CNA communication book. 4. Record review of sample resident #1's 3/8/07 and 12/7/06 MDS assessments evidenced that he/she had been assessed as having significant changes in condition. On both of these MDS assessments the resident was assessed to require extensive or total assistance with all Activities of Daily Living (ADLs) and had experienced falls.	F 309	This page left blank intentionally		

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F 309	Continued From page 36 a. Review of the resident's Nurse's Notes revealed the following: 11/10/06 at 6:00 PM, revealed that the "res (resident) had fallen - Assessment: ROM (range of motion) WNL (within normal limits) for resident - Laceration L (left) side of forehead - Sent to ER (emergency room). Returned with Steri Strips over wound. BP (blood pressure) Lying 211/87 - 71 (pulse) - BP Sitting 178/92 - 71 - Message sent to physician - Family notified." 11/11/06 (10:00 PM to 6:00 AM) noted "Res has denied pain all noc (night) VS (vital signs) T (temperature) - 97.1 (degrees Fahrenheit), P - 76, R (respirations) 20, B/P 174/78, Bleeding from around drsg (dressing) to head. Area cleaned, L (left) eye bruised, swollen increased drainage from L eye." 11/11/06 (2:00 PM to 10:00 PM) "Res C/O (complained of) H/A (headache) - Tylenol ii (two) given with good results. VS = 186/82, 97.8, 86, 20. Drsg change done to forehead d/t (due to) drsg soiled. New drsg. applied. Res has no C/O." b. Review of the Emergency Nursing Record, dated 11/10/06 and timed 5:20 PM, revealed that VS were checked and the Glasgow Coma Scale score was 15 on arrival (spontaneous eye opening, oriented, and obeys commands would equal 15, even though these were not marked on the form). The form was marked with a laceration/abrasion and ecchymosis (bruising) to the head/face. According to the documentation, the resident left the ER at 5:46 PM (26 minutes after arriving). The Injury Aftercare Instruction	F 309	This page left blank intentionally		

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F 309	Continued From page 37 Sheet indicated that the resident should be observed for 24 - 48 hours for "...confusion, delirium, or disorientation, blurred vision or double vision, a difference in pupil size comparing left to right, ..., persistent headaches..." c. Review of the Occurrence Report for the fall which the resident experienced on 11/10/06 had BP and P documented, but no neurological assessment noted. There were no neurological assessment documented in the Nurse's Notes.	F 309			
F 311 SS=E	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to provide adequate meal assistance to two of 15 sample residents (#4 and #8) and six supplemental residents (#23, #31, #21, #20, #35, and #19). These residents were facility-assessed and/or observed to be able to feed themselves all or part of his/her meals, but required supervision, cueing, and/or physical assistance to eat. The findings included: 1. On 4/2/07 from 5:50 PM to 6:53 PM, during an observation of the evening meal in the dining room, the following observations were made: a. Supplemental resident #23 was observed to receive a sliced meat sandwich. The sandwich was only partially cut in half. When the resident tried to pick up the sandwich, it pulled apart. The	F 311	The facility will ensure our residents are given the appropriate treatment and services to maintain or improve his or her abilities (as specified) by: 1. Residents #4, 8, 23, 31, 21, 20, 35, and 19 are now receiving the supervision, cueing, and/or physical assistance they require in order to eat. The dining room seating chart has been modified to reflect that resident #4 does not need assistance to eat. Residents # 19 and 20 are now receiving puree foods. Dietary staff doing the dish-up for meals have been instructed to follow the meal tray cards as written to assure that residents do not get foods that they do not want to receive and conversely receive the special requested foods. 2. The nursing staff will be in-serviced related to proper positioning at the meal tables, serving and setting-up the meals for the residents to include cutting foods and being sure that finger-foods are ready for consumption when the meal is placed in front of the resident.		

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F 311	Continued From page 38 resident was observed to struggle to eat this sandwich. No staff were observed to assist the resident. b. Supplemental resident #31 was observed to receive sliced ham which was not cut up. The resident was observed to put the slices of ham into his/her mouth without cutting them. No staff were observed to assist the resident. c. Resident #21 was seated at a table with three other residents who were all served by 5:40 PM. A staff person was noted to sit down to feed another resident at the table at 6:00 PM (20 minutes later). Resident #21 was cued when the meal was served and was noted to drink but made no attempt to eat. Staff did not cue the resident again until 6:26 PM. When the staff did cue the resident to eat the resident stated, "Well, yes who is going to help me?" Staff then assisted the resident with pieces of fruit and quiche. The resident began to cough and was taken into the restroom. Staff reported that the resident had been having problems chewing. Staff stated, "Today I got him/her up after a nap and he/she coughed up a piece of peach from lunch." d. Resident #20 was seated at another round table with four other residents. The resident was served at 6:02 PM. The resident asked for something else and was brought a sliced roast beef sandwich. The resident fed himself/herself very quickly without stopping between food items or a break and was noted to cough at times while continuing to eat. The resident had his/her mouth stuffed full with the resident cheeks expanded, mouth partially open and food visible. Staff Q was alerted by the surveyor due to a concern for the resident's risk for choking. Staff Q immediately went to the resident. The resident emptied the	F 311	3. Meal observations will be done routinely by the RCD, LTC Assessment Coordinator, and Social Worker. These will include delivery of meals, appropriateness of set-up of foods for resident consumption, supervision/cueing/assistance with eating. Data will be gathered monthly and reported quarterly to the facility QA committee to assure continuous quality improvement.	5/18/07	

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F 311	Continued From page 39 food from his/ her mouth into a napkin after staff instruction and assistance. The staff Q reported that the resident had issues with stuffing his/her mouth, eating very fast and leaving the dining room. Staff stated, "___ (He/she really needs to be watched." The facility failed to provide adequate assistance, monitored or cueing for this resident. The resident was not cued to slow down or monitored to ensure the resident was swallowing his/her food properly. 2. During an observation of the breakfast meal on 4/3/07, the following observations were made: a. Resident #20 was served at 8:13 AM. The resident picked up a whole sausage link and puts it in his/her mouth. Staff serving other residents at the table made no attempt to cue the resident to chew or to take smaller bites. Staff D (nurse) was alerted and went to assist the resident. Staff D reported that the resident had all his/her medications crushed and needed to be watched with eating because of eating very fast and leaving the dining room. Staff D then instructed other staff to watch and cue the resident while eating. b. Resident #4 was identified on the dining room seating chart as "Feed". The resident did eat by self. Staff did not ask or offer second servings for a resident identified as a significant weight loss. Staff D reported that the resident had a decline in condition and had medications crushed and should be monitored during the meal. c. Resident #19 was seated at the nurses station on the 200 wing at 8:40 AM. The resident had a	F 311	This page left blank intentionally		

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F 311	Continued From page 40 breakfast tray in front of him/her. There was no staff in view of the resident. At 8:55 AM Staff B (nurse) came up to the resident and asked the why he/she didn't want to eat. The resident was noted to drink the juice and take a couple bites of pancake when cued by the staff. The nurse then asked if he/she wanted the pancakes warmed up. The resident stated, "Yes." The pancakes were warmed up and staff then left the area. The resident was not cued again until 9:10 AM. The resident had not eaten any additional food and declined when staff asked. The resident was not provided timely cueing and assistance with eating. The resident was identified by staff as having moderate cognitive impairment. 3. On 4/2/07 from 5:45 PM to 6:45 PM observation of the evening meal service revealed that the meal card for Resident #8 identified No Peaches, No Pears, No Green Beans, No Coffee, No Tea as personal preferences. The resident received Peaches, Pears and Green Beans. a. On 4/2/07 at approximately 6:45 PM, at the close of the meal service Staff Q reported, while completing the resident meal consumption report, that sample resident #8 is "resistive" and "refuses to eat," mimicking the resident in demeanor and tone. Staff Q arranged the resident's drinks, identifying a slice of banana cream pie by placing it nearer the resident, the resident ate the pie with relish. Staff Q then amended the meal consumption report to reflect that the resident consumed more than anticipated. b. On 4/2/07 from 5:45 PM to 6:45 PM and on 4/3/07 from 7:30 AM to 8:30 AM, during meal	F 311	This page left blank intentionally		

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F 311	Continued From page 41 observations in the dining room, sample resident #8 was observed to become fixed of gaze and freeze in mid motion during the meal. The resident received little attention, assistance or cueing until the end of the meal services. c. The RAP Rationale Report dated 12/07/06 for Resident #8, under Cognitive Loss/Dementia: "the Mini-Mental adjusted score was 7, (his/her) last was 5. This designated moderate impairment of his/her mental status. (He/she) requires cueing and supervision." Under the category Communication, "(He/she does have long and short term memory problems, which can inhibit (him/her) understanding the given message. (He/she) is on increased medication for (his/her) pain and this could also impair his/her ability to understand others."	F 311			
F 312 SS=D	4. On 4/3/07 from 7:30 AM until 8:30 AM, supplemental resident #35 was observed during the morning meal service in the dining room. The resident was seated in a wheelchair at a table with five other residents. A CNA seated at the opposite end of the table assisted two other residents. Due to the distance from the the resident's wheelchair to the table, the resident was required to reach a full arms length to the table. Each bite of food required a movement expanding the length of a fully extended arm from plate to mouth. The resident's hand lightly trembled and with each pass the resident spilled food on his/her clothing protector. The resident received no assistance during the meal service. 483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312	Starts on the next page		

