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

PRINTED: 02/25/2011
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
	566027	A. BUILDING _____ B. WING _____	3/14/11 02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN - registered nurse LPN - licensed practical nurse DON - director of nursing MDS - Minimum Data Set CNA - certified nursing assistant SDC - staff development coordinator Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations manual.	
F 170 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to prevent staff from allowing 2 of 18 sample residents (#4, #38) to self-administer medications after the interdisciplinary team (IDT) determined this was an unsafe practice for these residents. The findings were: 1. On 2/7/11 at 7:45 AM RN #1 was observed administering medications, including the bulk laxative, Benefiber, for resident #4 while s/he was in his/her room. The RN mixed the laxative in half a glass of water and handed it to the resident to drink when swallowing the other pills. However, the resident did not consume all the medicated fluid at once, and the RN left it at the bedside as	F 170	The facility will continue to ensure that residents may self-administer drugs if the interdisciplinary team has determined that this practice is safe. 1. Resident #4 is deceased as of 02/15/2011. 2. Medication administration to Resident #38 will be in accordance with the assessment for self-administration of medications, which includes observing him taking all of his medications. 3. All residents will continue to be assessed by the interdisciplinary team (IDT) through use of a Medication Administration Evaluation to determine safety for self-administration of medications. 4. Nursing staff were reminded at a general staff meeting on 02/16/2011 and again at a nurses' staff meeting on 03/02/2011 of the requirement to follow the directions outlined on the medication administration evaluation regarding the safety of self-administration of medication for each resident.	03/18/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deanna Karen NHA | TITLE: Administrator | (X6) DATE: 03/07/2011

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

Wyoming Department of Health
MAR 07 2011
Office of Healthcare Licensing and Surveys

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6BNR11 Facility ID: WY0006 Continuation sheet Page 1 of 18

This POC approved on 3/14/11 @ 1:18 C additions & corrections per phone conversation w/ Deanna Karen, Adm, and Betty Jelsen, RN, State Health Surveyor.

LTCC Officeofcarry Jansen (307) 578-2412 Monday, March 07, 2011 12:17 PM p.02

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F 176	Continued From page 1 she exited the room at 7:50 AM. This action left the resident with approximately 1/4 of the medication to self-administer. According to the IDT evaluation dated 12/14/10, the resident responded "yes" to the question "Wants nursing to stay with them until all medication is consumed." The final determination was that the resident was "Unsafe for pre-poured medication, must be observed." During an interview on 2/9/11 at 4:55 PM, the administrator confirmed the evaluation was current. 2. Observation on 2/8/11 at 7:45 AM showed resident #38 took medication from a cup placed by his/her breakfast plate. At that time the nurse was across the room passing medication to other residents. On 2/9/11 at 12:03 PM observation showed RN #2 set a medication cup next to the resident's plate and left. Review of the 10/11/10 medication administration evaluation showed the resident was "Unsafe for pre-poured medication, must be observed." Interview with RN #2 on 2/9/11 at 12:05 PM verified the medication left on the table for the resident was a multivitamin, and leaving it for the resident to take independently was the usual practice.	F 176	5. The Medication Administration Competency checklist will be revised to include information regarding the self-administration of medications. This competency checklist will be used to conduct monthly observations of medication passes to ensure the administration of medications is in accordance with each resident's medication administration evaluation. 6. The results of these monthly observations will be developed into a Quality Improvement (QI) indicator and reported by the DON on a quarterly basis to the Medication Safety Committee, with oversight from the organization-wide Quality Improvement/Performance Improvement (QI/PI) Committee until resolved. 7. The Director of Nursing will monitor.	
F 248 ss=D	483.10(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records	F 248	The facility will continue to ensure that an individualized activity program is provided to meet the needs of the residents. 1. A new activity assessment will be completed on Resident #8 in an effort to determine the resident's current interests, define what type of activities the resident would be interested in, and develop goals for activity participation on the plan of care. If one-to-one visits are provided, they will be documented on a weekly basis, and summarized in the quarterly documentation in the resident's medical record.	03/25/2011

