Reviewed & approved & changes on pages 15 & 19 and on 1 of 1 of the State tag at discussion & Larry Potter on 5/4/07 @

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

PRINTED: 05/17/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES	BOX 517 SUNDANCE, WY 82729

(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 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to have the most recent survey results and the plan of correction accessible to the residents in two of two posted locations. The findings were: Upon entering the facility on 4/30/07 at 7:05 PM until 9 PM, observation of the posted areas in the lobby and the nursing center revealed there was not a copy of the most recent survey or plan of correction accessible to the residents. Further observation on 5/1/07 from 7 AM to 6 PM and 5/2/07 from 8 AM to 1:30 PM confirmed there was not a copy of the most recent survey and plan of correction made accessible to the residents. Interview on 5/2/07 at 1:30 PM with the director of nursing (DON) revealed a copy of the survey results were to be posted in the hallway in the nursing home. The DON confirmed there was not a copy at that location. Further interview with the administrator at that time revealed there was not a copy of the survey or plan of correction accessible at the posted location in the nursing	F 167	A copy of the most recent survey with plan of correction is posted in the nursing home & the front lobby of the facility. They are in a folder labeled "State Survey Results". A quality indicator has been developed to monitor placement daily by Social Services & reported at monthly QI meetings. 5/3/07	

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

Larry Potter — CEO — 5-24-07

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.

RECEIVED
MAY 29 2007
Wyoming Dept of Health
Certification and Surveys

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F 167	Continued From page 1 home or in the front lobby. The administrator stated, "They were there last Thursday. Someone must have stolen them."	F 167		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of policies and procedures, and staff and resident interviews, the facility failed to assure a restraint was the least restrictive device and required to treat a medical symptom for one (#5) of one sample resident who utilized a restraint. The findings were: Observations on 5/1/07 at 8:18 AM, 9:40 AM and again at 2:10 PM revealed resident #5 was in bed with two full side rails up. Observation on 5/1/07 at 9:40 AM showed the resident was independent with bed mobility. The resident did not use the side rails for bed mobility. Review of the 4/23/07 quarterly Minimum Data Set (MDS) assessment revealed the resident was independent with bed mobility and required limited assistance with transfers. The assessment also indicated the resident utilized two full side rails. Review of a physician telephone order dated 1/12/07 showed side rails were ordered for "positioning and safety". The following concerns were identified: a. Review of an emergency room report showed on 1/3/07 the resident fell and fractured a femur. A safety assessment dated 1/15/07 showed the resident was non-weight bearing on	F 221	A) All residents requiring physical restraints will have the medical reason for the restraint documented including resident #5. B) Informed consents will be obtained on all use of restraints with explanations to the resident including resident #5. C) Physical restraints will be care planned in the resident's plan of care, including resident #5. D) All residents requiring physical restraints will have an assessment by the Interdisciplinary Team assuring that the least restrictive device is being utilized with updates as the residents condition improves- including resident #5. A quality monitoring tool has been implemented for reporting at monthly QI meetings. 5/4/07	

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F 221	Continued From page 2 the left leg. A physician's note dated 1/24/07 showed the resident needed a restraint and/or someone with him/her at all times to keep the resident from getting up. However, review of physical therapy notes dated 3/14/07 revealed the resident was now 100% weight bearing. Observation on 5/1/07 at 8:10 AM showed the resident ambulated with a walker. Review of the medical record showed no assessment to show what medical symptom required the use of side rails (especially since the resident's weight bearing status had changed). In addition, there was no assessment to show what other interventions were tried prior to the use of side rails (to show side rails were the least restrictive device). During an interview on 5/1/07 at 3:15 PM, the director of nursing (DON) stated there should have been an assessment for the side rails because they were a restraint for the resident. The DON stated "...we missed it." b. Review of the medical record showed no informed consent for the use of the side rails. According to the 4/23/07 quarterly MDS assessment, the resident had independent cognitive skills for daily decision-making. During an interview on 5/2/07 at 11:30 AM, the resident stated s/he did not know what the side rails were for. The resident stated "they are part of the bed." c. Review of the 4/24/07 care plan showed side rails were not addressed. On 5/1/07 at 3:15 PM, the DON confirmed the care plan did not address side rails. The DON stated the side rails should have been care planned as a restraint. d. Review of the facility's policy "Physical Restraints" (7/24/04, reviewed 12/6/05) showed prior to using any form of restraints staff must have documented non-restrictive interventions have been attempted. The policy also stated "explain to the resident the need for a	F 221		