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F 312	Continued From page 42 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined that the facility failed to provide adequate and/or timely meal/snack assistance to two of 15 sample residents (#11 and #1) and one supplemental resident (#33). Additionally, the facility failed to assist two of 15 sample residents (#1 and #11) and one supplemental resident (#33) with appropriate and adequate incontinence care. These residents were facility assessed and/or were observed to be unable to perform the Activities of Daily Living (ADLs) and required extensive or total assistance with these ADLs. The findings included: MEALS/SNACK 1. On 4/4/07 at 1:05 PM, a tray of 10:00 AM snacks was observed sitting on the Certified Nurse Aide (CNA) desk on the 400 Wing. The supplements included a carton of Resource Breeze and a Magic Cup labelled for sample resident #1 and a Mighty Shake (with no thaw date) for supplemental resident #33. These supplements were warm to touch. a. On 4/4/07 at 2:03 PM, in an interview with CNA R, she indicated that she had tossed the supplements since they were left from 10:00 AM and had not been refrigerated. b. On 4/6/07 at 9:47 AM, in an interview with the Resident Care Director (RCD), she confirmed that there was no charting for the between meal	F 312	The facility will ensure our residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene by: a) Snacks are now being offered daily with assistance to resident #1. Resident #33 and #11 now have the gait belt used for transfer and toileting needs. b) A system for documenting between-meal snacks will be developed. Staff will be in-serviced on snack documentation. c) This will be randomly monitored by the LTC Coordinator and reported to the PI Committee quarterly. d) Staff will be in-serviced on proper pericare. Staff will be observed by nursing staff performing pericare randomly on a monthly basis for various shifts. The data will be reported to the PI Committee quarterly. e) A new policy for gait belt use will be implemented and nursing staff will be in-serviced regarding its use. Staff will be checked for proper usage of gait belts by nursing staff randomly on various shifts on a monthly basis. PI Committee reporting will be required quarterly.		5/18/07

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F 312	Continued From page 43 snacks. c. On 4/5/07 at 4:38 PM, in an interview with CNA J, she indicated that between meal snacks are not charted. She commented that the meal supplements are charted by the nurses. The lack of charting of the snacks limited the information which was available to the Registered Dietitian when she was assessing the effectiveness of the nutritional interventions. 2. On 4/2/07 during the evening meal service, the following observations were made in the dining room: Sample resident #11 was at a table with three other residents. The residents at the table were all served by 5:40 PM. Resident #11 was totally dependent on staff for eating. Staff did not sit down to feed resident #11 until 6:00 PM (20 minutes later). The resident's food was not reheated and sat in front of the resident until the resident was fed. Staff identified the resident as being totally dependent on staff to be fed. PERI CARE 1. On 4/4/07 at 9:55 AM, supplemental resident #33 seated in a wheel chair across the 400 Wing hallway from the nursing station desk had an explosive bowel movement. The Hallway and surrounding areas were filled with the odor. On 4/4/07 from 1:05 PM to 1:30 PM, CNA K was observed to toilet supplemental resident #33. The resident was wheeled into the shower/toilet room located across from the CNA desk on the 400 Wing. The CNA encouraged the resident to grab the handicap bar and to stand up. After	F 312	This page left blank intentionally		

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F 312	Continued From page 44 several minutes of coaxing, the resident stood up with the assistance of the CNA pulling him/her up, grabbing the back of the resident's sweatpants and lifting with the pants. No gait belt was used. The resident did not straighten up, but stood with his/her knees bent, making him/her off balance. When the CNA attempted to remove the resident's pants and incontinent brief, the resident was observed to have a large amount of feces up his/her buttocks to the top of the brief and the his/her pants and brief were wet. As the CNA attempted to clean the resident's buttocks, the resident urinated a large amount of urine onto his/her pants, feet, and the floor in front of the toilet where the resident was standing. Since the CNA was not able to turn the call light on (both hands were in use), the surveyor asked the CNA if she wanted the call light turned on and she said "yes". The surveyor turned the call light on. The CNA then pulled the resident over and sat him/her on the front portion of the toilet. At this point, CNA E entered the toilet room; she left and returned with a mop and a laundry hamper and then cleaned the floor. CNA E left and returned with the resident's clothes. CNA K had partially cleaned the resident's buttocks up. The resident was stood up with CNA E holding him/her (no gait belt was used) and CNA K continued to clean the resident's buttocks. The resident's knees were bent and CNA E appeared to be straining and struggling to hold the resident up and the resident's buttocks were getting lower to the floor as his/her knees bent more and more. Finally, the two CNAs transferred the resident to the front edge of his/her wheelchair. Observation of the resident's buttocks during this	F 312	This page left blank intentionally		

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F 312	Continued From page 45 procedure revealed that the buttocks were red and there were red spots on the upper left side of the buttocks. The resident's groin and front perineal area were not cleaned during this observation of pericare. On 4/4/07 at 2:33 PM, in an interview with CNA K, she revealed that she changed the resident's brief right after breakfast (about 9:00 AM). 2. Record review of sample resident #1's 3/8/07 and 12/7/06 Minimum Data Set (MDS) assessments evidenced that he/she had been assessed as having significant changes in condition. On both of these MDS assessments the resident was assessed to require extensive or total assistance with all Activities of Daily Living (ADLs) and incontinent of bladder and occasionally incontinent of bowel. On 4/4/07 at 1:38 PM, CNA K was observed to transfer resident #1 to the toilet, using the Sara lift (sit to stand lift). The CNA indicated that the resident's brief was wet. When the resident was finishing toileting, the CNA provided pericare. She cleaned the resident's buttocks and rectal area but did not wash the resident's groin or front perineal area. 3. Review of sample resident #11's medical record revealed that the resident was admitted to the facility on 2/18/05 with diagnoses which included: CVA (cerebral vascular accident), osteoarthritis, DJD (degenerative joint disease), osteoporosis and arthritis of the right shoulder. The resident was also identified as having a history of multiple fractures and falls with right elbow fracture (7/12/06) and a right tibia and fibula fracture (10/17/06).	F 312	This page left blank intentionally		

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F 312	Continued From page 46 a. Review of sample resident #11's MDS significant change assessment dated 12/5/06 revealed the resident had moderate cognitive impairment. The resident required extensive assistance for Activities of Daily Living (ADLs), which included bed mobility, transferring, dressing, toilet use, personal hygiene and bathing. Additionally, the resident was coded as being frequently incontinent of bladder and having a limitation in ROM (range of motion). The area under accidents identified falls in the past 31-180 days and other fracture in the last 180 days. b. Review of the "Nurse's Notes" dated 2/21/07 stated, CNA notes blood to brief and wipes when resident put to bed RN (registered nurse) checked; note 3 sm (small) open areas inside lower vagina oozing blood. Calmoseptine applied and CNA inst (instructed to use Attends wipes instead of pink wipes. Reported to next shift." c. On 4/5/07 at 3:10 PM, a CNA (J) was observed providing pericare for resident #11. The CNA assisted the resident from the recliner in the hall into an wheelchair. Staff did not use a gait belt and lifted the resident with a one person lift. The resident was taken into the resident's bathroom and instructed by staff to stand by using the grab bar. The CNA assisted the resident by pulling up on the back of the resident's pants. The resident was positioned over the toilet, pants pulled down, brief removed and placed on the toilet. The CNA reported that the incontinent brief was wet. After the resident voided the resident was to a standing position holding the grab bar. Then with gloved hands and wipes the CNA wiped the resident's perineum from front to back	F 312	This page left blank intentionally		

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F 312	Continued From page 47 while standing behind the resident. A brief was then put on and resident's pants pulled up. The CNA made no attempt to wipe the resident's groin from the front to ensure the area was properly cleansed after had been incontinent.	F 312			
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined that the facility failed to ensure that the environment was as free of accident hazards as possible. The findings included: SAFETY OF BED RAILS: Reference for Professional Standards of Practice for bed rail-related entrapment deaths/injuries: Bed rail-related entrapment deaths and injuries can occur in the elderly population, who are often at risk due to limited mobility, psychoactive or sedative medications, confusion, sedation, restlessness, lack of muscle control, size and physical deformities. Death by asphyxiation or injuries to the resident 's extremities can occur when the resident becomes caught between the mattress and the bed rail; the headboard and the bed rail; or getting his or her head/extremity stuck in the bed rail. Both split and full rails have the potential to cause fall-related injuries as well as entrapment. Additionally fall-related injuries or injuries to extremities can occur when confused/disoriented residents climb over the top of side rails or get an arm or leg entrapped.	F 323	The facility will ensure that the resident environment remains as free of accident hazards as is possible by: a) Resident #13's side rails are not available for use. b) Side rails not identified for use as enablers will be tied down so they are not available for use. c) Staff is using the Enabler Screening form, which has been updated, requiring residents to demonstrate safe, correct use of side rails as enablers. These forms are updated and reviewed twice yearly. d) Resident #6, #11, #19 have gait belts used on them for safe transfers. e) Resident #11 is not left alone in her wheelchair or in the BR without supervision. f) Resident #1 has the gait belt used for transfers with two persons assisting or the Opera lift for all transfers. g) We are developing a new policy on gait belt use. h) All nursing staff will be in-serviced on the policy and procedure for gait belt use. i) Monitoring will be done on gait belt use by the RCD randomly. Staff not using the gait belt, when and how specified, will receive counseling. Data on gait belt use will be collected monthly and presented		

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F 323	Continued From page 48 Placement of air pressure mattresses (either overlay air mattresses placed on top of a regular mattress or beds with built-in air mattresses) alters the space between the mattress and the rail when the mattress compresses as the resident shifts his/her weight on the bed. See FDA Safety Alert: Entrapment Hazards with Hospital Bed Side Rails August 23, 1995 and Joint Commission on Accreditation of Healthcare Organization: Sentinel Event Alert, Issue 27, September 6, 2002. U.S. Food and Drug Administration /web page www.fda.gov/cdrh/beds/ <http://www.fda.gov/cdrh/beds/> -Updated October 31, 2006. "The Hospital Bed Safety Workgroup (HBSW) is a partnership among FDA, the medical bed industry, national health care organizations, patient advocacy groups, and other federal agencies (Centers for Medicare & Medicaid Services, Consumer Product Safety Commission, and the Veterans Administration). Its goal is to reduce the risk of side rail entrapment in hospital beds. Between January 1, 1985 and January 1, 2006, FDA received 691 incidents of patients caught, trapped, entangled, or strangled in hospital beds. The reports included 413 deaths, 120 nonfatal injuries, and 158 cases where staff needed to intervene to prevent injuries. Most patients were frail, elderly or confused. The efforts of the FDA and the Hospital Bed Safety Workgroup have culminated in FDA's release of Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. This guidance provides recommendations for manufacturers of new hospital beds and for facilities with existing beds (including hospitals, nursing homes, and private residences)..."	F 323	quarterly to the PI Committee. j) All cautionary and hazardous materials have been removed from resident access. k) The scissors have been removed from the side of the medication cart. l) Medications are not being left unattended on top of the medication cart by nursing staff. m) Safe storage of potentially hazardous materials will be monitored by staff using a PI process. The data will be collected monthly and reported quarterly.	5/18/07	

