STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	05/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to notify the physician regarding one (#45) of eleven sample residents who had a change in condition or	F 157	F 157 The facility will ensure that the resident, family and physician are notified immediately when there has been a significant change in the resident's condition. This will be accomplished by: Resident #45 has expired. Upon admission, the Director of Nursing, charge nurse or floor nurse will be responsible for completing a skin assessment on all new patients. If new skin issues are presented, the resident, family and physician will be contacted immediately and orders will be obtained to treat. The Director of Nursing or designee will review admission & skin assessments within 48 hrs. Medical Records will also include a review of skin assessment during the admission audit. The Director of Nursing will be responsible for monitoring this process and will report to the Quality Assurance Committee at least quarterly. This will be completed by ~~7/01/07~~ 6/28/07	6/28/07

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

Administrator 6/21/07

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 survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 otherwise required physician notification. The findings were: Medical record review revealed resident #45 was discharged on 5/9/07 and readmitted on 5/11/07. Observation on 5/16/07 at 5:45 PM revealed the resident had a large heart shaped DuoDerm dressing that covered the lower sacral and coccyx area. There was no date or time written on the dressing. Licensed practical nurse (LPN) # 4 removed the dressing, which revealed a stage two pressure ulcer on the coccyx which was 3 centimeters (cm) by 0.5 cm, and 0.5 cm deep. The nurse reapplied a DuoDerm dressing to the area. The following concerns were noted: a. Nursing progress notes from the facility and hospice staff revealed there was no documentation of a pressure ulcer on the coccyx nor was there documentation that the physician had been notified of a pressure ulcer from the time of admission on 5/11/07 thru 5/16/07 at 2:30 PM. There were no physician treatment orders for a pressure ulcer on the coccyx during that period of time. b. Interview with LPN #4 on 5/16/07 at 5:30 PM revealed she was the nurse that admitted the resident on 5/11/07. The nurse stated she identified the stage two pressure ulcer on the resident's coccyx at the time of admission and changed the DuoDerm dressing, but did not notify the physician. Interview with the director of nursing (DON) on 5/17/07 at 8:30 AM confirmed the physician was not notified of the stage two pressure ulcer. The DON revealed the physician was notified of the pressure ulcer on 5/16/07, six days after the resident's admission	F 157		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a	F 241	F 241 The facility will ensure that care is provided to residents in a manner and environment that maintains or enhances each resident's dignity and respect. This will be accomplished by:	

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F 241	Continued From page 2 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to assure a dignified and homelike dining atmosphere during two of three meals observed in two of two dining rooms, affecting seven residents (#23, #26, #28, #30, #31, #36, #40). The findings were: 1. The following concerns regarding the lack of a homelike dining atmosphere in the secure care unit (SCU) were identified: a. Observation in the SCU on 5/14/07 at 6 PM revealed certified nurse aide (CNA) #5 removed trays containing resident meals from the serving cart, and placed the trays in front of the residents. The plates and beverages were left on the plastic serving trays for the duration of the meal for all eight residents (#5, #14, #16, #20, #26, #28, #30 #31). A comparison observation of the main dining room on 5/14/07 at 6:40 PM revealed no plastic serving trays were left on the tables; all plates and beverage containers had been placed directly on the tables. b. Observation on 5/15/07 at 5:55 PM once again revealed CNA #5 set the trays down in front of the residents. The plates and beverages remained on the plastic serving trays for the duration of the meal for all eight residents. c. Review of the current care plans for all eight residents revealed only four residents (#20, #16, #5 and #14) had care plans which stated their plates should be on trays in order to defined	F 241	Residents #23,#26, #28, #30, #31, #36, #40 will not have their meals served on plastic trays. Meal service will be comparable to main dining area. All items will be removed from the serving trays and placed on the dining table. A list of resident requiring the use of serving trays to establish boundaries per the care plan was placed in the communication book for the Special Care Unit. An in-in-service for all nursing personnel will be held on 06/15/07 to discuss appropriate interactions (i.e. being more attentive to resident needs and more compassionate) and creating a more positive and homelike environment for each resident, especially during meals. The Social Service Director will also provide minutes of the Resident Council Meeting to the Administrator for review and appropriate departments will address concerns that are identified. The charge nurse, floor nurse and CNA's will be responsible for maintaining each resident's dignity during each meal. The Administrator, General Manager, Director of Nursing or Social Service Director will also monitor this area by being present in the dining areas during meals 2-3 times per week.	

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F 241	Continued From page 3 boundaries. The care plans of the other four residents (#26, #28, #30, #31) did not indicate plates were to be left on plastic serving trays. During an interview on 5/16/07 at 4:32 PM, the director of nursing (DON) stated she was not sure why all residents in the SCU would have their meals left on plastic serving trays. 2. Observation in the main dining room on 5/14/07 from 6:05 PM to 6:37 PM (32 minutes) revealed staff failed to address residents by name, offer a courteous or dignified manner of addressing residents, or did not respond appropriately to residents requiring assistance. CNA #22 served food to residents #23 and #36 and did not speak to either resident while serving the evening meal. CNA #20 spoke in a loud, abrupt manner to resident #40, asking, "Cut it?" in reference to the resident's sandwich. She did not address the resident by name, speak at an appropriate volume for the setting, or address the resident in a courteous manner when asking if s/he needed assistance. 3. Seven of nine anonymous resident interviews collected randomly during survey revealed residents felt staff were discourteous at times and appeared to "...cluster up..." on the units and in the dining room. Residents stated staff discussed "personnel business...like their dates and boy friends..." during meals and found this to be irritating. Further, residents stated staff were not attentive to their needs when engaged in conversation with other staff members, and requests for assistance were not met in a timely fashion, particularly during meals. One resident stated s/he had to ask three times and wait over 30 minutes to have his/her meat cut into small pieces.	F 241	The Administrator will report to the Quality Assurance Committee at least quarterly on the progress. This will be completed by ~~7/01/07~~ DW 6/28/07	