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F 221	Continued From page 3 restraint...document in the chart if the resident is able to comprehend.....interdisciplinary team and physical therapy to evaluate resident for need of restraint...fill out restraint consent form and obtain signatures from appropriate parties...". Review of the medical record and interview with the DON on 5/1/07 at 3:15 PM confirmed the facility's policy was not followed.	F 221		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and	F 272	1) A comprehensive sleep assessment has been implemented and completed on residents #6 &#25. 2) A comprehensive anxiety assessment has been implemented and completed on resident #5. A side rail assessment for evaluation of need for physical restraints has been completed by the Interdisciplinary Team and Physical Therapy on resident #5 and will be completed on all residents requiring physical restraints. 5/16/07 A quality monitoring tool will be implemented to ensure residents who are being placed on hypnotics & anti-anxiety medications have had comprehensive assessments completed before the medications are started. 5/31/07	

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F 272	Continued From page 4 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of policies and procedures, and staff interview, the facility failed to complete a comprehensive assessment of all needed areas for three (#5, #6, #25) of ten sample residents. The findings were: 1. Review of physician orders on 8/29/06 showed resident #6 was ordered Restoril (sedative-hypnotic) 15 milligrams (mg) at bedtime. Review of the medication administration records (MARs) from that date through May 1, 2007 showed the resident received the medication each night. A physician's note dated 9/8/06 showed Restoril was started because the resident went to bed at 6:30 PM and rose at 4 AM and his/her sleep habits were disruptive to the roommate and others. Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for going to bed early and rising early. According to the facility's "Psychotropic Drugs" policy (11/02, reviewed 2/10/04), drugs for sleep induction will only be used if evidence exists that other possible reasons for insomnia (depression, pain, noise, light, caffeine) has been ruled out. On 5/1/07 at 3:15 PM the director of nursing (DON) confirmed there was no sleep assessment. 2. Review of physician orders showed on 9/29/06 resident #5 was ordered Lorazepam (a	F 272		

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F 272	Continued From page 5	F 272		

benzodiazepine) 0.5 mg 1/2 to 1 tablet every six hours as needed. Review of the March and April 2007 MARs showed the resident received the medication 13 times in March and 17 times in April. Review of a 4/9/07 physician note showed the resident usually took one or two Lorazepam a day and would ask for his/her "nerve pill". Review of the medical record showed no evidence an assessment was done to look at the reasons for the resident's anxiety. During an interview on 5/1/07 at 3:15 PM, the DON stated there was no assessment of the resident's anxiety. According to the facility's policy "Psychotropic Drugs" (reviewed 2/04), the use of anxiolytic/sedative drugs for purposes other than sleep induction will only occur when information is available that other possible reasons for the resident's distress have been considered.

Observations on 5/1/07 at 8:18 AM, 9:40 AM and again at 2:10 PM revealed the resident was in bed with two full side rails up. Review of the 4/23/07 quarterly Minimum Data Set (MDS) assessment revealed the resident was independent with bed mobility and required limited assistance with transfers. The assessment also indicated the resident utilized two full side rails. Review of the medical record revealed no assessment to show what medical symptom required the use of side rails. In addition, there was no assessment to show what other interventions were tried prior to the use of side rails (to show side rails were the least restrictive device). During an interview on 5/1/07 at 3:15 PM, the DON stated there should have been an assessment for the side rails because they were a restraint for the resident. The DON stated "...we missed it." Review of the facility's policy "Physical Restraints" (7/24/04, reviewed 12/6/05) showed "....interdisciplinary team and physical therapy to