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F 248	Continued From page 2 and activity documentation, and resident and staff interviews, the facility failed to ensure an individualized activity program was developed to meet the needs of 3 of 13 sample residents (#8, #23, #52). The findings were: 1. Review of the 8/8/10 annual MDS assessment showed resident #8 was awake mornings and afternoons and was interested in exercise, music, walking, TV, and talking. According to the 8/26/09 activity assessment, the resident was "not much interested in anything at this time...will check back when resident feeling better." Activity notes dated 3/1/10 and 9/2/10 documented the resident was self-directed and usually refused group activities. Review of the activity participation records showed that in December 2010 the resident participated in "Morning Greeting" 6 times, pet visits 5 times, and ice cream social 3 times. In January 2011, the resident participated in "Morning Greeting" 5 times, pet visits once, and had a one-to-one activity once. However, there was no documentation to describe the activity. As of February 9, 2011, the resident had only participated in "Morning Greeting" 5 times. The following concerns were identified: a. Review of the care plan dated 9/2/10 revealed only that the resident went outside to smoke. There lacked goals or approaches related to activities to ensure the needs of the resident were met. b. During an interview on 2/9/11 at 10:10 AM, the resident stated s/he did not attend many group activities because "music and Bingo is not my thing." The resident further stated s/he was "bored." c. Other than the single one-to-one activity documented in January, there was no evidence the facility provided individualized activities with	F 248	2. A new activity assessment will be completed on Resident #23 in an effort to determine the resident's current interests, define what type of activities this resident would be interested in, and develop goals for activity participation on the plan of care. If one-to-one visits are provided, they will be documented on a weekly basis, and summarized in the quarterly documentation in the resident's medical record. 3. A new activity assessment will be completed on Resident #52 in an effort to determine the resident's current interests, define what type of activities this resident would be interested in, and develop goals for activity participation on the plan of care. If one-to-one visits are provided, they will be documented on a weekly basis, and summarized in the quarterly documentation in the resident's medical record. 4. Goals for one-to-one activity interventions will be developed for all residents who receive one-to-one activities, and this information will be reflected on the resident's care plan. 5. The Activities Coordinator or the Activities Assistant will review the documentation for each resident receiving one-to-one activities on a monthly basis, and document the resident's response to the activities on a quarterly basis in the resident's medical record. 6. The information from the monthly and quarterly documentation of one-to-one activities will be developed into a QI indicator and the results reported to the organization-wide QI/PI Committee by the Administrator on a quarterly basis until resolved. 7. The Administrator will monitor.	

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F 248	Continued From page 3 this resident which were meaningful to him/her. d. During an interview on 2/10/11 at 8:30 AM, the activity director stated the care plan would be on the assessment form, but she acknowledged goals were lacking. 2. Observation throughout the survey revealed resident #25 did not get out of bed or participate in any activities while the surveyor was present. An attempt to converse with him/her on 2/9/11 at 1:25 PM revealed the resident's speech was garbled and extremely difficult to understand. On 2/10/11 at 8:40 AM CNA #3 stated the resident had recently been refusing to get out of bed or use his/her electric wheelchair or computer. Review of the 12/1/10 annual MDS assessment showed no evidence an activity assessment was completed, and the care plan for activities was "...Prefers individual activities in room to group activities." However, the individual activities were not defined. Review of the facility's daily activity participation records for December 2010 showed the resident participated in "Morning Greeting" three times, had three pet visits, and ate ice cream four times. The January 2011 record showed the resident received four "Morning Greetings." Review of the activity notes showed they were dated 8/1/10, 9/1/10, and 12/1/10. The documentation indicated the resident refused group activities and would turn his/her head to the wall if s/he did not want to visit. However, the notes also indicated the resident did enjoy family visits. On 2/10/11 at 7:55 AM the administrator stated they were unable to find an activity assessment. The administrator also reviewed the activity notes and confirmed they were "...sparse..." There was no evidence the resident received one-to-one visits or that staff provided, or had involved the family in providing,	F 248		