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F 323	Continued From page 49 The guidance also included, "... assess an individual patient's needs when using a side rail; and consulting with the hospital bed manufacturer and their facilities' risk managers..." Siderail Usage 1. On 4/2/07 at 2:25 PM, during an initial tour of the 200 and 300 wings with the RCD (Resident Care Director) residents' beds were observed to have siderails. There were two different types of half rails on the head and foot ends of the beds available for use. The RCD reported that there were only a few residents who used the side rails as enablers. The one type of siderail had three spaces within the rail itself large enough to pose a risk for potential entrapment. There were no siderails of this type in the up position during the tour. 2. During the environmental tour on 4/4/07 at 10:15 AM with the Maintenance Supervisor, and the Resident Care Director the siderail issue was addressed. The surveyor demonstrated her concern by passing her head through the inherent gap in the 3 sectioned siderail. Staff reported that most of the facilities's beds had some type of side rail. The list provided showed eight residents with some type of siderail used as an enabler and four of those were the type with wide gaps. The RCD also confirmed that rails on the other beds were still available for use. She stated, "We have not removed the other rails because of the access to the bed control." Staff also reported there had been no attempt to secure or remove the siderails to prevent misuse. 3. Record review for sample resident #13 evidenced that the resident had diagnoses that	F 323	This page left blank intentionally		

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F 323	Continued From page 50 included stroke, debility, dysphagia, and urinary incontinence. Review of the resident's 3/6/07 significant change Minimum Data Set (MDS) assessment revealed that the resident required extensive assistance with bed mobility, transfer, walking in corridor, dressing, eating, toilet use, personal hygiene, and bathing. Review of the resident's 9/11/06 Nurses' Notes evidenced "Res (resident) fell from bed, catching ____ (his/her) head in the siderail. ____ (He/she) pushed call button & (and) I went to answer call light & found ____ (him/her) hanging in ____ (his/her) bed Checked Res for injuries: Skin tear to chin, L (left) elbow, bruise to R (right) knee.. Lowered side rail and placed a fall mat..." Review of the facility Occurrence Report for this resident's 9/11/06 occurrence evidenced the following: Nature of occurrence: Attended Fall Fall: From bed Safety Measure: One siderail up and Call light in reach Nature of injury: 2 skin tear, bruise No physician notification was noted Follow-up Action: Fall mat placed beside bed. The surveyor was unable to locate the resident's CP on the wing where he/she resided. On 4/5/07 at 6:00 PM, in an interview with the MDS Coordinator, she verified that sample resident #13's CP was not currently at the nurses' station, but in her office. She confirmed that this resident's CP was last updated in 12/06. The CP was not kept updated and it was not available for the staff to use to provide consistent care to this dependent resident.	F 323	This page left blank intentionally		

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F 323	Continued From page 51 Review of the resident's care plan for the "Descriptor" (problem) of potential for falls due to history of fall with hip fracture, fall resulting in fractured clavicle, fall resulting in fractured hip, requires extensive assistance with transfer, toileting, and personal hygiene, impaired balance, Diagnoses of dementia, latent effects CVA (stroke), HTN (hypertension), Cancer and Cataracts. Uses anti-hypertensive, antidepressant and NSAIDs (non-steroid pain medication) revealed an approach of "DO NOT raise ____ (his/her) bed rails." On 4/5/07 at 4:40 PM, an observation of sample resident #13's bed revealed that there was a half siderail on the bed which was in the down position. This siderail had vertical bars, allowing for gaps which had the potential for entrapment. This siderail was not tied down so that staff could not easily use it. There was no evidence found, except in the CP which was not available to staff, to indicate that this resident should not have siderails used due to the 9/06 entrapment or the potential for future entrapment. On 4/6/07 at 8:30 AM with the RCD the side rails were measured on resident #13's bed. The gaps in the siderails measured. The middle section was seven and a fourth inches in width and height (7 1/4 x 7/14) and the two outside sections were nine inches wide by seven and a fourth inches tall (9 x 7 1/4). The siderails were available for staff to use. Transfer Technique/Unsafe transfers: 1. Review of sample resident #11's medical record revealed that the resident was admitted to	F 323	This page left blank intentionally		

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F 323	Continued From page 52 the facility on 2/18/05 with diagnoses which included: CVA (cerebral vascular accident), osteoarthritis, DJD (degenerative joint disease), osteoporosis and arthritis of the right shoulder. The resident was also identified as having a history of multiple fractures and falls with right elbow fracture (7/12/06) and a right tibia and fibula fracture (10/17/06). a. Review of sample resident #11's MDS significant change assessment dated 12/5/06 revealed the resident had moderate cognitive impairment. The resident required extensive assistance for Activities of Daily Living (ADLs), which included bed mobility, transferring, dressing, toilet use, personal hygiene and bathing. Additionally, the resident was coded as being frequently incontinent of bladder and having a limitation in ROM (range of motion). The area under accidents identified falls in the past 31-180 days and other fracture in the last 180 days. b. On 4/5/07 at 3:10 PM, a CNA (J) was observed providing care for resident #11. The CNA transferred the resident three times. Observations of these transfers included: 1) The CNA assisted the resident with a transfer from the recliner in the hall into an wheelchair. Staff did not use a gait belt and lifted the resident (one person lift) by lifting under the resident's armpits. 2) The resident was taken into the resident's bathroom and instructed by staff to stand by using the grab bar and lowered back on to the toilet. 3) After the resident voided the resident was assisted with staff lifting up under the resident's	F 323	This page left blank intentionally		

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F 323	Continued From page 53 arms. The resident assisted self by holding the grab bar. The CNA used one hand to hold and push the resident's back to maintain the standing position while the other hand was used to do care. Then the staff assisted the resident into the wheelchair. The resident's legs were bent and he/she had trouble standing long enough for the CNA to finish the care. The CNA did not utilize any safety device such as a gait belt when transferring this resident. c. In an interview with the CNA after the observation, she reported that the resident was not to be left alone due being at risk for falls. The CNA was asked if staff was to use gait belts when transferring residents needing assistance. The CNA stated, "Yes we are supposed to." The CNA then showed the surveyor where the gait belts were kept in the 200 wing closet. 2. On 4/5/07 at 7:20 AM resident #19 was seated in a recliner by the nurses station on the 200 wing. The resident was attempting to exit the chair with the foot rest elevated. A CNA (E) intervened and the resident reported he/she had to go to the bathroom. The CNA stood in front of the resident and did a total lift to the wheelchair. The CNA lifted the resident by lifting under the resident's armpits and back of the resident's pants. The CNA did not utilize any safety device such as a gait belt when transferring this resident. 3. On 4/4/07 at 10:00 AM, sample resident #6 was observed as he/she was transferred from a wheelchair to a recliner. The resident was transferred by one staff using one arm of the resident and the back of the residents sweat pants. The CNA did not use any safety device such as a gait belt. The resident was observed to	F 323	This page left blank intentionally		

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F 323	Continued From page 54 grimace in pain during the movement and pressure was applied to a recent 4/21/07 fracture of left shoulder. Resident's arm was immobilized in a sling. On 4/4/07 at 10:05 AM, an interview with resident #6 revealed that he/she was in pain. The CNA was advised of the resident's status and he/she located the LPN (Licensed Practical Nurse). The LPN verified the resident's pain and a prn (as needed) pain medication was administered. 4. On 4/5/07 at 11:15 AM, CNAs K and H were observed to transfer sample resident #1 from the recliner (at the CNA desk on the 400 unit) to his/her wheelchair. The resident was lifted under his/her arms without a gait belt. Review of the resident's care plan evidenced a problem of "Mostly dependent for ADL (Activities of Daily Living) needs" and included ".... requires total assistance of 2 persons for transfer per OPRA lift. Has a history of not standing for use of SARA lift." The staff failed to safely transfer this dependent resident and failed to follow his/her care plan. Chemical Hazards/Mechanical Hazards 1. During the environmental tour on 4/4/07 at 10:15 AM with the Maintenance Supervisor, and the Resident Care Director the following items were observed: a. The soiled storage room on the 200 wing was unlocked. The cupboard contained a bottle of replacement for "911 Aromatic Absorbant" which had a cautionary chemical label. This room also had an open gallon of whirlpool disinfectant under	F 323	This page left blank intentionally		

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F 323	Continued From page 55 the sink. b. A closet on the 200 wing by the nurses station had 5 gallon paint cans stored. c. The clean storage rooms on the 300 and 400 wings were unlocked and each contained 3 gallons of whirlpool disinfectant. d. Interview with the Resident Care Director during the tour reported that chemicals were not to be stored in unlocked areas. The accessibility of cleaning supplies to cognitively impaired residents is a potential hazard. 2. On 4/3/07 at 10:00 AM, during observations of the 400 Wing, a wing where cognitively impaired residents resided, a pair of scissors was observed to be stored in a resident accessible bin on the side of the medication cart. Medication Delivery Reference for Professional Standards of Practice in medication delivery: Fundamentals of Nursing, The Art & Science of Nursing Care, Fourth Edition, Taylor, Lillis, LeMone, Lippincott, 2001, Chapter 28: Medications, page 581: "After the nurse begins to prepare drugs for administration, they should not be left unattended. If it is imperative to leave for a short time, the drugs that have been prepared should be placed in a locked area. The nurse who prepares the medication also administers the drug and records the drug administration. When the nurse is not working at the medication cart, it	F 323	This page left blank intentionally		