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F 241	Continued From page 4 4. Review of resident council minutes dated 3/5/07 revealed a comment regarding staff behavior at meal times. The Social Services Director (SSD) stated on 5/16/07 at 2:30 PM the director of nursing had addressed "...several of the younger CNAs [certified nurse aides] about their behavior in front of residents..." as a result of resident concerns raised in the March council meeting. The SSD acknowledged residents had complained about situations in which staff talked about personnel matters, such as dating, particularly during meals. She further stated some residents complained staff would rather talk among themselves than assist residents.	F 241	F 278 The facility will ensure that a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals and then sign and certify that the assessment is completed. This will be accomplished by: On 06/10/07, the Director of Nursing met with MDS coordinator, dietary manager, activities director and social service designee and discussed the importance of MDS completion and the need for signatures, dates and appropriate section designations. The MDS coordinator will only sign R2B for all residents after all disciplines have completed their sections, signed and dated in the appropriate locations. Resident #14 MDS dated 10/06/06 has been signed by remaining disciplines and dated with current date. Signatures have been obtained and sections identified for	
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278		

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F 278	Continued From page 5 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the Minimum Data Set (MDS) assessments contained dated signatures for all staff completing portions of the assessments for 11 of 12 sample residents (#1, #3, #10, #14, #19, #23, #26, #33, #42, #44, #47). The findings were: According to the Revised Long-Term Care Resident Assessment Instrument User's Manual, for section AA9, "...All staff responsible for completing any part of the MDS...must enter their signatures, titles, sections they completed, and the date they completed those sections...". The following concerns were identified: 1. Review of the 10/16/06 significant change MDS assessment for resident #14 showed two of the four signatures at AA9 lacked dates. In addition, there was only one signature for the 4/16/07 quarterly MDS assessment, and no sections of completion were identified. 2. Review of the 6/12/06 significant change MDS assessment for resident #26 revealed two of the three signatures at AA9 lacked dates. In addition, review of the 3/12/07 quarterly MDS assessment showed two of the four signatures lacked dates. 3. Review of the 4/28/07 quarterly MDS assessment for resident #33 revealed two of the	F 278	the 04/16/07 quarterly assessment and current date provided. Resident #26 MDS dated 06/12/06 has received the appropriate signatures and current date. The 03/12/07 quarterly assessment has also received the appropriate signatures and current date. Resident #33 MDS dated 04/28/07 has received the appropriate signatures and current date. The 03/04/07 assessment for Resident #1 has signatures and current dates. The quarterly assessment for Resident #3 on 04/26/07 has signatures and current dates for completion. Resident # 19's quarterly assessment for 04/24/07 has the required signatures and current dates of completion. Resident #23's quarterly assessment has appropriate signatures and current dates of completion. Resident #42's annual assessment on 05/13/07 has the required signatures and current completion dates.	

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F 278	Continued From page 6 four signatures at AA9 lacked dates. 4. Review of the 3/4/07 MDS assessment for resident #1 showed two of the four signatures at AA9 lacked dates. 5. A quarterly MDS assessment for resident #3 dated 4/23/07 lacked attestation dates for three of four signatures in section AA.9. 6. A quarterly MDS assessment for resident #19 dated 4/24/07 lacked attestation dates for three of four signatures in section AA.9.	F 278	Resident #44's assessment on 12/02/06 is complete with current dates. Quarterly assessment for 03/03/07 is signed with current date. Resident #47's admission assessment dated 02/12/07 Section AA9 has been completed by dietician and social services with signatures and current dates. Resident #10's assessment dated on 01/10/07 and 04/11/07 has been completed by dietician and social services designee with signatures and current dates. The MDS Coordinator will be directly responsible for ensuring that the MDS's for all residents have the required signatures, dates and sections completed. The Director of Nursing, designee or nurse consultant will review at least five (5) MDS per month to ensure they are being completed in appropriate time frames and to review for accuracy. The Director of Nursing will report to the Quality Assurance Committee at least quarterly on the process. To be completed by ~~7/01/07~~ 6/28/07	
	7. A quarterly MDS assessment for resident #23 lacked attestation dates for three of four signatures in section AA.9. In each case, the assessment coordinator had already signed and dated Section R.2.b, attesting to the accuracy and completion of the MDS. 8. In addition, an annual MDS assessment for resident #42 dated 5/13/07 lacked signatures and dates for two of three care providers completing sections of the MDS; the assessment coordinator had already signed Section R.2.b indicating the assessment was complete and accurate. 9. Review of the significant change MDS assessment dated 12/2/06 for resident #44 revealed the dietitian and the social service director failed to date the day they signed section AA9. Further review showed they failed to date their signatures under AA9 on the resident's quarterly MDS dated 3/3/07. 10. Review of the admission MDS assessment dated 2/12/07 for resident #47 revealed the dietitian and the social service director failed to date the day they signed section AA9.			

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F 278	Continued From page 7 11. Review of the admission MDS assessment dated 1/10/07 for resident #10 revealed the dietitian and the social service director failed to date the day they signed section AA9. Further review showed they failed to date their signatures under AA9 on the resident's quarterly MDS dated 4/11/07. 12. On 5/17/07 at 10:30 AM, the director of nursing (DON) confirmed the signatures lacked dates.	F 278		
F 279 SS=D	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 observation, staff interview, and	F 279	F 279 The facility will ensure the results of each resident's assessment will be utilized to develop, review and revise the resident's plan of care. This will be accomplished by: The Director of Nursing will provide an in-service to the nursing staff on 06/15/07 the need for interim care plan on all newly admitted residents to the facility that will address all needs ~~relative to skin concerns.~~ bw Resident #45 has expired. On 05/16/07, the Director of Nursing met with hospice agency to discuss admission assessments, interim care plans and the responsibilities both for the SNF and hospice agency in the care of the resident.	