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F 272	Continued From page 6 evaluate resident for need of restraint...". 3. Medical record review revealed resident # 25 had a doctor's order for Ambien (a hypnotic)10 mg every night with a start date of 8/22/06. Review of the MAR for April 2007 confirmed the resident received Ambien 10 mg every night. Further medical record review revealed there was no initial sleep assessment completed or any record of effectiveness of medication administration. On 5/1/07 at 3:15 PM, the DON confirmed there was no sleep assessment.	F 272		
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, medical record review,	F 279	The comprehensive care plan for all residents will be updated as needed when the residents condition changes, this includes resident #5, for falls, side rails, pain & anti-anxiety medications. The comprehensive care plans on all residents receiving hypnotics/sleeping pills & anti-anxiety medications will be addressed including resident's #5 & #6. A quality monitoring tool will be implemented to ensure all residents who have been placed on hypnotics & anti-anxiety medications have a comprehensive care plan completed. 5/31/07	

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F 279	Continued From page 7 and staff interview, the facility failed to develop a comprehensive care plan for two (#5, #6) of ten sample residents. The findings were: 1. Review of the 1/23/07 significant change Minimum Data Set (MDS) assessment showed resident #5 fell in the past 30 days and had a fracture. In addition, the resident utilized full side rails, had moderate pain daily, and took antianxiety medication. The following concerns were identified regarding the resident's care plan: a. Review of an emergency room report showed the resident fell on 1/3/07 which resulted in a femur fracture. However, review of the 4/24/07 care plan showed falls was not addressed. b. Observation on 5/1/07 at 8:18 AM and again at 2:10 PM showed the resident was in bed with two full side rails up. Review of the 4/24/07 care plan showed the side rails were not addressed. c. Review of a 4/23/07 pain assessment showed the resident reported his/her left leg still bothered him/her on most days. Review of physician's orders showed the resident was ordered Tylenol #3 as needed every four hours for pain. Review of the March and April 2007 medication administration records (MARs) showed the resident took the pain medication 41 times in March and 24 times in April. Review of the 4/24/07 care plan showed pain was not addressed. d. Review of physician orders revealed the resident was ordered Lorazepam 0.5 milligrams (mg) every six hours as needed. Review of a 4/9/07 physician note showed the resident usually took one or two Lorazepam a day, asking for his/her "nerve pill". Review of the March and April 2007 MARs showed the resident received	F 279		

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F 279	Continued From page 8 Lorazepam 13 times in March and 17 times in April for anxiety. Review of the 4/24/07 care plan showed anxiety was not addressed. e. On 5/1/07 at 3:15 PM, the director of nursing (DON) looked at the current care plan with the surveyor. The DON confirmed falls, pain, side rails and anxiety were not addressed, but should have been. The DON stated the old care plan (1/07) addressed pain, but not the other items. 2. Review of physician orders on 8/29/06 showed resident #6 was ordered Restoril 15 mg at bedtime. Review of the MARs from that date through May 1, 2007 showed the resident received the medication each night. A physician's progress note dated 8/29/06 showed nursing staff requested a sleeping pill because the resident went to bed at 6:30 PM and then wanted to move around at 4 AM. Review of the 3/6/07 care plan showed interventions for sleep disturbance other than the Restoril were not addressed. On 5/1/07 at 3:15 PM the DON stated the care plan did not address interventions for insomnia.	F 279		
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 staff interview, medical record review and observation, the facility failed to follow accepted standards of clinical practice with one of twenty medications administered during the medication pass. The findings were: Observation on 4/30/07 at 7:30 PM revealed	F 281		