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F 323	Continued From page 56 should be locked." 1. On 4/4/07 at 7:23 AM, during the observation of a medication pass on the 400 wing, there were multiple vials of insulin and an open bottle of glucose monitoring strips sitting on the medication cart. These were left unattended when nurse A administered medications to residents in their rooms. 2. On 4/4/07 at 7:41 AM, during the observation of a medication pass on the 300 wing, two large bottles of Miralax were left sitting on top of the medication cart. These were left unattended when nurse L administered medication to residents in their rooms. 3. On 4/5/07 at 7:25 AM, during the observation of a medication pass on the 300 wing, multiple large bottles of medications and a bottle of eye drops were left sitting on the medication cart. These were left unattended when nurse D administered medications to residents in their rooms.	F 323			
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to supervise and provide adequate assistance to one of 15 sample residents (#11) and one supplemental resident (#27) in order to minimize the potential for accidents. The findings included:	F 324	The facility will ensure that each resident receives adequate supervision and assistance devices to prevent accidents by: a) Only nursing staff is assisting resident #27 with transferring needs. b) Resident #11 is not left in her wheelchair or in the bathroom without supervision. c) Staff will be monitored randomly by the RCD for supervision of high-risk residents. Data will be collected monthly and reported quarterly to the Safety Committee.		5/18/07

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F 324	Continued From page 57 1. On 4/2/07 from 5:50 PM to 6:53 PM, during an observation of the evening meal in the dining room, staff member M was observed to physically assist supplemental resident #27 to stand up. Review of this staff member's job description evidenced the person was to perform "support help in the dining room environment during resident meal times. This position will be responsible to assist the nursing and dietary staffs in the delivery and coordination of the resident meal service..." There was no evidence that the staff member was trained or qualified to safely transfer the resident. 2. Review of sample resident #11's medical record revealed that the resident was admitted to the facility on 2/18/05 with diagnoses which included: CVA (cerebral vascular accident), osteoarthritis, DJD (degenerative joint disease), osteoporosis and arthritis of the right shoulder. The resident was also identified as having a history of multiple fractures and falls with right elbow fracture (7/12/06) and a right tibia and fibula fracture (10/17/06). a. Review of sample resident #11's MDS (minimum data set) significant change assessment dated 12/5/06 revealed the resident had moderate cognitive impairment. The resident required extensive assistance for Activities of Daily Living (ADLs), which included bed mobility, transferring, dressing, toilet use, personal hygiene and bathing. Additionally, the resident was coded as being frequently incontinent of bladder and having a limitation in ROM (range of motion). The area under accidents identified falls in the past 31-180 days and other fracture in the last 180 days.	F 324	This page left blank intentionally		

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F 324	Continued From page 58 b. Review of the "Nurses Notes" identified the resident having repeated falls. The notes included: 9/29/06 "Resident helped self off toilet, fell to floor denies any injuries-non observed..." 10/12/06 "Called to Activities by CNA found Res (resident) lying on the floor. Asked the resident if he/she hurts; he/she pointed to forehead. Res. has sustained a bruise with scrape to mid forehead and front of scalp, also has a very small skin tear to bridge of nose..." 10/17/06 "1415 (2:15 PM) CNA found Res on floor in BR (bathroom). Took 3 CNA's to get him/her into the W/C (wheelchair). Res c/o (complained of) pain R (ankle) ankle. VS (vital signs) 177/88 (blood pressure) 106 (pulse), O2 (oxygen) 95% RA (room air). PROM (passive range of motion) WNL (within normal limits) ex (except) R (right) ankle. Sent res to Xray. Dr. (____name) will splint in ER (emergency room)." 1/18/07 "Had been taken into supper at about 1720 (5:20 PM) left dining room and was found on floor lying on R side down by double doors entering the dining room. [Symbol for no] sx (symptom) of injury X (except) for reddened area upper right cheek..." 2/7/07 "Res in recliner -verbal with discomfort -loud and high pitched tones. Questioned as to pain." 2/9/07 noted resident whimpering and signs of increased pain. The resident was taken to have right foot and ankle rerayed and sen by the physician.	F 324	This page left blank intentionally		

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F 324	Continued From page 59 2/23/07 "06-14 -1110 - Resident found on floor in shower room BR (bathroom). Resident denies discomfort-although has hematoma on head-moves all extremities as well as usual, assisted off floor with assist of 2; placed in w/c (wheelchair) please see neuro [symbol for check] sheet physician notified and residents [family]. c. Review of the "Neurological Assessment" noted entries at 11:15, 11:20, 11:30, 11:45, 12:00, 13:00 (1:00 PM), 1500 (3:00 PM) and 1630 (4:30 PM). d. Review of the "Comprehensive Fall Assessment" sheets identified the resident at a high fall risk. The sheets included: 6/13/06 review which identified the resident as having a score of 26 points and 12/12/06 with a score of 24 points. "A score of 16 or more indicates a high risk for falling." e. Review of "Occurrence Report" sheets included: 10/19/06 identified the fall as "Unattended". The reported documented that the resident was left in the activity room unattended and alarm going off when found. The follow -up action stated, "Spoke with staff resp. (responsible) for care." 1/18/07 identified the fall as "Unattended". The report documented that the resident was left in dining room unattended. The follow -up action stated, "Unsure of cause of fall safety devices in place. Resident does attempt to stand on his/her own (frequently) needs assistance. " 3/1/07 identified the fall as "Unattended" in the	F 324	This page left blank intentionally		

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F 324	Continued From page 60 shower room bathroom. The plan of prevention stated, "Resident cannot be left alone in shower room. CNA was preparing his/her bath around the corner in same room but not at resident's side. "The follow-up action stated, "Education of staff." f. Review of the resident plan of care with print date of 2/28/07 did not indicate the care plan was updated with fall on 3/1/07. The care plan did not address that the resident was not to be left unattended. There was no evidence of other approaches being implemented or attempts to protect the resident and prevent other falls. The facility failed to ensure this cognitively impaired resident received adequate supervision and assistance to prevent accidents with injuries.	F 324			
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to store, prepare, and distribute food in a manner that minimized the potential for the spread of food-borne illness. The findings included: 1. On 4/2/07 starting at 3:27 PM, on the initial kitchen tour with the Dietary Manager (DM) present, the following observations were made: a. The faucet handles on the sink located across from the stove were coated with mineral deposits.	F 371	The facility will ensure that the food is stored, prepared, distributed and served under sanitary conditions by; a). The deposits of mineral on the sink faucet across from the stove have been removed. The faucet itself has been tightened to eliminate excessive mineral deposits. This sink is cleaned on a regular basis with a mineral dissolving solution to prevent build up. This will be addressed on the monthly in-service, and followed through random inspections. b). The outer edge along the seam of the stove hood has been cleaned and removed. This is done on a routine basis. The staff		

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F 371	Continued From page 61 b. The outer edge along the seam of the stove hood had dust on it. c. In the walk-in freezer, there were five unlabelled bags of food. Two of the five bags had dates and three did not have dates on them. The DM identified the food in three of the bags to be chicken, which she verified was freezer burnt, cod, and diced chicken. The bag of diced chicken was not closed. There was ice build-up on the floor right inside the door. The DM indicated that the seal on the freezer door was not tight. d. In the Janitor room, there were two large trash containers. The lids were held open with utility strap cords. Food items were present in the containers. The DM confirmed that the lids are left open. e. In the Store room: i) The thermometer in the freezer section of the white refrigerator (facility named "ice room freezer") registered 36 degrees Fahrenheit (F). Some food items were soft to touch. In the refrigerator section of this unit, there were two thawed Plus 2 Root Beer shakes with expiration dates of 3/16 and one Plus 2 carton which was dated 4/14 but the pour spout was left open. ii) The plastic bin of cracker meal contained a metal measuring cup. iii) The thermometer in the two door freezer registered 20 degrees F. Some of the cartons of Mighty Shake were thawed, the berry Magic cups were soft, and the ice cream cups were soft to touch. The DM commented that the fan in this	F 371	will be in-serviced for education on this issue at the monthly meeting. c). A new policy is being written to address outdated items. A new system is being developed which will alert staff about items that will be outdated within the week. It will be distributed and discussed at a dietary staff meeting. Staff will be educated on labeling and dating all foods. Counseling will be done with staff that are not following the procedure and further steps will be taken following the disciplinary actions needed with staff who do not follow the policy. d). The trash lids have been covered after they were addressed on 4/3/07. The staff was educated and now know that they must leave the lids on the trash at all times. The bungy cords have been removed from the area. e). A de-ice fluid is used as needed to remove ice build up on the door and inside the freezer f). The storeroom freezer is no longer in service and is being replaced with a new one. The white freezer/refrigerator in the storeroom is being monitored and is meeting temperature guidelines. h). A pour type plastic container is being used for the cereal in the nourishment center to eliminate the use of scoops. Staff is educated on proper use of scoops in food items. i). A new policy is being written to address freezer and refrigerator temperatures. The staff will be educated on this policy and the procedure will be followed. Temperatures are taken and logged on a daily basis. Staff		

