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 _____	02/02/2012

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

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADL: Activities of Daily Living CAA: Care Area Assessment CNA: Certified Nurse Aide DON: Director of Nursing IDT: Interdisciplinary Team LPN: Licensed Practical Nurse MDS: Minimum Data Set RD: Registered Dietitian RN: Registered Nurse 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 176 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, staff interview, and medical record review, the facility failed to prevent 1 of 10 residents (#48) observed during medication passes from self-administering medications. The resident had been determined unsafe to self-administer medications. The findings were: Observation on 2/1/12 showed RN #1 administered medications for resident #48 at 11:50 AM while in the second floor dining room. After setting the medication cup down in front of the resident, the RN turned and walked back to	F 176	1. The facility will continue to ensure that residents do not self administer medications unless they have been determined to be safe to do so. 2. Resident #48 will be reassessed for safety in self administering of medications. The resident's electronic medication administration record (EMAR) and care plan will be revised as necessary to accurately reflect the results of the safety assessment. 3. The medication self-administration assessments of all residents will be reviewed to ensure they accurately meet the needs of the residents, and their EMARs and care plans documented with the appropriate information. 4. Facility nurses will be educated by the Staff Development Coordinator and the Director of Nursing regarding the process for determining which residents are safe and unsafe to self-administer medications.	03/18/2012

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

Jan Kyncl NHA — Administrator — 02/24/2012

RECEIVED
WY Dept of Health
FEB 27 2012
Healthcare Licensing and Surveys

Refer to Page 2.

3/8/12

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F 176	Continued From page 1 the medication cart where she resumed preparing medications for other residents. When asked if the resident had been assessed and care planned for self-administration, the RN stated she knew the resident was care planned to take medications independently. Review of the current care plan showed self-administration of medications was not included. Furthermore, according to the facility worksheet, "LTCC Med Admin Eval Tool" dated 6/6/11, the facility answered 'Yes' to the question "Unsafe for pre-poured medication, must be observed" and 'No' to "Can manage medication without supervision", thus determining that the resident was unsafe to self-administer medications.	F 176	5. A Quality Improvement/Performance Improvement (QI/PI) indicator will be developed to monitor the accuracy of and compliance with residents' ability to self-administer medications, and the results reported on a quarterly basis to the Medication Safety Committee with oversight by the organization-wide QI/PI Committee. 6. The Director of Nursing will monitor.	
F 248 SS=E	483.15(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, staff interview and review of CNA flowsheets, the facility failed to provide an ongoing program of activities designed to meet individual interests and improve or maintain the physical, mental and psychosocial well-being of residents residing in 1 of 3 resident areas (secure unit). The findings were: 1. Observation of the secure unit on 1/31/12 showed the following concerns related to lack of meaningful, life-enhancing activities:	F 248	1. The facility will continue to ensure that an on-going program of activities is provided to meet the individual interests and improve or maintain the physical, mental and psychosocial well-being of the residents. 2. The activities assessments for all residents in the special care unit, (SCU) including Residents #29 through #43, will be reviewed and revised as necessary to reflect the residents' current activities needs. #29, #31, #32, #33, #34, #35, #36, #37, #38, #39, #40, #41 3. The nursing staff assigned to the SCU will be educated by the Activities Coordinator and the Director of Nursing regarding providing activities and documentation of the residents' response to the activity.	03/18/2012

This POC accepted on 2/8/12 between Jeanne Kaiser-Administrator and Tony Mallory with agreed to changes and a DOC of 2/18/12.