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F 279	Continued From page 8 medical record review, the facility failed to provide an interim care plan which addressed pressure ulcer care and hospice care for one (#46) of one newly admitted sample residents. The findings were: Medical record review revealed resident #45 was readmitted on 6/11/07. Observation on 5/16/07 at 5:45 PM revealed the resident had a large heart shaped DuoDerm dressing which covered the resident's lower sacral and coccyx area. Licensed practical nurse (LPN) #4 removed the dressing to reveal a stage two pressure ulcer on the coccyx which measured 3 centimeters (cm) long, 0.5 cm wide, and 0.5 cm deep. Review of the Roster/Sample Matrix provided by the facility revealed the resident received hospice services. The following concerns were noted: a. Medical record review revealed no documentation of a pressure ulcer on the resident's coccyx from time of admission on 5/11/07 thru 5/16/07 at 2:30 PM, and there was no evidence of an interim care plan from the facility or hospice that addressed this pressure ulcer. Interview with the director of nursing (DON) on 5/17/06 at 10 AM confirmed that neither the facility staff nor the hospice staff initiated an interim care plan that addressed the pressure ulcer on the resident's coccyx. b. Medical record review revealed no collaborative care plan between the facility and hospice, which would outline the responsibilities of each. During an interview on 5/16/07 at 5 PM, the DON confirmed there was no collaborative care plan for hospice. The DON stated they had not received a care plan yet from hospice.	F 279	The charge nurse and floor nurses will be responsible for ensuring that assessments are completed and temporary care plans in place to address specific resident needs within 24 hours of admission. The Director of Nursing will also review admission assessments and care plans within 72 hours of admission. A report to the Quality Assurance Committee by the Director of Nursing will be done at least quarterly. To be completed by ~~7/01/07~~ 6/28/07	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility	F 281	F 281 The facility will ensure that services provided or arranged for the resident will meet professional standards of quality. This will be accomplished by:	

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F 281	Continued From page 9 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure professional standards of practice were maintained related to the documentation. Four (#3, #19, #26, #45) of eleven open sample resident records were affected. The findings were: 1. Review of the May 2007 physician's orders showed resident #26 was ordered a personal alarm and a lap buddy (cushioned lap restraint) in the wheelchair for meals and activities. Review of the restraint review note dated 3/28/07 showed the lap buddy was used to deter unassisted transfers, and the restraint would continue to be used. However, observations of the resident on 5/14/07 from 5:50 PM until 6:35 PM and on 5/15/07 from 7:35 AM until 1:40 PM revealed a personal alarm and lap buddy were not used. Review of the treatment record showed the nurses initialed that the personal alarm and lap buddy were in place on 5/14/07 and 5/15/07. During an interview on 5/16/07 at 9:45 AM, the director of nursing (DON) stated the personal alarm and lap buddy were discontinued about one week ago. The DON stated the physician's order should have been changed. The DON also stated it was a professional standards issue that the nurses continued to initial the treatment record when the interventions were actually not in place. According to the Wyoming Nursing Practice Act 2005 and Administrative Rules and Regulations, page 3-6, the nurse shall function under the direction of a licensed physician.	F 281	Due to the frequent refusal of Resident #26 to use the personal alarm and lab buddy, a physician order was obtained on 06/20/07 to d/c. Nursing staff will continue with q 30 minute checks to monitor resident's safety. Licensed nurses will document medication immediately following the administration to Resident #19 and #3 and for all residents receiving medications, including narcotics. The Director of Nursing will review med pass administration at least monthly or more frequently if necessary and will report any negative findings to Quality Assurance Committee at least quarterly. Resident #45 has expired. An in-service will be held on 06/15/07 to discuss the importance of following physician orders, proper protocol for passing medications and emphasis on documenting treatments when they are done. all residents ~~with restraints~~ will have appropriate documentation in the medical record.	

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F 281	Continued From page 10 According to the sixth edition of "Clinical Nursing Skills", by Smith, Duell, and Martin a nurse should "...administer treatments per physician's orders...". Furthermore, according to "Nursing Malpractice: Sidestepping Legal Minefields", copyright 2003, by Ann Helm, "...complete, accurate, and timely documentation is crucial...the medical record provides legal proof of the nature and quality of care the patient received...". 2. On 5/15/07 at 4:30 PM observation of a random narcotic count on the 300 hall medication cart revealed the following concerns: a. Observation of a bubble pack of lorazepam 0.5 milligrams (mg) for resident #19 revealed it contained four tablets. Review of the narcotic sign out book revealed it a count of three tablets of this medication for this resident. b .Observation of bubble packs of lorazepam 1 mg for resident #3 revealed 99 tablets. Review of the narcotic sign out book revealed a count of 98 tablets of this medication for this resident. c. Interview on 5/15/07 at 4:30 PM with licensed practical nurse (LPN) #2 revealed that she signed out her scheduled narcotics at the beginning of her shift. During an interview on 5/15/07 at 5:05 PM, the DON stated, "Nurses should sign them [narcotics] out after they give them." According to the facility's policy #2026 "Medication- Administration of Drugs" (effective 5/22/98), "...Medications must be charted immediately following the administration by the person administering the drugs...". Review of the 3rd edition of , "Nursing Interventions and Clinical Skills" by Elkin, Perry, and Potter, showed "...Sign out the narcotic on the narcotic sheet after taking narcotic out of the drawer..."	F 281	The Director of Nursing will be responsible for ensuring that nursing staff meet acceptable professional standards of quality by reviewing medication passes at least monthly and reviewing skin assessments weekly. She will report to the Quality Assurance Committee at least quarterly on any problems that are identified. To be completed by ~~7/01/07~~ 6/28/07	

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	535038	A. BUILDING _____ B. WING _____	05/17/2007

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F 281	Continued From page 11 3. Observation on 5/16/07 at 5:45 PM revealed resident #45 had a large heart shaped DuoDerm dressing covering the lower sacral and coccyx area. LPN #4 removed the dressing which revealed a stage two pressure ulcer on the resident's coccyx. The following concerns were noted: a. Interview with LPN #4 on 5/16/07 at 5:30 PM revealed she was the nurse who admitted the resident on 5/11/07. The nurse stated she identified the stage two pressure ulcer on the resident's coccyx at the time of admission and changed the DuoDerm dressing. The LPN further stated she did not document the pressure ulcer or the treatment she provided in the medical record. b. Medical record review confirmed there was no documentation of a pressure ulcer or any treatment that was provided at the time of admission. According to "Nursing Malpractice" by Ann Helm, publication date 2003 "...Complete, accurate, and timely documentation is crucial to the continuity of each patients care...The medical record provides legal proof of the nature and quality of care the patient received...the prevailing rule is 'If it isn't documented, it hasn't been done."	F 281		
F 312 SS=D	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 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 312	F 312 The facility will ensure that residents who are unable to carry out ADL's receive the necessary services to maintain good nutrition. This will be accomplished by: Resident #21 and all residents who require extensive assistance will continue to receive the necessary assistance. Nursing staff will ensure that residents are placed appropriately at the dining table and that assistance with set-up and eating takes place as required. An in-service will be held on 06/15/07 for nursing staff to discuss how to better assess and provide the necessary services to each resident during meals.	