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F 248	Continued From page 4 meaningful, life affirming activities that were important to the resident. 3. Review of the 1/7/11 activity notes for resident #62 showed s/he spent a large amount of time in the room. The note further showed activity staff visited with the resident two to three times per week. However, review of the activity log information for December 2010 and January and February 2011 showed no information or evidence of staff visits, and most days the resident only participated in "Morning Greeting." Review of the 10/20/10 annual MDS assessment showed, that when interviewed, the resident identified music, animals, news, going outside in good weather, and religious services as very important to him/her. Review of the resident's activity care plan showed the only goal related to these important activities was making sure the newspaper was available daily. 4. On 2/10/11 at 8:30 AM, the activity director stated activity staff did not develop goals or document residents' responses for one-to-one activities because they did not have time. Furthermore, she stated "Morning Greeting" consisted of the activity staff going to the units to check on the residents to see if there had been any changes with them.	F 248		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI	F 272	The facility will continue to ensure that a comprehensive, accurate, standardized, reproducible assessment is conducted of each resident's functional capacity. 1. A new bowel assessment will be conducted on Resident #10. And current, annual assessments will be reviewed to ensure they remain accurate. As 2. Resident #18 is deceased as of 03/01/2011. 3. A new activity assessment will be conducted on Resident #23. and current activity assessments will be reviewed to ensure they remain accurate. As	03/25/2011

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F 272	Continued From page 5 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 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by; Based on observation, medical record review, and staff interview, the facility failed to complete comprehensive assessments in various areas for 3 of 14 sample residents (#10, #18, #23). The findings were; 1. According to the 12/10/10 annual MDS assessment, resident #10 triggered for bowel incontinence and required a comprehensive assessment. Review of the assessment information showed the last comprehensive bowel assessment was in 2008. Interview with the MDS coordinator on 2/9/11 at 10:23 AM confirmed a	F 272	4. Each resident's assessment will be reviewed at least annually and upon any significant change to assure the information is consistent with the residents' current functional capacity. 5. A representative sampling of resident assessments will be reviewed quarterly by the Director of Nursing to assure they accurately reflect the residents' current functional capacity. 6. The information from the review of resident assessments will be developed into a QI indicator, and the results will be reported by the DON on a quarterly basis to the Medicine/Critical Care Committee with oversight by the organization-wide QI/PI Committee until resolved. 7. The Director of Nursing will monitor.	

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F 272	Continued From page 6 current assessment was lacking. The coordinator stated she reviewed the bowel tracking form but had not completed another assessment or referred to the 2008 assessment information. 2. Review of the 2/3/11 MDS admission assessment showed resident #18 required a comprehensive bowel assessment due to total bowel incontinence. Detailed review of the medical record showed no evidence the assessment was conducted. During an interview on 2/9/11 at 2:45 PM, the MDS coordinator reviewed the medical record and confirmed a bowel assessment had not been completed. 3. Review of the 12/1/10 annual MDS assessment showed no evidence an activity assessment was completed for resident #23. Refer to F248 for detailed information.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP 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	F 279	The facility will continue to ensure that comprehensive care plans are developed for each resident. 1. A new pain assessment will be conducted on Resident #22 and the results of the assessment will be included on the resident's care plan. 2. All residents who are receiving interventions for pain management will have this information reflected on their care plan. 3. A representative sampling of residents' care plans will be reviewed monthly by the Director of Nursing to ensure that residents with identified pain management needs have that information reflected on their care plan.	03/25/2011

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F 279	Continued From page 7 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 medical record review and staff interview, the facility failed to develop a care plan for all needed areas for 1 of 14 sample residents (#22). The findings were: Review of the 7/13/10 significant change MDS assessment revealed resident #22 had moderate pain less than daily. Further review of the 1/5/11 quarterly MDS assessment showed the resident had frequent pain which was described as severe. According to the physician's orders, the resident received Hydrocodone/APAP 5/500 milligrams three times per day for pain. Review of the care plan dated 12/30/10 showed pain was not addressed. During an interview on 2/10/11 at 8:55 AM, the MDS coordinator stated pain should have been included on the care plan.	F 279	4. The information from the review of residents' care plans will be developed into a QI indicator, and the results will be reported by the DON on a quarterly basis to the Medicine/Critical Care Committee with oversight by the organization-wide QI/PI Committee until resolved. 5. The Director of Nursing will monitor.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on random observations, medical record review, staff interview, and review of policies and procedures, the facility failed to ensure staff conformed to professional standards of practice related to medication administration. Staff failed to cleanse the connection site prior to injecting	F 281	The facility will continue to ensure that the services provided or arranged by the facility meet professional standards of quality. 1. The physician's order for bladder irrigation on resident #11 was discontinued on 02/16/2011, and there are no other residents receiving this service at this time. RN #4 was provided 1:1 education by the Staff Development Coordinator (SDC) and the Director of Nursing (DON) regarding the standard for clean technique to be used for bladder irrigation. 2. LPN #5 was provided one-to-one education by the DON regarding keeping all medications, including insulin, in locked storage when unattended	03/16/2011