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F 371	Continued From page 62 freezer was not working at the time of the observation. iv) The thermometer in the three door freezer registered 6 degrees F. The breads and muffins were soft to touch. v) There were expired cases/cans of supplements: Peratine (1/1/07) one case plus one can; Pulmocare (3/1/07) one case; Glucerna (3/1/07 one can and 4/1/07 one can). vi) There were cases of Dinex dishes stacked on the floor. f. During the initial observation of the kitchen, review of the temperature logs for 12/06, 1/07, 2/07, 3/07, and 4/07 revealed the following: i) 12/06: 10 of 31 days lacked documented temperatures; 7 of the 21 days had temperatures outside of the facility's acceptable range. Facility's Food Storage policy (last review date 8/04) indicated "The temperature range for the cooler must be 34 - 40 degrees F (Fahrenheit)... will be checked and recorded daily... The temperature range for the freezer must be -20 to 10 degrees F." ii) 1/07: 12 of 31 days lacked documented temperatures; 6 of the 21 days had temperatures outside the facility's acceptable range. iii) 2/07: 6 of 28 days lacked documented temperatures; 5 of the 22 days had temperatures outside the facility's acceptable range. iv) 3/07: 10 of 31 days lacked documented temperatures; 21 of 21 days had temperatures	F 371	will note the circumstances that have occurred when finding temperature variations and corrective measures will be performed. The Dietary Manager is spot checking them and the dietitian is checking them weekly. j). The activity department will be in-serviced on the policy for outdated items and safe storage of foods in their areas. Activities will spot check to ensure that the foods are being disposed of when needed. k). The automatic feed for the sanitizer has been adjusted and the staff are now checking temperatures during every use. The staff have been re-educated on the bleach buckets and are being checked random for compliance. l). All staff will be educated on how to deliver meals safely during meal service and delivery. m) Call lights will be monitored for average time to answer. Busiest times of each shift will be identified. Management will compile this information and look for trends and solutions to shortening the length of time call lights are answered. n) Staff will be in-serviced on the results of the above and asked for input to help reduce call light answer time. o) Call light answering times will be collected monthly from various shifts by the RCD. This data will be reported quarterly to the PI Committee.	5/18/07	

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F 371	Continued From page 63 outside the facility's acceptable range. v) 4/07: (This log was reviewed on 4/2/07 at 4:00 PM.) There were no entries on 4/1 or 4/2, but on 4/3 (which was the day after the review of the record.) The temperatures were out of range on this notation. g. In an interview with the DM at the time of the tour, she verified that no staff had reported that the temperatures were above the acceptable range. She revealed that she was not aware that the staff were not documenting temperatures daily as was the facility's policy. 2. On 4/3/07 at 7:35 AM, the following observations were made in the Servedy, located adjacent to the dining room: a. In the refrigerator, there were three vanilla custard cups marked not good after 3/31, one no added sugar Mighty Shake dated 3/29, one apple cinnamon supplement dated 3/29, a bag of hard boiled eggs which was not labelled or dated, and two bags of cooked bacon which was not labelled or dated. The thermometer inside the refrigerator registered 48 degrees F. The thermometer in the freezer section of the refrigerator registered 28 degrees F; at this time, the food items were frozen. At 8:50 AM, the unlabelled and outdated items were still present in the refrigerator. b. In the white freezer, the thermometer registered 10 degrees F. The ice cream cups were soft to touch. 3. On 4/3/07 at 5:03 PM, during an observation of the kitchen area in the Activity Room, the following items were present in the	F 371	This page left blank intentionally		

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F 371	Continued From page 64 refrigerator/freezer for resident use: 46 ounce tomato juice, dated 2/1 46 ounce cranberry juice, dated 3/8 46 ounce grape juice, dated 3/8 Frozen beef tongue. 4. On 4/3/07 at 5:12 PM, in an observation in the resident nourishment room, the following was observed: a. On the top shelf of the center cupboard, there were three 7.5 liter plastic containers of cereal. In each container there was a Styrofoam cup. b. In the right cupboard, there was an open bag of cereal. c. In the freezer compartment of the refrigerator, there was no thermometer, an open bag of individual pizzas, and two Health Shakes which had been previously frozen (thaw dates of 3/24 and 4/5), thawed, and re-frozen. d. In the refrigerator, there was an open package of cream cheese (best used by 3/30), a ziplock bag with two pieces of chicken which were not labelled or dated, and an expired can of Glucerna (4/1/07). There was a ziplock bag marked for the 8 PM snacks on the 400 hallway, which contained one Mighty Shake (for supplemental resident #32) and one Health Shake (for supplemental resident #33). These two supplements did not have a thaw date on them. On 4/4/07 at 8:06 AM, the supplements for residents #32 and #33 remained in the ziplock bag in the refrigerator with no thaw dates marked on them. 5. On 4/4/07 at 7:23 AM, during the observation	F 371	This page left blank intentionally		

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F 371	Continued From page 65 of a medication pass on the 400 wing, an open carton of Resource Breeze (nutritional supplement) was left sitting on the medication cart during the medication pass. Additionally, this supplement was not placed on ice to keep it cold. 6. On 4/4/07 at 7:41 AM, during the observation of a medication pass on the 300 wing, an open container of pudding, a carton of Resource Breeze (nutritional supplement), and juice were left sitting on the medication cart during the medication pass. These items were not kept cold. 7. On 4/5/07 at 7:25 AM, during the observation of a medication pass on the 300 wing, there was a partially used carton of Med Pass Plus supplement sitting on the medication cart. This supplement was not being kept cold. 8. On 4/4/07 at 8:19 AM, during an observation in the kitchen with the Dietary Manager (DM), she revealed that juice containers after the seal was broken were good for 14 days. The following observations were made: a. In the Janitor room, lid on one of the two large trash containers was held open with a utility strap cord. This was observed again during an environmental tour of the kitchen at approximately 11:00 AM. b. In the Storage Room, the double door freezer was empty. The DM commented that the condenser was going out in that freezer. c. In the walk-in freezer, there was an open, unlabelled and undated bag of meat. d. In the walk-in refrigerator, there was an open,	F 371	This page left blank intentionally		

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F 371	Continued From page 66 unlabelled and undated bag of meat, which the DM identified as Canadian bacon. e. The temperature in the sanitizer section of the three compartment sink was 79.8 degrees F. According to the literature posted above the sink, the safe temperature range was 65 - 75 degrees F. f. The bucket of surface cleaner in the dishwashing room was tested by the DM. The test strip indicated that there was no sanitizer in the bucket. She revealed that bleach is to be used in this bucket. 9. On 4/4/07 at 9:58 AM, in an interview with the Dietary Manager (DM) and Registered Dietitian (RD), they indicated that the policy was to keep the juice only 14 days after it was opened. The surveyor requested a copy of this policy. 10. On 4/4/07 at 5:20 PM, the RD revealed that there was no policy/procedure for the storage of juice (how long to keep open juice). 11. On 4/5/07 at 8:18 AM, in an interview with the Chief Nursing Officer (CNO), she indicated that there was a policy for the storage of juices. She provided the following "Food Storage" policy. Review of the unsigned Banner Health "Food Storage" Policy and Procedure, dated with a revised date of 8/04, revealed "Q. All opened unused portions of canned juice must be poured into plastic pitchers, covered, labeled, dated and placed in the cooler. Juices packaged in boxes may be dated and stored in those boxes." There were no time limitations in this policy for open perishable items or leftovers.	F 371	This page left blank intentionally		

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F 371	Continued From page 67	F 371			
F 428 SS=E	12. On 4/3/07 at 7:45 AM, observations during breakfast residents, meal found that staff were touching the tops of drink glasses and coffee cups with fingers, during delivery and set up. 483.60(c)(1) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure that a comprehensive drug regime review was conducted for all residents, including five of 15 sample residents (#4, #11, #3, #9, and #15), at least once a month by a licensed pharmacist. Additionally, there was no evidence that the pharmacist observed or reviewed the actual administration of medications. The findings included: Reference for Professional Standards of Practice in Drug Regimen Review: According to the American Society of Consultant Pharmacists, a Drug Regimen Review should encompass a range of activities designed to guarantee that residents receive the proper medications at the right time in the correct doses. This review begins by collecting information on the resident's medical history, diagnoses, treatments, physician orders, laboratory tests, medication history, diet and care plan. The drug review should sufficiently identify any drug-drug or diagnoses-drug combination which is potentially inappropriate for the elderly or creates a high risk for adverse drug reaction in	F 428	The drug regimen of each resident will be reviewed once a month by a licensed pharmacist. A new comprehensive drug regimen review will be conducted on residents #4, #11, #9 and #15. All additional residents of the facility will receive a new comprehensive drug regimen review starting with the May 2007 review. The drug review will sufficiently identify any drug-drug or diagnosis-drug combination which may be potentially inappropriate for the elderly or creates a high risk adverse drug reaction in the elderly. Other areas of consideration will include potential or actual drug-food interactions and appropriateness of dosages and the intervals at which medication are to be taken. This drug review will insure that the resident's drug regimen is free of any drugs given in excessive doses, given in sub-therapeutic doses, duplicate therapies, excessive duration, without adequate indication for its use, without adequate monitoring or in the presence of potential dangerous reactions. Policies and procedures will be developed based on new CMS guidelines for medication regimen review. Policies and procedures will include measure taken to		

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F 428	Continued From page 68 the elderly. Other areas of consideration should include potential or actual drug-food interactions, the appropriateness of dosages and the intervals at which medications are to be taken. This drug review should insure that the resident's drug regimen is free of any drugs given in excessive dose, given in sub-therapeutic doses, duplicate therapies, excessive duration, without adequate indications for its use, without adequate monitoring or in the presence of potential dangerous adverse reactions. 1. On 4/3/07 at 4:30 PM, in an interview with the Administrator and Chief Nursing Officer (CNO), the CNO commented that about three months ago she provided the Pharmacist, who does the residents' monthly drug reviews, a copy of the new interpretative guidelines for drug review. 2. On 4/4/07 at 4:50 PM, in an interview with the Pharmacist who did the residents' monthly drug regimen review, she indicated that she communicates verbally with the Director of Nursing (DON) and physicians. She revealed that if she identifies a problem with a resident's drug regimen, she uses an issue form and gives that to the charge nurse on the unit. She commented that she was not aware if the the DON gets that information or not and that afterwards the form should be filed in the residents' charts. The Pharmacist indicated that if there was a lab (laboratory) issue, such as no results from a lab test, she would contact the lab and get the results. When the surveyor asked if the Pharmacist had reviewed the new guidelines for medications, including the need to review anticholinergics, she said that "she was not sure if she had seen these	F 428	monitor drug administration and the reporting of drug irregularities to the RCD and attending physician. A PI process will be implemented to monitor appropriate pharmacy services based on the new CMS guidelines. The consultant pharmacist will monitor this process monthly and report to the PI Steering Committee quarterly.	5/18/07	