2/8/12

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F 248	Continued From page 2 a. At 9:45 AM six residents were sitting in the dining room. Residents #39, #37 and #33 were aimlessly moving puzzle pieces around while resident #36 watched them. Residents #31 and #40 were sleeping. b. At 10:40 AM eight residents were siting in the dining area. Five residents were sitting at the tables with nothing to do. Resident #37 continued to move puzzle pieces around. Resident #33 wandered in the hallway. c. At 10:55 AM, residents #43 and #38 sat in the lounge area with the television on; however, they were not engaged in watching the program. d. At 11:25 AM, after a period of one and three fourth hours of staff not engaging the residents in activities, the CNAs started setting up for lunch. 2. Lack of activities were observed again at 4:15 PM on 1/31/12. At that time, twelve residents were just sitting in the lounge. Of those twelve, resident #35 was sleeping, residents #30 and #29 were looking around, and resident #44 started wandering in the hallway. At 4:35 PM residents #32, #37, and #43 were wandering in the hallway. 3. Observations on 2/1/12 revealed the following: a. At 2:10 PM eight residents were sitting in the lounge with the television on, but five of them, residents #34, #35, #32, #31, and #39, were sleeping. The other three were just looking around instead of watching the program. b. At 2:25 PM resident #36 was sitting in the lounge. After eating a snack, the resident started to wander with resident #37 and went into the room of resident #38. At that same time resident #43 was wandering with his/her walker	F 248	4. A calendar with daily activities for the SCU will be developed by the Activity Coordinator and posted in the SCU. The activities posted will be provided by the SCU nursing staff and/or the Activity Department staff as determined on a daily basis. The residents' activity participation and response will be documented daily by nursing and/or Activities staff, and summarized on a quarterly basis by Activities staff in the resident's electronic medical record. 5. A QI/PI indicator will be developed to monitor the provision and documentation of activities in the SCU. The results of this monitoring will be reported to the organization-wide QI/PI Committee on a quarterly basis. 6. The Administrator will monitor.	

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F 248	Continued From page 3 through the hallway and dining area. c. At 2:55 PM resident #44 wandered in the hallway and started to take clothes from a clothes rack located in the hallway. 4. During an interview on 1/31/12 at 4:50 PM, CNA #1 stated resident activities were supposed to be documented on the computer, but this was not always done. Further, she stated sometimes the activities were documented on the CNA flowsheets located on top of a filing cabinet in the break room. Review of the available January CNA flowsheets on 1/31/12 at 6:15 PM showed there was no documentation for activities. During an interview on 2/2/12 at 9:10 AM, CNA #2 revealed the CNAs on the special care unit determined the daily activities for the residents. She stated the CNAs had not received formal training for activities. 5. During an interview on 2/2/12 at 8:05 AM, the activities director stated activities for the secure unit were only scheduled once a week by the activity staff, and the exercise session, scheduled three times a week by other personnel, was not consistently provided. She stated documentation for activities was "sparse" and the current computer system was difficult to navigate. The activities director stated resident attendance was documented, but not the resident's response to the activity. The activities director confirmed the CNAs had not received additional training for activities. She further stated there was no coordination of the activities provided by the activities department and the CNAs. Finally, the director acknowledged that a system for determining residents' activities needs based on individualized activity assessments had not been	F 248		

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F 248	Continued From page 4 implemented.	F 248		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of an infection control risk assessment for an ongoing floor replacement project, the facility failed to maintain a clean environment for 1 of 3 resident units (second floor). The findings were: A tour of the second floor common areas and hallways on 2/1/12 at 1:25 PM revealed a layer of dust covering handrails, window frames, and other horizontal surfaces. Sampling the dust on the handrail showed it to be off-white in color, with a slightly abrasive texture when rubbed between the fingers. A floor replacement project was in progress and black plastic sheeting was hung floor-to-ceiling on either end of the work area. However, the sheeting was not attached along either of its sides, and dust was observed to accumulate most heavily in those areas adjacent to the openings in the barrier. A second tour of the second floor was conducted with the infection control nurse and administrator on 2/1/12 at 1:55 PM. Both staff members acknowledged dust was present; the administrator stated at this time that	F 252	1. The facility will continue to provide a safe, clean, comfortable and homelike environment. 2. The second floor areas affected by the dust from the floor replacement project were thoroughly cleaned on 02/01/2012. 3. An Infection Control Risk Assessment (ICRA) will be completed by the infection control nurse on any area where work is being completed that could affect the residents' environment, and the ICRA will be complied with by all contractors and staff members. 4. Rounds will be made by the infection control nurse or the environmental services supervisor on each day that work is proceeding in areas that directly affect the residents' environment, to ensure the requirements of the ICRA are in compliance. 5. The infection control nurse and the Plant Operations Director will make quarterly environmental rounds throughout the facility to ensure the environment is maintained in a safe and clean manner. 6. A QI/PI monitor will be developed to monitor the results of findings from the environmental rounds, and the results reported to the Environment of Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 7. The Plant Operations Director will monitor.	03/02/12