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F 312	Continued From page 12 and staff and resident interviews, the facility failed to provide necessary services to assist in dining for one non-sample resident (#21) during one of three meal observations. The finding were: Review of a quarterly minimum data set (MDS) assessment for resident #21 dated 1/29/07 showed the resident required extensive assistance of one person for eating. According to the December 2002 Centers for Medicare & Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 2.0, revised December 2005, extensive assistance was defined as, "... weight bearing support provided three or more times.... full staff performance of activity (3 or more times) during part (but not all) of last seven days." Further record review revealed the MDS assessment dated 4/30/07 continued to have the resident assessed as requiring extensive assistance for eating. Observation on 5/14/07 at 5:55PM revealed the resident was sitting in the wheelchair approximately two feet away from the assistive dining table. The resident attempted to move the wheelchair, but only succeeded in moving in a small circle. At 6:15 PM the resident's meal was placed on the assistive dining table and the plate cover was removed. The resident remained in the wheelchair approximately two feet from the table. At 6:45 PM (30 minutes after the meal was delivered) certified nurse aide (CNA) #20 moved the resident's wheelchair up to the table and cut the meat on the tray. Further observation revealed the CNA did not open the health shake container for the resident or offer any further assistance. Interview on 5/17/07 at 8:16 AM with the director of nurses revealed that her expectations	F 312	The Administrator, Director of Nursing, charge nurse and floor nurse will be responsible for monitoring this concern during meals. The Director of Nursing will report to the Quality Assurance Committee at least quarterly regarding progress. To be completed on ~~7/01/07~~ 6/28/07	6/28/07

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F 312	Continued From page 13 for a resident who was assessed as requiring extensive staff assistance with dining would be that the resident's meal would be set up by staff, the resident would receive cueing throughout the meal, and the resident would have actual assistance during the meal, assistance would be provided in a timely manner. Two anonymous resident interviews randomly collected during the survey revealed facility staff did not provide timely assistance to residents during meals. One resident stated s/he had trouble opening drink cartons and "...if you don't catch them [staff] the first time, forget about getting help..." Another resident stated s/he had to ask three times and wait over 30 minutes on one occasion to have his/her meat cut into smaller pieces.	F 312		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to provide necessary treatment and services for one (#45) of four sample residents with pressure ulcers. The findings were:	F 314	F 314 The facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the clinical condition demonstrates they were unavoidable. Resident #45 has expired. On admission or as necessary, a skin assessment will be performed by the nurse to determine current skin problems or to identify the potential for skin breakdown. A plan of care will then be established to address potential problems. The MD will be notified & orders obtained. An in-service will be held on 06/15/07 with nursing staff to review pressure sore prevention	

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F 314	Continued From page 14 Medical record review revealed resident #45 was readmitted on 5/11/07. Observation on 5/16/07 at 5:45 PM revealed the resident had a large heart shaped DuoDerm dressing covering the lower sacral and coccyx area. Licensed practical nurse (LPN) #4 removed the dressing and revealed a stage two pressure ulcer on the coccyx that measured 3 centimeters (cm) long, 0.5 cm wide, and 0.5 cm deep. The following concerns were noted: a. Interview with LPN #4 on 5/16/07 at 5:30 PM revealed she was the nurse who admitted the resident on 5/11/07. The nurse stated she identified the stage two pressure ulcer on the resident's coccyx at the time of admission and changed the DuoDerm dressing, but she did not document the pressure ulcer or the treatment she provided in the medical record. Furthermore, the LPN stated she did not notify the physician of the pressure ulcer. b. Medical record review confirmed the lack of documentation of a pressure ulcer on the resident's coccyx upon admission. Further medical record review from 5/11/07 thru 5/16/07 at 2:30 PM showed no documentation of the pressure ulcer or any treatment provided during that six day period. There was no physician order for pressure ulcer treatment and the nursing care plan lacked interventions addressing pressure ulcer care. c. Review of the decubitus ulcer policy #2014 in the Rocky Mountain Policy and Procedure Manual dated 5/22/98 under treatment protocol 5.,c.,(2) revealed for a stage two, "a protective wet to dry dressing was to be applied twice a day unless otherwise specified by the physician." Interview with the director of nursing (DON) on 5/17/07 at 8:30 AM revealed that at the time of admission a wet to dry dressing was not applied	F 314	protocols and appropriate treatment protocols. The Director of Nursing will be responsible for monitoring pressure sore management in the facility. Licensed nurses will complete a weekly skin assessment for each pressure sore. The Director of Nursing will provide the Administrator a monthly summary of all pressure sores. This information will then be reported to the Quality Assessment and Assurance Committee at least quarterly. To be completed by ~~7/01/07~~ 6/28/07	

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F 314	Continued From page 15 to the resident's coccyx area. Further interview with the DON confirmed the physician was not notified of the pressure ulcer until 5/16/07 and there were no physician treatment orders until that time.	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide catheter care for 2 (#23, #45) of 2 residents observed during catheter care in a manner which would minimize the risk of urinary tract infections. The following concerns were noted: 1. Observation on 5/15/07 at 3:30 PM revealed certified nurse aide (CNA) #22 performed catheter care for sample resident #23. Using a washcloth, the CNA wiped the catheter tubing (from the body to approximately 6 inches down the tubing) using a back and forth motion without changing the position of the washcloth. Interview with the director of nursing (DON) on 5/16/07 at 9:15 AM revealed the procedure was to wipe down (away from the body) the catheter four times, changing the area of the washcloth to a	F 315	F 315 The facility will ensure that all residents will receive appropriate catheter care and personal care. This will be accomplished by: all res's w/ caths, including #23, will receive proper catheter care. SD Resident #45 has expired. An in-service will be held on 06/15/07 with all nursing staff to review proper catheter care. The Director of Nursing will provide information relative to the proper cleaning of catheters as well as the importance of good hand-washing and proper glove techniques. The Director of Nursing, Director of Staff Development and licensed nurses will be responsible for ensuring our residents receive appropriate catheter care through frequent rounds in the facility. The Director of Nursing will report quarterly to the Quality Assurance Committee any negative results. To be completed by ~~07/04/07~~ SD	6/28/07