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F 281	Continued From page 8 medication for resident #11 and left unsecured medications in the corridor while administering insulin for residents #5 and #13. The findings were: 1. Observation on 2/7/11 at 7:20 PM showed RN #4 used a syringe to inject 60 milliliters of a solution into the indwelling urinary catheter of resident #11. The RN did not cleanse the connection site prior to inserting the syringe and injecting the solution she identified as the antibiotic, Gentamycin. Immediately after the observation, the surveyor asked the RN about cleaning the connecting site before irrigating the resident's catheter. The RN replied, "I never have." On 2/9/11 at 10:35 AM the SDC stated she contacted the physician and produced an order from him instructing that the daily catheter irrigation "...is to be done per clean technique." The SDC defined clean technique as use of an alcohol pad to cleanse the connecting site prior to inserting the syringe containing the irrigation solution. She stated the physician demonstrated this technique prior to initiation of the catheter irrigations. According to Elkin M Perry, A and Potter P "Nursing Interventions & Clinical Skills" St. Louis, Missouri: Mosby; 2007; 62; "...clean technique...includes procedures used to reduce the number of and prevent the spread of microorganisms." 2. Review of the facility's policy and procedure, "Pharmacy: Storage of Medications and Solutions in Patient Care Areas", number 7300, last revised 05/09, showed "Drugs shall be kept in locked storage when unattended and shall be inaccessible to unauthorized individuals." Review of Smith, S Duell, D and Martin B, "Clinical	F 281	3. All staff was educated at a general staff meeting on 02/18/2011 and again at a nurses' staff meeting on 03/02/2011 regarding the professional standard for clean technique for bladder irrigation, and the policy for the proper securing of medications when unattended. 4. Organization-wide annual education completed 09/28/2011 required all nursing employees complete an education module on Infection Control, including aseptic technique. 5. The cart used in the facility to transport the glucometer and supplies for blood glucose monitoring will be clearly labeled as not for use for transport or storage of medications. 6. If a resident receives new orders for bladder irrigation or other procedures requiring aseptic technique, the SDC or designee will provide additional staff education at that time regarding the appropriate aseptic technique to be used. 7. Monthly observations will be conducted by the SDC and/or the DON of medication passes, including insulin administration, to assure that medications are kept in locked storage when unattended. 8. The information gathered from the monthly observations will be developed into a QI indicator and reported by the DON on a quarterly basis to the Medication Safety Committee with oversight by the organization-wide QI/PI Committee until resolved. 9. The Director of Nursing will monitor.	

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F 281	Continued From page 9 Nursing Skills Basic to Advanced Skills." New Jersey: Pearson Education, Inc.; 2008; 677, supported the facility's policy. Failure to conform to this standard of practice was identified in the following instances: a. On 2/8/11 LPN #5 was observed to enter resident #6's room and administer insulin at 5:26 PM. During this process, the RN left the cart containing supplies and various types of insulin out in the corridor. The insulin was unsecured and out of the RN's sight while she administered the resident's medication in private. During interview on 2/9/11 at 10 AM, the DON identified insulin as a medication and stated medications "...are to be locked when not observed" by licensed staff. b. Observation at 5:38 PM on 2/8/11 showed LPN #5 left the cart containing unsecured insulin in the corridor while she privately administered insulin for resident #13. The medication was out of the LPN's sight during the time she was in the resident's room. Interview with the DON on 2/9/11 at 10 AM confirmed insulin should be "...locked when not observed" by licensed staff.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment for	F 323	The facility will continue to ensure that a safe environment is provided for residents. 1. The electric recliner chair in the special care unit was moved away from the wall mounted sink and replaced with a manual chair on 02/08/2011. 2. The metal joint protector for the baseboard radiator in the second floor dining room was put back in place on 02/10/2011. 3. Staff was educated at a general staff meeting on 02/18/2011 and at a nurses' meeting on 03/02/2011 regarding maintaining a safe environment for the residents.	03/25/2011