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F 252	Continued From page 5 housekeeping would be sent to the second floor to clean the hallways and common areas. Subsequent observation on 2/1/12 at 5:12 PM revealed the second floor kitchen had uncovered dinner plates in a plate warmer adjacent to the food serving area. The food serving room had two doors, one of which opened to the area where flooring was being replaced. The topmost dishes in the warmer were observed to be covered with a fine layer of dust, similar in appearance and texture to the dust observed earlier in the hallway. A surveyor pointed out the dirty plates to dietary aide #1 and she removed them from the serving line. A copy of an infection control risk assessment (ICRA) for the floor replacement project was provided by the infection preventionist on 2/2/12 and reviewed the same day at 9:35 AM. The ICRA identified dust abatement as a priority and required dust barriers to seal dust and debris from non-work areas.	F 252		
F 272 SS=E	483.20(b)(1) 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 resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272	1. The facility will continue to provide a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. 2. The assessments for residents #14, #19, #26, #41, and #47 will be reviewed and updated in the electronic medical record to accurately reflect the residents' current functional capacity.	03/18/2012

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F 272	Continued From page 6 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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records, and resident and staff interviews, the facility failed to provide comprehensive assessments in a variety of areas for 5 of 15 sample residents (#14, #19, #26, #41, #47). The findings were: Reference: The Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, October 2011, "Review a triggered	F 272	3. A template will be developed that includes all of the required aspects of the comprehensive assessment, and as completed on each resident within the required time frames, the information will be transferred to the electronic medical record. 4. A comprehensive post-fall assessment will be developed to ensure that all factors related to a resident's fall are addressed and the information reflected in the resident's electronic medical record. 5. The completion and accuracy of comprehensive assessments will be developed into a QI/PI indicator, and a representative sampling of residents will be reviewed each month by the Director of Nursing, and the results reported to the Medicine/Critical Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 6. The Director of Nursing will monitor.	

7/18/12

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F 272	Continued From page 7 CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions... This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in the MDS data...Use the information gathered thus far to make a clear issue or problem statement." 1. Review of the 7/19/11 MDS assessment revealed resident #14 required comprehensive assessments for cognitive loss, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, dehydration/fluid maintenance, pressure ulcers, and psychotropic drug use. According to Section V (CAA Summary), the comprehensive assessment for cognitive loss was included in the 7/13/11 social service note; comprehensive assessments for the remaining areas were listed as located in nursing notes dated 7/19/11. Review of the itemized notes showed they failed to address the causes and contributing factors for each area. In addition, none addressed how the resident was impacted by the triggered areas. Furthermore, the area of ADLs was not assessed at all. On 2/2/12 at 10:25 AM the MDS coordinator stated she "missed" the ADLs, and she confirmed the other assessments were not comprehensive. 2. Review of the 1/31/12 admission MDS assessment was conducted on 2/1/12 for resident #19. This review showed comprehensive assessments were required for ADL functional/rehabilitation potential, pressure ulcers, urinary incontinence, psychosocial wellbeing,	F 272		