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F 315	Continued From page 16 clean area each time. 2. Observation on 5/16/07 at 5:45 PM reveal licensed practical nurse (LPN) #4 performed a dressing change on the coccyx area of sample resident #45. After completing the dressing change, the LPN then provided catheter care on the resident without washing her hands or changing her gloves. Interview with the DON on 5/17/07 at 8:15 AM revealed the correct procedure would have been for the nurse to complete the dressing change then remove the soiled gloves, wash her hands, and put on new gloves before she provided catheter care.	F 315		
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, medical record review, review of facility documentation, and staff interview, the facility failed to assure supervision to prevent accidents during one of three meals observed in the secure care unit (SCU). The potential for involvement in an accident affected six residents (#14, #20, #26, #28, #30, #31). The findings were: Observation on 5/14/07 at 6:26 PM revealed seven residents (#14, #16, #20, #26i #28, #30, #31) were eating in the SCU. One certified nurse aide (CNA #5) was present in the dining room; no other staff were in the SCU. At 6:27 PM, CNA #5 took resident #16 to the bathroom in the resident's room, leaving the other six residents	F 324	F 324 The facility must ensure that each resident receives adequate supervision and assistive devices to prevent accidents. This will be accomplished by: During meals in the SCU, a staff member will be present to assist each resident. If a staff member needs to leave the dining area to assist another resident or for any other reason, they will locate another staff member who will remain in the dining room until they return. This will ensure that adequate supervision is present to prevent an accident. All residents, including #14, 16, 20, 26, 28, 30 and 31 are receiving appropriate supervision during meal times.	

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F 324	Continued From page 17 unsupervised while they were still eating. At 6:32 PM (five minutes later), the CNA returned to the dining room. Medical record review revealed the following: a. Review of the 4/16/07 quarterly Minimum Data Set (MDS) assessment showed resident #28 required limited physical assistance for eating. b. Review of the 3/22/07 MDS assessment revealed resident #31 required supervision and set-up assistance for eating. c. Review of the 3/12/07 MDS assessment showed resident #26 required supervision and set-up assistance for eating. d. Review of the 4/16/07 MDS assessment revealed resident #14 required set-up assistance for eating. e. Review of the 5/7/07 MDS assessment showed resident #20 required set-up assistance for eating. f. Review of the 2/15/07 MDS assessment revealed resident #30 required set-up assistance for eating. When asked about the facility's policy on supervision at meals, the director of nursing (DON) provided the surveyor a typed document entitled "Dining Room Process", which stated "...Staff members monitor residents while in the dining room...there should always be at least one staff member in the dining room with residents who require assistance when feeding...one staff member remains in dining room until residents have exited...". On 5/16/07 at 4:45 PM, the administrator stated it was a mistake for residents in the SCU dining room to be left alone. The administrator stated the staff member should have called another staff to come back to the unit.	F 324	A memo was posted in the communication book for the SCU & main floor regarding the need to have a staff member present in the dining area during meals to provide adequate supervision and to prevent accidents for all residents. An in-service will be held with all nursing staff on 06/15/07 to review the protocols for dining areas. Charge nurse and floor nurse will monitor during each shift and will report any concerns to the Director of Nursing. The Director of Nursing will report to the Quality Assurance Committee each quarter noting any concerns. To be completed by ~~7/01/07~~ 6/28/07	

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F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the drug regimen was free of unnecessary drugs for one of 12 sample residents (#26). The findings were: Review of physician orders showed resident #26 was prescribed Zyprexa (antipsychotic) 7.5 milligrams (mg) everyday since 10/2/06. Review of the psychotropic medication review notes dated 3/28/07 showed staff recommended the Zyprexa be decreased to 5 mg everyday. The	F 329	F 329 The facility will ensure that each resident's drug regimen is free from unnecessary drugs. This will be accomplished by: Resident #26 physician order was written on 05/15/07 to decrease Zyprexa to 5 mg PO Q day. Psychotropic medication will be reviewed at least every quarter on all residents and as necessary by the psychotropic review committee. Recommendations will then be submitted to the physicians and psychotropic medication summary will be returned to the Director of Nursing for review and implementation. The Director of Nursing or designee will provide the physician with the committee's recommendations within 24 hrs. The licensed nursing staff will implement the physician's decision immediately. Within one week following the Psychotropic meeting, the Director of Nursing will follow-up on the recommendations to ensure a plan has been implemented.	

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F 329	Continued From page 19 psychotropic medication review summary sheet dated 3/28/07, showed the staff's recommendations that the Zyprexa be decreased was given to the physician. The physician responded on 4/9/07 and documented agreement with the recommendation. The physician also instructed the facility to implement the change. However, review of the physician orders and the medication administration records for April and May 2007 showed the resident was still receiving the original dose of 7.5 mg. During an interview on 5/14/07 at 3:35 PM, the director of nursing (DON) stated the dose was not decreased, but should have been. The DON stated that when the physician agreed with the psychotropic medication committee's recommendation, she would write out a telephone order for the change in dose, but it was not done for this resident.	F 329	The DON will report to the Quality Assurance Committee at least quarterly on the Psychotropic Committee's progress. To be completed by ~~7/01/07~~ 6/28/07	6/28/07
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334	F 334 The facility will ensure that each resident is offered influenza and pneumonia vaccine and that the medical record will contain documentation noting that education was provided to the resident, family or guardian. This will be accomplished by: Resident #23 has documentation on "Medication Administration Consent & Pneumovax Inquiry Form" in the medical record. Pneumococcal was given on 06/20/07. Influenza shot given on 11/16/06. Resident #26 has documentation in nurse's notes. Immunization & education record is also present. Pneumococcal given on 06/21/07.	