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F 428	Continued From page 69 guidelines." When she was shown these guidelines, she denied having received them. She revealed that the use of multiple drugs for the same purpose, such as multiple laxatives, might or might not be cause to question the drug usage, depending on the resident. She stated that she is allotted two days per month to do the drug reviews and that in that time she checks the physicians' orders, lab results, and Medication Administration Records (MARs). She revealed that she does not observe the actual medication passes by the nurses. 3. During an interview with the RCD (Resident Care Director) on 4/5/07 at 4:20 PM the process for the pharmacist reporting resident drug regimen irregularities was reviewed. The RCD reported that the pharmacist had written comments about lab work or vitals signs but she had not been given or made aware of any drug irregularities being identified by the pharmacist. 4. Resident #4's medical record review revealed the resident was admitted to the facility on 7/28/06. The resident's diagnosis included: dementia other than Alzheimer's, CHF (congestive heart failure), HTN (Hypertension), arthritis, diabetes, diverticulosis, anemia, hypertension, recurrent UTIs (urinary tract infections), and history of trigeminal neuralgia (pain in the facial area), and cancer of the colon. a. Review of sample resident #4's Minimum Data Set (MDS) dated 12/27/06 revealed the resident had moderate cognitive impairment. The resident required extensive assistance for Activities of Daily Living (ADLs), which included bed mobility, transferring, dressing, toilet use, personal hygiene and bathing. b. Review of the "Medication Record" sheets for 3/2007 and 4/2007 showed the resident's	F 428	Resident #4 will have a new comprehensive review following the new CMS guidelines.	5/18/07	

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F 428	Continued From page 70 medications included medications having a potential for causing increase CNS (central nervous system) reactions which include: drowsiness, sedation, weakness, and disorientation or increase anticholinergic side effects. They included: Seroquel 6.5 mg at 20:00 (8:00 PM) started 11/9/06 for "other persistent mental disorders due to conditions classified elsewhere." [Seroquel is an atypical antipsychotic use to manage psychotic disorders with a side effect of sedation.] Namenda 10 mg one time a day 7/28/06, [Namenda is listed as a central nervous system medication indicated for use for moderate to severe dementia with Alzheimer's. The adverse side effects may include confusion, depression, fatigue, pain edema, constipation incontinence, UTI, back pain, abnormal gait and falls.] Lasix 40 mg at 7:00 AM 1/01/07, [Lasix is a diuretic.] Celebrex 200 mg 1 tablet daily, 9/13/06, [Celebrex is a nonsteroidal anti-inflammatory medication. This medication has a number of potential drug-drug interactions as well as potential side effects.] c. Review of nurses notes from 1/15/07 to 4/1/07 showed the resident was having a decline in condition with included: increase in complaints of pain, edema requiring IV (intravenous) diuretic, recurrent UTIs (12/18/06 and 2/19/07), significant weight loss and increase in confusion and lethargy. d. Review of the "Pharmacy Consultant Monthly Review" sheets from 8/28/06 to 3/28/07 marked "No Problems Noted" and had no drug irregularities identified for this resident. The Pharmacist failed to report potential drug irregularities to the resident's attending physician	F 428	This page left blank intentionally		

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F 428	Continued From page 71 and DON (Director of Nursing) with the documented decline in the resident's condition. There was no documentation of a review with these medications having a potential for causing increase CNS (central nervous system) reactions which include: drowsiness, sedation, weakness, and disorientation or increase anticholinergic side effects. 5. Resident #11's medical record revealed that the resident was admitted to the facility on 2/18/05 with diagnoses which included: CVA (cerebral vascular accident), osteoarthritis, DJD (degenerative joint disease), osteoporosis and arthritis of the right shoulder. The resident was also identified as having a history of multiple fractures and falls with right elbow fracture (7/12/06) and a right tibia and fibula fracture (10/17/06). a. Review of sample resident #11's MDS significant change assessment dated 12/5/06 revealed the resident had moderate cognitive impairment. The resident required extensive assistance for Activities of Daily Living (ADLs), which included bed mobility, transferring, dressing, toilet use, personal hygiene and bathing. Additionally, the resident was coded as being frequently incontinent of bladder and having a limitation in ROM (range of motion). The area under accidents identified falls in the past 31-180 days and other fracture in the last 180 days. b. Review of the "Nurses Notes" identified the resident having repeated tongue infections and issues with dry mouth and multiple falls. The notes included also identified the resident as being frequently incontinent of urine which had been unchanged. c. Review of the "Medication Record" sheets for 3/2007 and 4/2007 showed the resident's medications included:	F 428	Resident #11 will have a new comprehensive review following the new CMS guidelines.	5/18/07	

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F 428	Continued From page 72 Detrol LA 4 mg tablet at 7:00 AM daily which was started 5/15/05. [Detrol is a medication use for urinary incontinence with anticholinergic properties. The adverse side effects included potential for fatigue, vertigo, dizziness, dry mouth, abdominal pain, dysuria, UTI, pruritus, rash and fungal infection.] d. The resident was observed on 4/2/07 supper meal attempting to wipe his/her tongue with the clothing protector. The resident's tongue was dry and cracked. Staff reported the resident had a on going problems with wanting to wipe /his/her tongue and had previous oral infections and thrush. [Oral thrush is a disorder caused by infection of the mouth with the fungus (yeast) Candida albicans.] e. Review of the "Pharmacy Consultant Monthly Review " sheets from 9/27/06 to 3/28/07 marked "No Problems Noted" and had no drug irregularities identified for this resident. The Pharmacist failed to report potential drug irregularities to the resident's attending physician and DON with the resident ' s on going oral infections and falls. There was no documentation to show the resident's medication had been reassessed for anticholinergic side effects with resident having symptoms of somnolence, dry mouth, urinary retention, and constipation or reassessed with the resident having repeated falls. The resident was observed throughout much of the survey to be in bed or recliner with eyes closed. 6. Resident #9's medical record revealed that the resident was admitted to the facility on 2/8/06 with diagnosis which included: dementia, chronic atrial fibrillation, chronic low back pain, breast cancer, recurrent UTIs (urinary tract infections), and history of constipation.	F 428	Resident #9 will have a new comprehensive review following the new CMS guidelines.		5/18/07

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F 428	Continued From page 73 a. Review of the "Medication Record" sheets for 3/2007 and 4/2007 showed the resident's medications included: Ditropan XL ER 5 mg twice a day, [Ditropan is a medication use for urinary incontinence with anticholinergic properties.] Macrochantin 100 mg one time a day, [Macrochantin is a medication used to treat UTIs.] Namenda 10 mg one time a day 5/1/06, [Namenda is listed as a central nervous system medication indicated for use for moderate to severe dementia with Alzheimer's. The adverse side effects may include confusion, depression, fatigue, pain edema, constipation incontinence, UTI, back pain, abnormal gait and falls.] Trazodone 50 mg one time a day at 1800 (6:00 PM) started 2/2/06, [Trazodone is a antidepressant medication with anticholinergic properties.] b. Review of the "Nurses Notes" identified the resident having signs and symptoms of a UTI with urinary frequency and burning on 2/5/07 and a URI (upper respiratory tract infection) 3/5/07. c. Review of the "Pharmacy Consultant Monthly Review" sheets from 8/28/06 to 3/28/07 marked "No Problems Noted" and had no drug irregularities identified for this resident. There was no documentation to show the resident's medications had been reassessed for anticholinergic side effects. 7. Resident #3's medical record revealed that the resident was admitted to the facility on 8/06/01 with diagnosis which included; Paranoid schizophrenia, depression, anxiety disorder, CHF, subdural hematoma, confusion, constipation and skin cancer. a. Review of the "Medication Record" sheets for 3/2007 and 4/2007 showed the resident's medications included:	F 428	Resident #3 will have a new comprehensive review following the new CMS guidelines.	5/18/07	

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F 428	Continued From page 74 Namenda 10 mg two times time a day started 6/28/04, [Namenda is listed as a central nervous system medication indicated for use for moderate to severe dementia with Alzheimer's.] Trazodone 75 mg one time a day at 1800 (6:00 PM) started 7/16/03, [Trazodone is a antidepressant medication with anticholinergic properties.] Paxil CR 25 MG started 4/30/04, [Paxil is a antidepressant medication.] Elavil 50 mg at bedtime started 1/25/06, [Elavil is is a antidepressant medication.] Loxitane 30 mg at bedtime started 4/23/03, [Loxitane is an antipsychotic medication.], Tranxene 15 mg at bedtime started 5/22/05, [Tranxene is a CNS (central nervous system) drug used for anxiety. It can cause CNS depression use with other CNS depressants.] Neurontin 300 mg three times a day started 6/8/05. [Neurontin is a CNS drug with a potential with risk for potential adverse effects and drug to drug interactions.] b. Review of the "Pharmacy Consultant Monthly Review" sheets from 8/28/06 to 3/28/07 marked "No Problems Noted" and had no drug irregularities identified for this resident. There was no documentation to show the resident's medications had been reassessed for; multiple drugs with anticholinergic side effects, multiple drugs used in the same drug category or group, indication for use and attempts at reductions if possible. c. Review of the resident ' s medical record from 1/6/07 to 3/23/07 documented the resident having; falls and unsteady on feet , weakness, fatigue, and resident complaining about eye pain and dry eyes. There was no evidence that the resident ' s drug regimens identified the resident at risk for adverse drug reaction and having	F 428	This page left blank intentionally		