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F 323	Continued From page 10 residents in two of three resident areas. The findings were: 1. Observation in the special care unit on 2/8/11 at 8:48 PM revealed non-sample resident #54 being positioned in a recliner chair by CNA #10. The elevational position of the chair was controlled with a wand attached to the chair by a 4 foot electrical cord. Another electrical cord was coming out from underneath the chair and was plugged into an electrical outlet. The chair was situated immediately next to a wall mounted sink. The CNA assisted the resident in getting comfortable in the chair by elevating the chair with the control wand. During the process of positioning the resident, the CNA placed the wand on the lip of the sink. Interview with SCU nurse #6 on 2/10/11 at 8:45 AM revealed the close proximity of an electrical source (electrical control wand) with a water source (sink) was a dangerous situation in the event there was water in the sink and the wand should fall into the water. 2. Observation on 2/8/11 at 11:40 AM revealed a 4 inch wide by 16 inch long metal joint protector for the baseboard radiator had come away from the radiator in the second floor dining room. As a result, the edges of the joint cover as well as the edges of the two radiator cover sheets were exposed creating a potential hazard to anyone who would brush up against the metal. Interview with RN #11 on 2/10/11 at 9:10 AM revealed the joint cover represented a potential hazard to anyone bumping against the sharp edges.	F 323	4. The DON and Director of Plant Operations will conduct quarterly environmental rounds throughout the facility to ensure a safe environment. The checklist used for these rounds will include the location of electrical devices in proximity to a water source, and inspection of radiator joint covers. 5. The information gained from the environmental rounds will be reported by the DON on a quarterly basis to the Environment of Care Committee with oversight by the organization-wide QI/PI Committee until resolved. 6. The Director of Nursing will monitor.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	The facility will ensure that it is free of medication error rates of five percent or greater. 1. Resident #4 is deceased as of 02/18/2011.	03/28/2011

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 02/10/2011

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✓ 3/14/11 BW

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F 332	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain a medication error rate under 5 percent (%). Four medication errors were observed out of 46 opportunities for error, resulting in an error rate of 8.69%. The findings were: 1. Observation on 2/7/11 showed RN #1 prepared medications, including Benefiber one teaspoonful, for administration to resident #4 at 7:46 AM. When the RN stated she was finished preparing the medications, the surveyor asked her to recheck the dosage of Benefiber as the label read "one tablespoonful." The RN read the label and, prior to correcting her error, stated, "I thought it said 'teaspoonful'." Reconciliation of the medications confirmed the correct dosage was one tablespoonful. 2. Observation at 8:10 AM on 2/9/11 showed LPN #6 administered medications for resident #69. These medications included Synthroid and Prilosec that were actually scheduled at 7 AM on the medication administration record (MAR). Reconciliation of the medication pass showed the medications were specifically ordered at 7 AM. Interview with LPN #7 on 2/9/11 at 11:25 AM revealed staff did not administer either medication at 7 AM because they had to complete treatments in the East wing prior to passing medications in the secure unit. Two errors occurred during this medication pass. 3. On 2/8/11 LPN #7 was observed preparing	F 332	2. The regular individualized routine and medication regimen for resident #69 will be assessed to determine the most beneficial time for her medications to be administered, and a physician's order obtained to best meet her individual care routine and personal preferences. 3. The regular individualized routine and medication regimen for resident #78 will be assessed to determine the most beneficial time for his medications to be administered, and a physician's order obtained to best meet his individual care routine and personal preferences. 3a All residents Emedication from adm orders at 0700 will be reviewed to determine if an alternate time would better meet the resident's individ. care routine & personal preferences. BW 4. All licensed nurses, including RN#1, LPN#5, and LPN #7 were educated at a nurses staff meeting on 03/02/2011 regarding the Five Rights of medication administration, including checking for proper medication dose and time. 5. The Medication Administration Competency checklist will be revised and provided to nursing staff to further educate them on the entire medication administration process. This tool will be used in weekly observations conducted by the SDC and the DON of medication passes to ensure proper medication administration processes are being utilized. 6. The information obtained from weekly medication pass observations will be developed into a QI indicator, and the results reported by the DON on a quarterly basis to the Medication Safety Committee with oversight by the organization-wide QI(P) Committee until resolved. 7. The Director of Nursing will monitor.	