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F 334	Continued From page 20 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or	F 334	Resident #10 has "Immunization and Education Consent" form in the medical record. Resident #10 received pneumococcal vaccine on 06/11/07. Documented on medication record and immunization record, nurse notes and order from physician. Resident #42 has "Immunization and Education Consent Form" in the medical record and documentation in nurses notes and an order from the physician. Pneumococcal was given on 06/21/07. On admission, the Director of Nursing or designee will complete the "Immunization and Education Consent Form" with resident or guardian and provide education on the vaccines. License nurses will administer the vaccines when appropriate and place documentation in the resident's medical record. Facility policy #2019 - "Immunization of Residents" has been updated to address the education of resident and/or legal representative.	

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F 334	Continued From page 21 the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policies, and staff interview, the facility failed to develop policies to address documentation for influenza and pneumococcal vaccinations. In addition, four of six records (#10, #23, #26, #42) reviewed for immunization status lacked all required documentation. The findings were: Review of the facility's policy and procedure "Client Care- Immunization of Residents" (policy number 2019, revised 2/16/07) revealed the policy did not address that the medical record must contain documentation of education provided and whether or not the resident received the influenza or pneumococcal vaccine. Review of medical records and documentation provided by the facility revealed the following: a. The medical record contained evidence dated 11/16/06 that resident #23 and/or the family was educated regarding the influenza vaccine, but there was no evidence the resident received the vaccination. The medical record lacked evidence the resident was up to date with the pneumococcal vaccine. On 5/16/07 at 9:45 AM the director of nursing (DON) confirmed there was no documentation the resident received the influenza vaccination. The DON stated she called the hospital that morning and the resident received the pneumococcal vaccine in 2003, but that wasn't documented in the medical record.	F 334	The Director of Nursing or designee will be responsible for ensuring that residents or legal representative receive the appropriate education regarding influenza and pneumonia and that vaccinations are given timely. Medical records will assist by auditing the medical record. The Director of Nursing will report to the Quality Assurance Committee at least quarterly. To be completed by ~~7/01/07~~ 6/28/07	6/28/07

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	533038	A. BUILDING _____ B. WING _____	05/17/2007

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F 334	Continued From page 22 b. There was no evidence in the medical record that resident #26 was up to date with the pneumococcal vaccine. On 5/16/07 at 9:45 AM the DON stated she called the hospital that morning and the resident received the pneumococcal vaccination on 12/17/05, but that information was not documented in the medical record. c. There was no evidence in the medical record that resident #10 had received the influenza vaccination, nor evidence the resident had ever received the pneumococcal vaccine. On 5/16/07 at 9:35 AM the DON stated the resident was admitted at the end of December, and she was not sure if the resident was offered the influenza or pneumococcal vaccine. d. There was no evidence in the medical record that resident #42 was up to date with the pneumococcal vaccine. On 5/16/07 at 9:45 AM the DON stated she called the hospital that morning and the resident received the pneumococcal vaccination on 4/16/06, but that information was not documented in the medical record.	F 334		
F 371 SS=F	483.35(i)(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 observation, review of dishwashing logs, and staff interview, the facility failed to assure nutritional supplements were labeled with the thaw dates in one of two refrigerators, failed	F 371	F 371 The facility will store, prepare, distribute, and serve food under sanitary conditions. This will be accomplished by: The cartons that were identified during the survey were disposed on 05/17/07.	

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F 371	Continued From page 23 to maintain one of three microwave ovens in a clean manner, and failed to monitor the sanitizer concentration of the dishwashing machine. The findings were: 1. Observation of the walk-in refrigerator in the kitchen on 5/14/07 at 4:55 PM revealed four large cardboard boxes of nutritional supplements. The boxes contained: approximately 36 cartons of thawed chocolate healthshakes, approximately 15 cartons of thawed vanilla healthshakes, approximately 30 cartons of thawed strawberry healthshakes, and approximately 35 cartons of thawed orange Resource drinks. Each carton contained instructions which stated the product was good for 14 days after thawing. Neither the large boxes nor the individual cartons contained a thaw date. Interview with the dietary staff at that time revealed the boxes should contain a thaw date. The staff member was not sure how long the product had been thawed. Observation on 5/15/07 at 11:35 AM revealed the large boxes and individual cartons still lacked a throw date. On 5/16/07 at 9:50 AM the surveyor showed the dietary manager the cartons. The dietary manager stated the boxes should contain a thaw date, but he confirmed they did not. The dietary manager was unsure how long the product was thawed. The dietary manager stated the "received by" date marked on the box might be close to the thaw date, but the received by date for the vanilla shakes was 4/25/07 and the date for the chocolate shakes was 5/2/07. 2. Observation on 5/16/07 at 8:50 AM and again on 5/16/07 at 9:30 AM revealed the microwave in the secure care unit (SCU) had dried food splatters on all inside surfaces. On 5/15/07 at 11 AM, certified nurse aide (CNA) #3 stated the	F 371	When nutritional supplements are removed from the freezer to thaw, dietary staff will immediately place current date on the box or carton to be thawed. Staff will then follow manufacturer's instructions and dispose of cartons that have not been used within 14 days of thawing. The Dietary Manager will provide education to dietary staff by 07/01/07 on dating the boxes or cartons of nutritional supplements. All Dietary staff will be responsible for ensuring that nutritional supplements are appropriately dated. The Dietary Manager This will check daily to ensure compliance. The Dietary Manager will report progress to the Quality Assurance Committee at least quarterly. The microwave in the SCU was cleaned on 05/16/07. Housekeeping will clean the microwave at least once per day. Nursing staff in SCU have been asked to clean the microwave as necessary in between. The Housekeeping Supervisor will be monitoring the cleanliness of all microwaves at least once per week. The supervisor will report to the Quality Assurance Committee each quarter on the progress.	