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F 281	Continued From page 9 licensed practical nurse (LPN) #1 administered three medications to resident #17, one of which was Lipitor. The label on the bottle read Lipitor 10 mg (milligrams), two tablets, every day po (by mouth). LPN #1 poured two tablets from the bottle and administered them to the resident. Medical record review revealed the February 2007 recap orders with an order for Lipitor 20 mg qhs (every night). The following concerns were noted: a. The March 2007 recapitulation physician orders read Lipitor 20 mg 2 tabs [40 mg total] po qhs. b. There were no written or telephone doctor's orders in the medical records that verified the dose change. c. The April 2007 recap orders also read Lipitor 20 mg 2 tabs [40 mg total] qhs. d. Review of the medication administration record (MAR) for April 2007 read Lipitor 20mg 2 tabs [total of 40 mg] po qhs. There were nurses' initials on every day of the month verifying this was the dose given. Interview with LPN #2 on 5/1/07 at 9 AM verified the label on the bottle read Lipitor 10 mg 2 tablets every day po., but the latest order and the MAR read Lipitor 20 mg 2 tabs qhs. LPN #2 stated, "I think it was copied wrong." Interview with the director of nurses (DON) on 5/1/07 at 10 AM confirmed the discrepancy and she stated, "That's a typo." The DON further stated she was sure the nurses were following the directions on the prescription bottle, not the MAR or the recap orders and she was confident that was the dose the doctor wanted administered. She confirmed this with a clarification order from the doctor for Lipitor 10 mg 2 tabs qhs. Nursing Interventions and Clinical Skills, 3rd edition, copyright 2004, page 414 states,"....The	F 281	All medication orders will be transcribed to MAR correctly, entered into computer correctly & reviewed monthly for accuracy. The medication nurses will clarify any discrepancies immediately including the Lipitor order for Resident #17. 5/1/07 All nurses will be educated on transcribing, clarifying, & monitoring the MAR & medication dosage for accuracy. A quality indicator tool will be implemented to ensure medication dosage accuracy. 5/31/07	

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F 281	Continued From page 10 nurse is responsible for verifying that the MAR is accurate and up-to-date by comparing each medication to the original order, including drug name, dose, route of administration, and times to be given..... The nurse who checks all transcribed orders is responsible for accuracy."	F 281		
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, review of policies and procedures, and staff and resident interviews, the facility failed to assure the drug regimen was free of unnecessary drugs for three	F 329	Same as F272 The physicians have been contacted and appointments scheduled for residents #5, #6, #25 to evaluate/ document the necessity for continued use of unnecessary medications. 5/16/07	

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F 329	Continued From page 11	F 329		

(#5, #6, #25) of ten sample residents. The findings were:

1. Review of physician orders on 8/29/06 showed resident #6 was ordered Restoril (sedative-hypnotic) 15 milligrams (mg) at bedtime. Review of the medication administration records (MARs) from that date through May 1, 2007 showed the resident received the medication each night. The following concerns were identified:

a. A physician's note dated 9/8/06 showed Restoril was started because the resident went to bed at 6:30 PM and rose at 4 AM and his/her sleep habits were disruptive to the roommate and others. A physician's progress note dated 8/29/06 showed nursing staff requested a sleeping pill because the resident went to bed at 6:30 PM and then wanted to move around at 4 AM. The family wanted to "normalize" the resident's schedule. During an interview on 5/1/07 at 3:15 PM the director of nursing (DON) stated the main reason the resident was started on Restoril was "roommate conflicts". A physician's note dated 3/13/07 showed the resident still had a tendency to get up at 4:30 AM but the resident went to bed at 7 PM so was getting a good night's rest. The note stated the resident does not disrupt anyone when s/he rises. During an interview on 5/2/07 at 11:30 AM, the resident's roommate (resident #5) stated s/he was able to sleep OK at night and was not disturbed by anyone. The Drug Information Handbook for Nursing, 2007, states that Restoril is used for short-term treatment of insomnia. According to Taber's Cyclopedic Medical Dictionary, edition 19, insomnia is prolonged or abnormal inability to sleep. During an interview on 5/1/07 at 10:20 AM, resident #6 stated s/he was able to fall asleep right away, and