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F 428	Continued From page 75 anticholinergic side effects. 8. Review of the job description for the pharmacist dated 6/17/2003 identified the following Job Summary: " The pharmacist is responsible for the delivery of pharmaceutical care to individuals based on his or her involvement with the four elements of the medication use process (prescribing, dispensing, administration, monitoring of drug effects) and comprehensive assessments, analysis, collaboration with integrated team members, as well as the educational needs of the patient. The pharmacist oversees the activities of pharmacy assistants (technicians/buyers), coordinating their work and checking all orders that they prepare for patients or departments. The pharmacist is also responsible for initial and monthly medication reviews for all Goshen Care Center residents. Additionally, the pharmacist is accountable for on-going evaluation and documentation of all components of pharmaceutical care delivered to customers in the Banner Health Torrington community." 9. On 4/5/07 at 1:00 PM, a record review of sampled resident #15's Psychoactive Medication review revealed only Goshen Care Center Psychoactive Medication Team Recommendations (Form #5 as identified in the Policy and Procedure) dated 10/23/06, 5/4/06, and 6/30/05. According to the Banner Health System, Torrington, Wyoming, Policy and Procedure, Dated 01-03; 4/06: Psychoactive Medications, Form #5 is one of eight forms in a five-part procedure. 10. On 4/5/07 at 6:55 PM, an interview with the RCD determined that the Policy and Procedure: Psychoactive Medications dated: originated: 2-03;	F 428	Resident #15 will have a new comprehensive review following the new CMS guidelines.		5/18/07

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F 428	Continued From page 76 4/06 "Is not followed." The RCD was able to provide and annotate only four of eight forms identified in the Policy and Procedure: Psychoactive Medications.	F 428			
F 442 SS=E	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to follow isolation techniques when caring for two of 15 sample residents (#6 and #9) and two supplemental residents (#16 and #32) who were determined to have infections. The findings included: 1. On 4/2/07 at 2:25 PM, during an initial tour of the facility with the resident care coordinator she identified residents as being in contact isolation for MRSA (Methicillin Resistant Staphylococcus aureus) infections. The residents identified were residents #32, #16, #9, and #6. 2. Review of the "Infection Control Program" with the ICC (Infection Control Coordinator) on 4/4/07 at 9:00 AM, revealed she was responsible for the infection control in facility. The facility had an individual tracking forms that were started when the resident was showing signs and symptoms of infection. She confirmed that there were four current residents identified with MRSA infections and a new admission coming in with MRSA. She	F 442	The facility infection control program will ensure that when it determines that a resident needs isolation to prevent the spread of infection, the resident will be isolated by: a) Following current CDC guidelines and /or infectious disease consult. b) Residents identified with MRSA or other multi-drug resistant organisms are all in contact isolation. All care plans for these residents are updated and available to all appropriate staff. Residents experiencing respiratory symptoms will also be placed in droplet precautions. c) Staff education concerning Transmission Based Precautions will be provided at least quarterly and will include increased hand hygiene for the resident and the necessity of keeping clean high touch areas of resident equipment that leaves the room. d) Nurses will be educated on pertinent nurses notes charting and its value. e) Staff compliance will be monitored using a PI process tool to visually monitor appropriate use of hand hygiene and personal protective equipment on a monthly basis by the charge nurses of each unit. Reporting will be done quarterly to the PI Committee.	5/18/07	

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F 442	Continued From page 77 reported that the staff were to be following the facility policy for "Contact Isolation" and "Modified Contact Isolation" for those residents who had been identified with a colonized resistant organism. 3. Review of the facility policy titled "Management of Clientele with Resistant Organisms" dated 8/02 included: "I. Purpose; To prevent the spread of infection or colonization of Resistant organisms to Clientele, personnel and visitors. This includes MRSA (Methicillin Resistant Staphylococcus aureus), VRE (Vancomycin Resistant Enterococcus) and ESBL's (Extended Spectrum B-Lactamases). General Information: Transmission of these organisms occurs mainly by contact, but can also be aerosolized in droplets. They do not float in the air but if coughed or sneezed out of the patient they can contaminate the nearest surface, where they can survive for hours or days. Several factors that increase the clientele's susceptibility for acquiring Resistant Organisms included: Increased length of stay, Multiple hospitalizations, age (over 65 years of age), multiple invasive procedures, wounds, severe underlying disease, administration of multiple broad spectrum or long-term use of antibiotics... II. Policy: All infected clientele are to be placed in appropriate isolation precautions adhering to current CDC guidelines and / or Infectious Disease consult. Resistant Organism Colonized clientele must be	F 442	This page left blank intentionally		

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F 442	Continued From page 78 place in a "modified" contact isolation that consists of... The clientele may leave the room and go to activities as long as good hygiene is observed. Colonized clientele must have extra precautions taken if respiratory infections are present. III. Procedure: Hand cleansing must be rigorously practiced. Hands will be cleansed after removal of gloves and after any contact of body secretions or any surface associated with a Resistant Organism infected or colonized clientele. This includes wheelchairs, walkers, light switches, door knobs etc. Gloves are indicated when there is a possibility of direct contact with clientele secretions and/or body fluids or contaminated surfaces. Gowns should be worn if contact with contaminated surfaces is likely and should be removed before leaving the room..." 4. Review of the "Patient and Family Education Sheet" -Isolation for Antibiotic-Resistant Organisms included: "... 3. It is very important for all persons entering and leaving your room to wash their hands." 5. Observation showed that staff caring for residents who have been identified as being in "Contact Isolation" were not following the facility policy for isolation when providing care. Examples included: a. On 4/5/07 at 7:45 AM Resident #32 who was identified as being in isolation had finished with a breathing treatment and left his/ her room by self	F 442	This page left blank intentionally		

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F 442	Continued From page 79 using a wheelchair. The resident then went to the dining room for breakfast. Staff provided no cueing or assistance to wash the resident's hands or ensure hand hygiene was done before going to the dining room. b. On 4/5/07 at 8:45 AM Staff I entered resident #32's room without putting on gloves and handed the resident the telephone. Staff was then observed to pick-up and adjust the oxygen tubing, make the resident's bed and straight belongings on the bedside table. The staff then exited the resident's room and assisted another resident in a wheelchair before washing his/her hands at the nurses station. The staff did not put on gloves before direct contact with the resident's belongs or ensure hand washing was completed before contacting other surfaces outside the resident's room. The facility failed to ensure isolation procedures were consistently followed. 6. On 4/2/07 at 5:00 PM, staff Q entered the room of resident #6 without identifying any need for contact precaution to the surveyor. After room tour and resident introductions, staff Q re-entered the room of resident #6, without the use of protective gloves, to assist the catheterized resident in moving from a reclining to prone position, and then to a wheelchair. Staff exited the room applying gel only and continued with initial tour. a. Posted at the entrance to room of resident #6 was the following notice: CONTACT PRECAUTIONS (English/Spanish) Visitors: Report to Nurses Station before entering room	F 442	This page left blank intentionally		

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F 442	Continued From page 80 Gown and gloves when in contact with patient or frequently touched surfaces Wash/Sanitize hand before leaving room Single use Item when possible Limit equipment Transport patient for essential purpose only Notify receiving departments Wash Hands/ No sanitizers for any GI Illness. b. On 4/4/07 at 8:00 AM, an interview with staff A revealed that the Contact Precautions posted at the entrance are to be followed as written, gloves are to be used, gel is to be used after gloves are removed, gowns are to be used for contact for example transfer. Staff A identified that there were no protective gowns available on the table with the other Contact Precaution items (gloves, sanitizing gel, masks). Staff A further stated that the MRSA was identified in the sinus area of the resident and that he/she had a habit of blowing his/her nose without the use of a Kleenex. If the resident is seated in the recliner near the nurses' station and blows his/her nose, the area is to be wiped down with "Dispatch" Hospital Cleaner Disinfectant Towels with Bleach. Staff A located the "Dispatch" container from a storage room. The container was observed to be empty. The empty container remained on the 400 wing nurses' station desk for the remainder of the survey. c. On 4/4/07 at 9:30 AM, review of medical record for resident #6 revealed that there were no Nurse's Notes referring to the MRSA from 3/15/07 to present (4/4/07 9:30 AM). d. On 4/4/07 at 9:50 AM, interviews with the ICC (Nurse) revealed that Nursing Report Notes contain communication documentation regarding	F 442	This page left blank intentionally		

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F 442	Continued From page 81 resident 6's status relating to MRSA, e. On 4/4/07 at 9:55 AM, interview with staff A revealed that "all Nursing Report Notes are shredded and there are no notes available." f. On 4/4/07 at 10:10 AM, interview and record review reveled that staff A was unable to locate any notation in the CNA communication book regarding the MRSA status of resident #6. Reference: CDC (Center for Disease Control) Antimicrobial Resistance - Multi-drug Resistant Organisms in Non-Hospital Healthcare Settings: They are bacteria and other microorganisms that have developed resistance to antimicrobial drugs... MRSA (Methicillin Resistant Staphylococcus aureus) and VRE (Vancomycin-resistant enterococci) are the most commonly encountered multidrug-resistant organisms in patients residing in non-hospital healthcare facilities. Non-hospital healthcare facilities can safely care for and mange these patients by following appropriate infection control practices. Current prevention methods is an ongoing investigation. No single prevention approach is likely to work alone. Careful handwashing is important for prevention of spread of many infections including Staph aureus..."	F 442			
F 465 SS=E	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	The facility will provide a safe, functional, sanitary and comfortable environment for residents, staff and the public by maintaining a clean laundry washing area. This will be accomplished by:		