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F 371	Continued From page 24 microwave was used to heat up resident food. On 5/16/07 at 9:50 AM, the dietary manager stated she was unsure who was responsible for cleaning the microwave, but it was not the responsibility of the dietary department. On 5/16/07 at 4:32 PM, the director of nursing (DON) stated she was not sure who was supposed to clean the microwave. According to the Food Code 2005, U.S. Public Health Service, 4-60.11: "...(B) The food-contact surfaces of cooking equipment and pans shall be free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. Observation of the dishwasher on 5/16/07 at 9:50 AM revealed a manufacturer's label which indicated the dishwasher required 50 ppm (parts per million) of chlorine. Review of the posted dishwashing log near the dishwasher showed staff were not monitoring the concentration of chlorine. During an interview at that time, the dietary manager stated the facility used to have a high temperature machine, but received this new chemical sanitizing machine last August. She stated staff were monitoring water temperatures because that's what they used to do, and she had let them continue that. The dietary manager stated staff did not monitor the chlorine concentration, and the facility did not even have any test strips. On 5/16/07 at 1:30 PM, the dietary manager stated the last time the dishwasher was serviced and chlorine concentration levels checked was on 2/20/07. According to the Food Code 2005, U.S. Public Health Service, 4-501.114 "...a chemical sanitizer used in a sanitizing solution for a manual or mechanical operation...shall be used in accordance with the EPA-approved manufacturer's label use	F 371	The Dietary Manager has purchased test strips in order to test the chlorine levels in the dishwasher. Manager or designee will be responsible for testing the chlorine three (3) times/day or as necessary. A log will be kept to record the results. The Dietary Manager will report to Quality Assurance Committee each quarter. To be completed by ~~7/01/07~~ 6/28/07 as recommended by the manufacturers instructions.	6/28/07

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F 371	Continued From page 25 instructions..." and 4-501.116 "...concentration of the sanitizing solution shall be accurately determined by using a test kit or other device."	F 371		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure staff followed acceptable standards for hand hygiene during two of three meals and two of four care procedures that were observed during the survey. Seven residents (#7, #17, #23, #28, #40, #42, #45) were affected. The findings were: 1. Observation on 5/14/07 from 6:05 PM to 6:32 PM (27 minutes) in the main dining room revealed staff failed to comply with established standards of practice for hand hygiene. The following concerns were noted: a. Certified nurse aide (CNA) #22 rubbed her nose with the back of her left hand while assisting resident #17 with the evening meal. After rubbing bare skin adjacent to mucous membranes, the CNA did not wash her hands before touching the resident's food, drinking glasses, eating utensils, or napkin. The CNA rubbed her face with her hands 3 times, touched her hair twice, and adjusted her clothing twice during the 27 minute observation. The CNA failed to sanitize her hands after each contact, or did so in a manner that	F 444	F 444 The facility will ensure that staff washes their hands after each direct resident contact in order to prevent the spread of infection. This will be accomplished by: All staff will receive education and training by 07/01/07 regarding proper hand washing techniques and the use of gloves. All residents, including #7, 17, 23, 28, 40, 42 and 45 are receiving appropriate infection control practices by effective hand washing and glove techniques during care and meal times. On 06/11/07, the Director of Nursing provided education and training to all staff emphasizing the importance of hand washing and changing gloves before applying ointments to different parts of the body or dressing changes. This education also addressed the use of alcohol based products.	

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F 444	Continued From page 26 would not reduce the potential for contamination to a resident. For example, CNA #22 used hand sanitizer from a small plastic bottle, rubbed her hands together, and then handled the contaminated bottle again, moving it around the table several times. b. CNA #20 was observed to assist residents #7 and #42 with their meals. The CNA twice lifted drinking glasses by the rims, with thumb and fingers covering areas likely to contact the resident's mouth. The CNA did not wash her hands or use a sanitizer between touching the two residents' drinking glasses. She kept a bottle of hand sanitizer on the window sill behind her chair and on two occasions, after using the sanitizing agent, placed a hand on the window sill to push her chair back to the feeding table. In each case, she assisted residents with their food without washing or sanitizing her hands. Observation of the window sill on 5/ 4/07 at 7:20 PM showed it to be covered with dust. 2. Observation in the main dining room on 5/16/07 from 6:05 AM to 6:14 PM (9 minutes) revealed CNA #20 twice rubbed her face and once covered her mouth with her right hand (yawning) while serving food to residents #23 and #40. Her actions included removing utensils rolled up in a napkin, affixing clothing protectors, and removing lids from food containers. The CNA did not wash her hands during the observation. After passing trays, the CNA assisted resident #42 to prepare a sandwich; the CNA removed a slice of bread, handled tomato slices, replaced the bread, and cut the sandwich. The CNA did not wash her hands prior to touching the resident's food. 3. Interview with the Infection Control Practitioner (ICP) on 5/16/07 at 2:10 PM revealed the topic of	F 444	The Director of Nursing, Director of Staff Development and the floor nurse will be responsible for monitoring these practices in nursing areas daily through compliance rounds. Department heads will be responsible for monitoring their own staff through daily observations and through providing consistent education and training. Concerns will be provided to the Quality Assurance Committee at least quarterly. To be completed by ~~7/01/07~~ 6/28/07	6/28/07

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F 444	Continued From page 27 hand washing was included during in-service training for staff on 1/31/07. She further stated her expectation that hand washing would be accomplished "...at every opportunity..." The ICP stated the facility monitored hand washing as part of the medical competencies required of care providers, but did not have an established program to evaluate hand hygiene practices among non-nursing staff or among employees assisting with resident dining. Facility policy #6026, "Handwashing," dated 5/22/98, required staff to wash their hands "...after personal body function (e.g...blowing or wiping the nose...)...before and after eating or handling resident food..." 4. The Center for Disease Control and Prevention (CDC) Guideline for Hand Hygiene in Health-Care Settings, published October 25, 2002, recommends hand decontamination after touching intact skin, mucus membranes or secretions, or after contact with inanimate objects and environmental surfaces (p. 33). The CDC guideline further recommends hand hygiene be monitored and recorded to determine compliance with accepted standards (p. 34). 5. Observation on 5/16/07 at 5:45 PM revealed licensed practical nurse (LPN) #4 performed a dressing change on the coccyx area of sample resident #45. After completing the dressing change, the LPN then provided catheter care for the resident without washing her hands or changing her gloves. Interview with the director of nurses (DON) on 5/17/07 at 8:15 AM revealed the correct procedure would have been for the nurse to complete the first procedure, then remove the soiled gloves, wash her hands, and put on new gloves before she started the second procedure.	F 444		