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(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 329	Continued From page 12 stayed asleep until she was ready to get up. There lacked evidence the resident actually had insomnia and required the use of a hypnotic. b. Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for going to bed early and rising early. In addition, there lacked evidence other non-pharmacological interventions were tried. On 5/1/07 at 3:15 PM the DON stated there was no sleep assessment. c. There lacked evidence a dose reduction had been attempted since the resident was ordered the Restoril routinely on 8/29/06. d. According to the facility's "Psychotropic Drugs" policy (11/02, reviewed 2/10/04), drugs for sleep induction will only be used if evidence exists that other possible reasons for insomnia (depression, pain, noise, light, caffeine) has been ruled out, and daily use of the drug is less than 10 continuous days unless an attempt at a gradual dose reduction is unsuccessful. 2. Review of physician orders showed on 9/29/06 resident #5 was ordered Lorazepam (a benzodiazepine) 0.5 mg 1/2 to 1 tablet every six hours as needed. Review of the March and April 2007 MARs showed the resident received the medication 13 times in March and 17 times in April. Review of a 4/9/07 physician note showed the resident usually took one or two Lorazepam a day and would ask for his/her "nerve pill". Review of the medical record showed no evidence an assessment was done to look at the reasons for the resident's anxiety, nor was there evidence other non-pharmacological interventions were tried. According to Drug Information Handbook for Nursing, 8th edition, 2007, "...assess for history of addiction; long-term use can result in	F 329		

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F 329	Continued From page 13 dependence, abuse, or tolerance..". During an interview on 5/1/07 at 3:15 PM, the DON stated she believed the resident had an addiction to the Lorazepam. The DON further stated there was no assessment of the resident's anxiety, nor documentation of other interventions tried. According to the facility's policy "Psychotropic Drugs" (reviewed 2/04), the use of anxiolytic/sedative drugs for purposes other than sleep induction will only occur when information is available that other possible reasons for the resident's distress have been considered. 3. Medical record review for resident # 25 revealed a telephone order from the physician on 8/22/06 to increase Ambien (a hypnotic) to 10 mg (milligrams) qhs (every night). The previous order was for Ambien 5 mg hs prn (as needed). There was a nurses' note dated 8/22/06 at 4 AM which stated, "Resident awake, in meri - walker. Staff reports resident has been awake most of the night yelling and noisy at intervals." At 12:30 PM that day, the physician was notified of the resident not sleeping and the order to increase the Ambien was received. There was no documentation of a sleep assessment being completed at the time of the order. On 5/1/07 at 3:15 PM, the DON confirmed there was no sleep assessment. Further record review revealed there were no physician progress notes that addressed a sleep disturbance or the need for the use of Ambien on a nightly basis. Also, there has been no planned dose reduction in the past six months.	F 329		
F 334 SS=C	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	F 334		

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F 334	Continued From page 14 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: (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	F 334	All residents or their legal representatives will be instructed on the benefits & side effects of pneumococcal & influenza vaccines, this will be evidenced by signed permission slips in each residents chart indicating education has been given to all residents or legal representatives, including residents #5, #6, #19, #25, #28, & #30 & #1. added per request of [illegible] Potter via phone on 6/19/07 @ 2pm Linda Brown RN A policy has been developed to ensure all residents or legal representatives are instructed on the benefits and side effects of pneumococcal & influenza vaccines. 5/17/07 A quality monitoring tool will be implemented for monthly reporting at QI meetings.	