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F 465	Continued From page 82 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide a safe, functional and comfortable environment for the residents, the staff, and the public. These practices related to not ensuring that the lint was removed from the dryers located in the laundry in order to minimize the potential for a fire and not repairing a water damaged wall in the laundry room. The findings included: During the environmental tour on 4/4/07 at 10:15 AM with the Maintenance Supervisor, and the Resident Care Director, observations made in the laundry identified the following: a. The wall behind the washing machines was noted to be damaged. The paint was peeling up on the wall and the bare wall board was bubbled. The area extended a foot to foot and a half up on the wall and was approximately 20 feet in length. The interview with the Maintenance Supervisor identified the wall as having water damage and had been identified as an area to be repaired. This water damaged wall has a potential for growth for mildew and mold. b. The room which had the washing machines also had a stacked washer and dryer unit. The dryer hose was noted to be down inside a bucket. There was a large build up of lint on the floor around the unit. There was also lint on the wall and ceiling behind this unit. During the tour maintenance supervisor reported that the area and the lint was supposed to be cleaned daily. The laundry staff reported it was not being	F 465	a) The wall board will be removed and replaced four feet up from the floor with waterproof cement board and vinyl panels. b) This will be monitored monthly by department and safety walk-throughs. c) Walk-throughs are reported monthly to the Safety Committee. d) The water filter on the stacked unit was re-attached and in working order on 4/5/07 and the walls and ceiling behind the unit was also dusted and washed. e) The stacked washer and dryer unit will continuously be vented into the water filter which will be cleaned and documented daily. f) Daily cleaning of the wash area will be performed by the wash staff. g) An in-service will be conducted with staff on cleaning procedures. h) Both actions will be monitored monthly by the laundry manager. Manager will report to the Safety Committee on a quarterly basis. i) Both dryers, their screens and bottom chambers were thoroughly cleaned on 4/4/07. The cleaning schedule of the dryers will include the following measure: The bottom chamber and screen of the dryers will be checked after each load and will be cleaned after each 2-3 dryer loads. The dryers will be vacuumed daily. j) This actions will be documented at the end of each daily shift. k) An in-service will be conducted with staff on proper and thorough dryer cleaning procedures. l) These actions will be monitored monthly by the laundry manager. Manager will		

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F 465	Continued From page 83 cleaned daily due to difficult access. c. The adjoining room identified as the clean laundry area had two large dryers. The bottom chambers of both dryers were checked and found to have a build up of lint and debris. The first dryer, when entering the room, had a one to two inch layer of lint covering the bottom chamber of the dryer and the screen. The second dryer had approximately a two inch layer with a thicker build-up in the back of the machine. The laundry staff reported that she cleaned the lint out about every two or three loads. The maintenance supervisor then commented it should be done more often. The build-up of lint in dryer units has a potential hazard for a fire.	F 465	report to the Safety Committee on quarterly basis.	5/18/07	
F 467 SS=E	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide functioning ventilation in resident rooms and/or bathrooms in order to minimize odors. The findings included: 1. On 4/2/07 at 2:25 PM, during an initial tour of sample resident rooms, the ventilation fan in the bathroom in resident room 211 was observed to	F 467	The facility will ensure that we maintain adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two by the following: 1) The exhaust fans on 200, 300 and 400 halls that were not operating have been replaced and are functioning properly. 2) Monitoring for continued function will be done through the monthly Preventative Maintenance program by maintenance staff. Quarterly reporting will be done to Safety Committee.	5/18/07	

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F 467	Continued From page 84 not be drawing air upward. When a tissue paper was held up to the vent, the paper was not pulled upward. 2. During the environmental tour on 4/4/07 at 10:15 AM with the facility maintenance supervisor, and the Resident Care Director, observation was made of the resident bathroom in the bathing room on the 200 Wing. The ventilation /exhaust was found not working. The maintenance supervisor confirmed that the exhaust system was not working and the facility had identified it as a problem which was being worked on. He reported that there were some rooms on each of the 200, 300, and 400 wings not working. The posting on the work board in the maintenance room identified rooms 7, 8, 9, and 11 on the 200 wing, 16, 17, 18, and 19 on the 300 wing, and 20, 21, and 22 on the 400 wing as needing repair.	F 467			
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of resident's assessments; the plan of care and services provided; results of any preadmission screening conducted by the State; and progress notes. 1. Computerized physician order summaries are currently being developed		

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F 514	Continued From page 85 Based on record review and staff interview, it was determined that the facility failed to ensure that the residents' medical records were accurate and complete. The findings included: 1. Following the medication pass observations on 4/4/07 and 4/5/07, the surveyor attempted to verify that the medications observed being given to residents were the correct medications based on the physicians' orders. The orders for some of the residents' current medications were not in the residents' current medical records. On 4/5/07 at 11:05 AM, in an interview with the MDS Coordinator and Nurse A, they verified that physician orders are purged from the residents' charts and that there are no physician order summaries in the records. After this interview, the surveyor requested purged physician orders to verify medications. 2. Record review of sample resident #1's 3/8/07 and 12/7/06 Minimum Data Set (MDS) assessments evidenced that he/she had been assessed as having significant changes in condition. On both of these MDS assessments the resident was assessed to require extensive or total assistance with all Activities of Daily Living (ADLs) and had experienced falls. a. Review of the resident's Nurse's Notes revealed the following: 11/10/06 at 6:00 PM, revealed that the "res (resident) had fallen - Assessment: ROM (range of motion) WNL (within normal limits) for resident - Laceration L (left) side of forehead - Sent to ER (emergency room). Returned with Steri Strips over wound. BP (blood pressure) Lying 211/87 -	F 514	for inclusion in the active resident record to allow for easy access of all current orders for each resident in the facility. 2. Nursing staff will be in-serviced on the recommended nursing standards for neurological assessments, including frequency of neurological assessments, and the recommended nursing standards for documentation and completion of documentation forms. 3) Nursing staff will be in-serviced about how and when to update care plans to address and keep current with resident needs and CNA care plans—which are being developed. a) Care plan status date, next review date, review date and target date will be changed for clarification and to reflect actual review dates. b) Care plans will be checked to see if they are updated and relevant to the residents' needs by the MDS Coordinator on a monthly basis. She will report quarterly to the PI Committee. 4. Quality assurance monitoring for completeness, including resident assessments, plan of care, services provided, results of preadmission screening conducted by the State, and progress notes will be done by the nursing department. Data will be collected monthly and reported quarterly to the QA committee.	5/18/07	

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F 514	Continued From page 86 71 (pulse) - BP Sitting 178/92 - 71 - Message sent to physician - Family notified." 11/11/06 (10:00 PM to 6:00 AM) noted "Res has denied pain all noc (night) VS (vital signs) T (temperature) - 97.1 (degrees Fahrenheit), P - 76, R (respirations) 20, B/P 174/78, Bleeding from around drsg (dressing) to head. Area cleaned, L (left) eye bruised, swollen increased drainage from L eye." 11/11/06 (2:00 PM to 10:00 PM) "Res C/O (complained of) H/A (headache) - Tylenol ii (two) given with good results. VS = 186/82, 97.8, 86, 20. Drsg change done to forehead d/t (due to) drsg soiled. New drsg. applied. Res has no C/O." b. Review of the Emergency Nursing Record, dated 11/10/06 and timed 5:20 PM, revealed that VS were checked and the Glasgow Coma Scale score was 15 on arrival (spontaneous eye opening, oriented, and obeys commands would equal 15, even these were not marked on the form). The form was marked with a laceration/abrasion and ecchymosis (bruising) to the head/face. According to the documentation, the resident left the ER at 5:46 PM (26 minutes after arriving). The Injury Aftercare Instruction Sheet indicated that the resident should be observed for 24 - 48 hours for "...confusion, delirium, or disorientation, blurred vision or double vision, a difference in pupil size comparing left to right, ..., persistent headaches..." c. Review of the Occurrence Report for the fall which the resident experienced on 11/10/06 had BP and P documented, but no neurological assessment noted. There were no neurological assessment documented in the Nurse's Notes	F 514	This page left blank intentionally		

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F 514	Continued From page 87 immediately after the fall or as follow up as directed by the ER instructions. 3. During the survey Active Care Plans were found to be incomplete, inaccessible, missing and not available to direct care staff on a timely basis. Cross Reference Tags F279 and F280. 4. On 4/4/07 at 8:00 AM, an interview with staff A revealed that Care Plans are often taken off the unit and do not return for periods of a month or more. The Care Plans are not available to floor staff during that period. "It has been this way the entire time here."	F 514			
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to have a functioning Quality Assurance committee as required by regulation, to identify issues which were problems/concerns related to the quality of care and quality of life for the residents, and/or to develop and implement corrective actions. The findings included: 1. On 4/5/07 at 4:30 PM an interview with staff N revealed she was the QA (Quality Assurance)	F 520	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff. 1) A facility Quality Assurance committee, separate from the hospital's QA meetings is being developed and will include the Resident Care Director, designated physician, QA coordinator, Social Worker, and Unit secretary as the core group, with representation and reporting by all departments. This committee will meet at least quarterly for continuous quality improvement. Compliance will be evidenced by meeting minutes.		5/18/07

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F 520	Continued From page 88 coordinator for the LTC (long term care). Staff N reported that the QA meetings for the LTC (long term care) were held as part of the hospitals QA meetings. 2. Review of the meeting schedules showed which departments reported. They were reviewed from April 13, 2006 to March 11, 2007. It showed a monthly meeting but did not show LTC had reported monthly or on a quarterly basis. The notes also showed that a physician designated by the facility had not been in attendance for the past 16 months. Staff N also reported that she did not attend all QA meetings. 3. Interview with the Chief Nursing Officer on 4/5/06 at 4:45 PM confirmed that the LTC was not meeting the requirements for maintaining a QA committee consisting of a physician designated, DON (Director of Nursing) and at least three other members of the facility's staff that meets at least quarterly. The Chief Nursing Officer verified that there had not been a physician in attendance at the hospital QA meetings for over 16 months.	F 520	This page left blank intentionally		