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F 332	Continued From page 12 medication, including Synthroid, that she administered at 8:45 AM to resident #26. Reconciliation of the medication pass showed the medication was ordered at 7 AM, and review of the MAR showed it was scheduled at that time. Interview with the LPN on 2/9/11 at 11 AM revealed the medication was not administered at 7 AM as the resident was gone by the time medications were passed and staff did not "...chase [him/her] down."	F 332		
F 371 SSGE	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food equipment and ventilation hoods located in the kitchen were maintained in a sanitary manner. The findings were: Observation on 2/7/11 at 5:30 PM showed a large stand mixer, a meat slicer, and a milk-shake blender located in preparation areas of the kitchen. Food preparation was not taking place at that time, and none of the pieces of equipment were being used. Upon closer inspection it was noted that the stand mixer had splatters of dried	F 371	The facility will continue to ensure that food equipment and ventilation hoods located in the kitchen are maintained in a sanitary manner. 1. The large stand mixer, the counter below the meat slicer, and the milk-shake blender were cleaned on 02/09/2011. 2. The hood vents above the range were cleaned on 02/11/2011. 3. The kitchen cleaning schedule/checklist has been revised to include daily, weekly, and monthly duties assigned to various departmental positions on a regular basis. All Nutrition Services staff will be educated regarding those responsibilities at a staff meeting, and the Dietary Manager will monitor the completion of the cleaning checklist. 4. The information obtained from the kitchen cleaning checklist will be developed into a QI Indicator and reported by the Director of Nutrition Services to the organization-wide QI/PI Committee on a quarterly basis until resolved. 5. The Dietary Manager will monitor.	03/25/2011

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3/14/11 BD

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F 371	Continued From page 13 food on the underside of the mixing arm. The counter below the meat slicer had an accumulation of dried food and debris, and the milkshake blender had dried food on the upper portion of the blending apparatus. In addition, the hood vents above the range were observed to have a thick accumulation of grease and dust. With the exception of the stand mixer, these items remained un-cleaned when observed on 2/9/11 at 2:40 PM. Interview with the dietary manager on 2/9/11 at 2:40 PM verified the equipment was in need of more thorough cleaning. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		
F 426	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 426	The facility will ensure that expired medications are not available for resident use. a. The bottle of ASA 81 milligrams for resident #61 was discarded on 02/08/2011. b. The four 30 milliliter containers of stock guaifenesin were removed from the medication room and returned to pharmacy for disposal on 02/08/2011. c. The bottle of Systane eye drops for resident #25 was discarded on 02/09/2011. d. The jar of Miralax in the East medication room was removed and returned to pharmacy for disposal on 02/11/2011. d. all areas of medication use & storage were checked & any expired medications removed. BD	03/28/2011

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F 425	Continued From page 14 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure expired medications were unavailable for resident use in 3 of 5 medication storage areas. The findings were: According to the facility's policy and procedure entitled "Pharmacy: Outdated Drug Determination" last revised 06/09, expired medications "...will be removed from distribution on or before the last day of the month and year stated." Failure to conform to this policy was identified as follows: a. On 2/8/11 at 4:45 PM observation of the medication cart located on the secure unit revealed a bottle of ASA 81 milligrams for resident # 81 that expired on 11/10. LPN #6 confirmed the expiration date during the observation. b. Four 30 milliliter containers of stock guaifenasin were found in the second floor medication room; they expired on 10/10. At 2:55 PM RN #2 confirmed they were available for resident use. c. A bottle of Systane eye drops with an expiration date of 01/11 was found in the second floor medication room on 2/9/11. At 2:55 PM, RN #2 stated the drops were used for resident #25. d. The East medication room contained a jar of Miralax 17.9 ounces with the expiration date of 07/09 for resident #72. Interview with RN #8 on	F 425	e. All nurses were educated at a nurses staff meeting on 03/02/2011 regarding the requirement to check for and remove any expired medications or biologicals to ensure they are not available for resident use. All pharmacy staff were educated regarding checking expiration dates to assure they are current BW f. A form will be developed to monitor medication storage in medication rooms and carts to ensure expired medications are not available for resident use. This tool will be used by the SDC and DON on a monthly basis to monitor the expiration dates of all medications and biologicals in patient care areas. g. The information obtained from the monthly monitoring will be developed into a QI indicator and reported by the DON on a quarterly basis to the Medication Safety Committee with oversight by the organization-wide QI(P) Committee until resolved. h. The Director of Nursing will monitor.	