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F 334	Continued From page 15 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 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 policies and procedures, and staff interview, the facility failed to document education for seven of seven sample residents (#1, #5, #6, #19, #25, #28, #30) reviewed who received the influenza and pneumococcal vaccine. The findings were: 1. Review of the physician order sheet and medication administration records (MARs) showed resident #5 received the pneumococcal vaccine on 10/19/06 and the influenza vaccine on 10/30/06 and 2/28/07. Further review of the medical record showed no documentation that education regarding benefits and side effects was provided. 2. Review of the physician order sheet and MARs	F 334		

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F 334	Continued From page 16 showed resident #6 received the pneumococcal vaccine on 10/18/05 and the influenza vaccine on 10/30/06 and 2/28/07. However, review of the medical record showed no documentation that education regarding the benefits and side effects was provided. 3. Review of the physician order sheet and MARs revealed resident #19 received the pneumococcal vaccine on 2/1/06 and the influenza vaccine on 10/30/06 and 2/28/07. Further review of the medical record showed no documentation that education regarding benefits and side effects was provided. 4. Review of the physician order sheet and the MAR showed resident #1 received the pneumococcal vaccine in 10/06 and the influenza vaccine on 2/28/07. Further review of the medical record showed no documentation that education regarding the benefits and side effects was provided. 5. Review of the physician order sheet and the MAR showed resident #25 received the pneumococcal vaccine on 12/1/06 and the influenza vaccine on 2/28/07. Further review of the medical record showed no documentation that education regarding the benefits and side effects was provided. 6. Review of the physician order sheet and the MAR showed resident #28 received the pneumococcal vaccine on 10/25/06 and the influenza vaccine on 2/28/07. Further review of the medical record showed no documentation that education regarding the benefits and side effects was provided. 7. Review of the physician order sheet and the	F 334		

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F 334	Continued From page 17 MAR showed resident #30 did not receive the pneumococcal vaccine per physician order, but did receive the influenza vaccine on 2/28/07. Further review of the medical records showed no documentation that education regarding the benefits and side effects was provided. 8. When asked about vaccination policies on 5/1/07 at 10:12 AM, the director of nursing (DON) showed the surveyor the facility's standing orders policy which showed residents should be given the influenza and pneumococcal vaccines. On 5/1/07 at 3:15 PM, the DON stated the facility did not have a policy which addressed education regarding immunizations. The DON further stated the facility did not document if education was provided to residents and/or family members.	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of policies and procedures, and staff interview, the consulting pharmacist failed to make recommendations regarding unnecessary medications for three (#5, #6, #25) of ten sample residents. The findings were:	F 428		

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F 428	Continued From page 18 1. Review of physician orders on 8/29/06 showed resident #6 was ordered Restoril (sedative-hypnotic) 15 milligrams (mg) at bedtime. Review of the medication administration records (MARs) from that date through May 1, 2007 showed the resident received the medication each night. The following concerns were identified: a. A physician's note dated 9/8/06 showed Restoril was started because the resident went to bed at 6:30 PM and rose at 4 AM and his/her sleep habits were disruptive to the roommate and others. A physician's progress note dated 8/29/06 showed nursing staff requested a sleeping pill because the resident went to bed at 6:30 PM and then wanted to move around at 4 AM. The family wanted to "normalize" the resident's schedule. During an interview on 5/1/07 at 3:15 PM the director of nursing (DON) stated the main reason the resident was started on Restoril was "roommate conflicts". A physician's note dated 3/13/07 showed the resident still had a tendency to get up at 4:30 AM but the resident went to bed at 7 PM so was getting a good night's rest. The note stated the resident does not disrupt anyone when s/he rises. During an interview on 5/2/07 at 11:30 AM, the resident's roommate (resident #5) stated s/he was able to sleep OK at night and was not disturbed by anyone. The Drug Information Handbook for Nursing, 2007, states that Restoril is used for short-term treatment of insomnia. According to Taber's Cyclopedic Medical Dictionary, edition 19, insomnia is prolonged or abnormal inability to sleep. During an interview on 5/1/07 at 10:20 AM, resident #6 stated s/he was able to fall asleep right away, and stayed asleep until she was ready to get up.	F 428	The consulting pharmacist will make recommendations on all residents receiving unnecessary medications including residents #5, #6, & #25. This will be evidenced by monthly monitoring of residents receiving anti-anxiety & hypnotic medications with recommendation to the physician. This will be monitored by the Director of Nursing monthly & presented to the QA Committee 5/31/07 ~~quarterly~~ added per request of Kathy Potter RN via phone on 6/14/07 @ 2:40 pm Janet Dr Beaver RN	