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F 444	Continued From page 28 6. Observation on 5/15/07 at 8:50 PM showed LPN #4 applied Ildex 0.05% ointment to non-sample resident #28. The LPN washed her hands, put on gloves, applied the Ildex ointment to a glove and then applied it to the resident's buttocks. She then applied more ointment to the same glove and rubbed the ointment unto the back of the resident's knees. Interview with the DON on 5/16/07 at 2:45 PM revealed the correct procedure after an application of ointment to one area of the body would be for the nurse to dispose of the soiled gloves, wash her hands and put on new gloves before applying ointment to a different area of the body. 7. Review of the facility policy #6028, Handwashing (5/22/98), revealed staff were required to wash their hands "...after handling used dressings, contaminated equipment, etc." Further, the policy required handwashing "...after handling items potentially contaminated with blood, body fluids, excretions, or secretions..." Interview with the ICP on 5/16/07 at 2:10 PM confirmed the handwashing policy was current and reflected standards expected of direct care staff.	F 444		
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to maintain a comfortable, safe, and aesthetically pleasing	F 465	F 465 The facility will provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. This will be accomplished by: On 06/04/07 the facility has hired a landscaper to begin working on the grounds and to provide a more aesthetic appearance to the exterior of the building and to keep the surrounding areas free of garbage. This will also include the area around the patio. The Maintenance Supervisor will repair the areas of chain-link fence that are in disrepair and identify any other areas needing attention.	

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F 465	Continued From page 29 exterior appearance to the facility. The findings were: Multiple observations from 5/14/07 through 5/17/07 revealed the exterior building and grounds were in an unkempt condition. The grounds and general landscaping were overgrown, and grass along the building in the vicinity of the main entrance was up to 28 inches tall. Several areas of the chain-link fence enclosing the facility grounds were in disrepair, most notably at the northeast corner adjacent to a service road. The garbage pick-up point at the rear of the facility was littered with disposable plastic items, paper, and beverage cans. The exterior of the building had paint cracked, bubbled, or peeling from 10% to 15% of the wall surface. In addition, the roof at the north end of the building had 2-3 shingles misalignedeged and loosened from the roof. An outdoor patio area accessible from the main dining room was frequented by residents as a smoking area. The covered patio area had several cracks in the cement slab, some of which had gaps up to 2 inches wide and created an unlevel surface. Further, dried grass, leaves, cigarette butts, and paper litter had accumulated under two benches where residents sat to visit and, on occasion, smoked. Resident #39 stated in an interview at the outdoor smoking area on 5/16/07 at 3:35 PM "...yeah, the place is trashed up, but it's been worse..." The maintenance supervisor stated on 5/17/07 at 9:15 AM that the facility lawn mower was being repaired as a result of improper maintenance by a contractor. He acknowledged maintenance and repainting was needed on the exterior of the building and stated funding for siding and	F 465	The Maintenance Supervisor has realigned the shingles on the roof and will identify the need for repairs on any of the other areas of the roof. The Facility Administrator and General Manager have obtained an estimate to replace the existing wood siding with a more durable and maintenance free vinyl siding, but the cost is very high. The Facility is seeking estimates on painting the exterior of the building and should have them by 07/01/07. Then a decision will be made to begin work on improving the exterior of the physical plant. The Maintenance Supervisor will fill in the gaps in the concrete and then rent a concrete grinder to smooth out the uneven or rough sections of the patio. The Maintenance Supervisor will assess other areas around the facility for similar repairs. The Administrator and general Manager will be responsible for monitoring the appearance of the exterior of the facility and ensuring that it is aesthetically pleasing by walking around the facility at least weekly and identifying any potential hazards or items that are in disrepair or unkempt. The Administrator and/or General Manager will report to the Quality Assurance Meeting at least quarterly on the progress. To be completed by ~~7/01/07~~ 6/28/07	

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F 465	Continued From page 30 repainting had been requested.	F 465		
F 507 SS=D	483.75(l)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory reports were posted in the clinical records for two (#3 and #19) of eleven open sample residents. The findings were: Review of the medical records for residents #3 and #19 on 5/15/07 at 10:45 AM revealed each was missing laboratory reports. Progress notes dated 4/6/07 documented a urine specimen from resident #3 was sent to the laboratory on 4/6/07 to investigate a potential urinary tract infection (UTI). The resident's record further indicated antibiotic treatment was initiated on 4/6/07, and subsequently modified on 4/9/07, on the basis of laboratory culture and sensitivity reports. However, laboratory reports from the culture and sensitivity tests were missing from the resident's record. Clinical records for resident #19 included a progress note dated 4/25/07 documenting a provider's request for a urine specimen to be sent to the laboratory to evaluate a possible UTI. The outcome of the requested laboratory testing was missing from the resident's record. The Director of Nursing (DON) stated in an interview on 5/15/07 at 5:30 PM the facility was "...a little behind..." in sorting and filing laboratory reports. A urine culture and sensitivity report was	F 507	F 507 The facility will ensure that each resident's laboratory reports and other diagnostic services will be signed, dated, and placed in the medical record. This will be accomplished by: Resident #3's urine results and culture for 04/05/07 have been placed in the medical record, documented, signed and dated. Resident #19's urine results and culture for 04/25/07 have been placed in the medical record, documented, signed and dated. The charge nurse will be directly responsible for ensuring that once ~~a lab results is obtained~~ tests results are obtained for all residents the result will be placed in the medical record immediately and that the appropriate notifications and documentation are also completed. The Director of Nursing has put a monitoring tool in place to ensure lab results are placed in the medical record. This will be done semi-monthly. The DON will report to the Quality Assurance Committee at least quarterly on the progress. **To be completed by ~~07/01/07~~** 6/28/07	

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F 507	Continued From page 31 found for resident #3 in a collection of laboratory reports waiting to be posted. These findings were added to the clinical record on 5/15/07 at 4 PM. Subsequently, a urine analysis and culture report were found for resident #19 and posted to the clinical record on 5/16/07 at 4:25 PM. Interview with the laboratory manager at the reference laboratory on 5/16/07 at 1:35 PM revealed each of the missing laboratory reports had been faxed to the facility consistent with established procedures. The laboratory manager stated the fax log showed reports for resident #3 were faxed to the facility on 4/6/07 (preliminary findings) and 4/9/07 (final report); laboratory reports for resident #3 were faxed to the facility on 4/27/07.	F 507		