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3/14/11 KD

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F 425	Continued From page 16 2/9/11 at 8:30 PM revealed the medication was recently brought in by the resident's family and checked by the facility's pharmacy staff prior to being approved for resident use. During an interview 2/10/11 at 8:58 AM, the DON confirmed expired medications are not to be used. She stated they "...need to be removed."	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except when the facility uses single unit	F 431	The facility will ensure that all medications contain a legible expiration date. 1. Resident #4 is deceased as of 02/18/2011 2. An expiration date will be added by the pharmacist to the jar of Cortamiron 10% and Betamethasone/Dip 0.05% for resident #48. 3. The bottle of Deep Sea Nasal Spray was disposed on 02/10/2011. 4. An expiration date will be added by the pharmacist to the jar of Triamcinolone Cream 0.1% in use for Resident #61. 5. An expiration date will be added by the pharmacist to the unopened jar of Triamcinolone Cream 0.1% for Resident #61. 6. Labels placed on pharmaceutical products will be placed in such as manner as to not cover the manufacturer's expiration date. In the event this is not possible, the expiration date will be written on the label by pharmacy staff prior to dispensing the item. 7. The Pharmacy staff will indicate an expiration date in writing on the label of any compounded product, not to exceed one year of manufacture as indicated by the Pharmacy Compounding log book. or the earliest expiration of any ingredient.	03/25/2011

KD KD KD

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F 431	Continued From page 16 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that medications in 4 of 8 storage areas contained expiration dates. The findings were: 1. Observation of the East medication cart on 2/9/11 at 4 PM showed it contained a 16 ounce jar of Cetaphil Cream for resident #4. Interview with RNs #9 and #4 at that time revealed the medication was currently used by the resident; they confirmed the lack of an expiration date. The RNs acknowledged, that without an expiration date, there was no way to determine if the medication was good. 2. On 2/9/11 at 2:55 PM observation of the second floor medication room revealed a jar of Crotamiton 10% and Betamethasone/Dip 0.05% for resident #48. During the observation RN #2 stated the medication was a compound mixed by the pharmacy. She confirmed the lack of an expiration date and verified it was available for the resident's use. 3. At 2:55 PM on 2/9/11 observation of the second floor medication room revealed a bottle of Deep Sea Nasal Spray without a visible expiration date. The lack an expiration date was confirmed by RN #2 at the time of the observation. 4. Observation of the secure unit medication cart	F 431	8. The Registered Pharmacist will conduct monthly inspections of all labels on drug containers and/or the containers themselves to ensure that an expiration date is visible and the drug is within useable date. 9. The Registered Pharmacist will conduct monthly reviews of all drug use or storage areas and correct or remove any items with missing or expired expiration dates. 10. The information regarding monthly reviews of all drug use and storage areas will be reported to the organization-wide QI/PI Committee on a quarterly basis by the Chief Pharmacist until resolved. 11. The Registered Pharmacist will monitor and be responsible for compliance.	

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3/14/11 KS

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F 431	Continued From page 17 on 2/8/11 at 4:45 PM showed a jar of Triamcinolone Cream 0.1% for resident #01 that did not have an expiration date. LPN #6 stated the medication was used when needed. 5. Observation of the East medication room on 2/8/11 at 3:40 PM revealed an unopened jar of Triamcinolone Cream 0.1% for resident #01. This jar also lacked an expiration date, and RN #8 confirmed the lack during the observation.	F 431		