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F 428	Continued From page 19 There lacked evidence the resident actually had insomnia and required the use of a hypnotic. b. Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for going to bed early and rising early. In addition, there lacked evidence other non-pharmacological interventions were tried. On 5/1/07 at 3:15 PM the DON stated there was no sleep assessment. c. There lacked evidence a dose reduction had been attempted since the resident was ordered the Restoril routinely on 8/29/06. d. According to the facility's "Psychotropic Drugs" policy (11/02, reviewed 2/10/04), drugs for sleep induction will only be used if evidence exists that other possible reasons for insomnia (depression, pain, noise, light, caffeine) has been ruled out, and daily use of the drug is less than 10 continuous days unless an attempt at a gradual dose reduction is unsuccessful. e. Review of the monthly pharmacy reviews from January 2006 through April 2007 revealed no recommendations regarding the Restoril. 2. Review of physician orders showed on 9/29/06 resident #5 was ordered Lorazepam (a benzodiazepine) 0.5 mg 1/2 to 1 tablet every six hours as needed. Review of the March and April 2007 MARs showed the resident received the medication 13 times in March and 17 times in April. Review of a 4/9/07 physician note showed the resident usually took one or two Lorazepam a day and would ask for his/her "nerve pill". Review of the medical record showed no evidence an assessment was done to look at the reasons for the resident's anxiety, nor was there evidence other non-pharmacological interventions were tried. According to Drug Information Handbook for	F 428		

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F 428	Continued From page 20 Nursing, 8th edition, 2007, "...assess for history of addiction; long-term use can result in dependence, abuse, or tolerance..". During an interview on 5/1/07 at 3:15 PM, the DON stated she believed the resident had an addiction to the Lorazepam. The DON further stated there was no assessment of the resident's anxiety, nor documentation of other interventions tried. According to the facility's policy "Psychotropic Drugs" (reviewed 2/04), the use of anxiolytic/sedative drugs for purposes other than sleep induction will only occur when information is available that other possible reasons for the resident's distress have been considered. Review of the monthly pharmacy reviews from October 2006 through April 2007 showed no recommendations regarding the Lorazepam. 3. Review of Minimum Data Set (MDS) assessments dated 9/7/06, 12/6/06, and 3/6/07 revealed resident #25 had a diagnosis of depression. Review of physician recap orders for April 2007 showed the resident received Zoloft (an antidepressant) 150 milligrams (mg) daily with a start date of 3/20/04. Further review of the recap orders revealed the resident received Ambien 10 mg every night since 8/22/06. There was no documentation in the medical records of a sleep assessment being completed and there were no physician progress notes that addressed a sleep disturbance or the need for the use of Ambien on a nightly basis. Further record review revealed there were monthly pharmacy reviews documented for the past six months, but these reviews did not address the nightly use of Ambien, the precautions of use with a resident with depression, or a recommendation to the physician for a planned dose reduction. The Geriatric Dosage Handbook, 12th edition, page 1672 lists the following warning/precaution	F 428		

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F 428	Continued From page 21 for Ambien: "Should be used only after evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve after 7 - 10 days may indicate psychiatric or medical illness. Use with caution in patients with depression.... Prescriptions should be written for the smallest effective dose (especially in the elderly) and for the smallest quantity consistent with good patient care (especially with depression)". 4. During a phone interview on 5/2/07 at 4:15 PM, the consultant pharmacist stated there would "probably not" be recommendations in his reviews regarding the lack of documentation to show indication for use of psychoactive medications. He stated he did not necessarily look to see if there was an assessment for anxiety or insomnia for residents utilizing hypnotics or antianxiety medication. In addition, he stated they have worked on dose reductions in the past, but they "didn't work". The pharmacist stated he did not have the new federal guidelines on unnecessary medications.	F 428		