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F 272	Continued From page 8 falls, dehydration/fluid maintenance, and psychotropic medication use. According to Section V, all listed comprehensive assessments were located in nursing notes dated 1/30/11. Review of that information showed the facility failed to analyze the data to determine why each triggered area was or was not a problem impacting the resident. 3. Observation on 2/1/12 at 11:10 AM showed resident #26 had a dressing on the little finger side of the right hand. While conversing with the resident at that time, s/he stated the dressing was the result of an injury sustained during a fall on 1/29/12. Review of the 1/29/12 nursing note and the tracking record confirmed the resident did fall. According to the 10/17/11 comprehensive and 1/17/12 quarterly MDS assessments, the resident was not cognitively impaired, required limited assistance with transfers, and was at risk for falls. However, since the resident had not fallen, a comprehensive assessment had not been completed. Review of the nursing documentation completed after the fall on 1/29/12 showed no evidence the resident was asked how the fall occurred or about side effects from the recently started antidepressant. On 2/1/12 at 5:27 PM the resident stated s/he got up to try to go to bed and the wheelchair slid backwards as s/he had not locked the brakes. The administrator stated in an interview on 2/1/12 at 5:25 PM that post-fall assessments were included in the IDT notes. Review of that note dated 1/31/12 showed the resident's fall on 1/29/12 occurred at 9:30 AM; the assessment revealed the following deficient practice: a. The documentation indicated the resident was found on the floor near the foot of	F 272		

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F 272	Continued From page 9 the bed, was started on an antidepressant on 1/17/12, and the alarm did not sound. This note provided no evidence the cognitively intact resident was interviewed to determine what happened, if s/he suffered lethargy or dizziness before or during the fall, whether or not the alarm was in use, or whether the wheelchair was locked. b. The documentation indicated the resident was independent with transfers. There was no explanation of the discrepancy with the 1/17/12 assessment where the resident required limited assistance. c. Despite the resident's fall, the facility's plan was to "observe for improvement or continued symptoms." d. On 2/2/12 at 10:18 AM, the MDS coordinator stated the IDT determined the fall was an isolated event and there was no need to revise the care plan. However, she acknowledged there was no evidence a comprehensive post-fall assessment had been conducted and, therefore, no way to justify their decision. 4. Review of the medical record for resident #41 showed the resident received a non-displaced basicervical femur fracture when s/he fell at the facility on 12/29/11. Review of the 1/2/12 MDS assessment, comprehensive assessments for the triggered areas and the CAA summary showed no assessment of the causes and contributing factors regarding the resident's fall. On 2/2/12 at 10:35 AM the MDS coordinator stated staff were required to complete a comprehensive assessment/post-fall assessment after all falls, but it was "missed" this time. 5. Review of the 1/10/12 admission MDS	F 272		

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F 272	Continued From page 10 assessment revealed resident #47 required comprehensive assessments for urinary incontinenc/ indwelling catheter. According to Section V (CAA Summary), the comprehensive assessment for urinary incontinence/indwelling catheter was included in the nursing notes dated 1/17/12. Review of the itemized notes showed none addressed how the resident was impacted by this triggered area, and causes and contributing factors were not addressed.	F 272		
F 278 SS=C	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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 assessment.	F 278	1. The facility will continue to ensure that the signatures of the individual assessors were completed prior to the Registered Nurse (RN) coordinator's signature, certifying overall completion of the Minimum Data Set (MDS) assessment. 2. At the time of the next MDS assessment for Residents #3, #10, #14, #16, #19, #26, #35, #37, #38, #41, #42, #47, #58, #76, and #77, the RN coordinator for the MDS assessments will certify the overall completion of the MDS by signing the document after the other individual assessors have completed their portions. 3. Each MDS team member will print the first page of the MDS on the day they complete their portion, sign and date it and turn it in to the MDS Coordinator. The MDS Coordinator will review all of the information submitted by the individual assessors, and sign the MDS, certifying its overall completion.	03/18/2012

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F 278	Continued From page 11 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 ensure the signatures of individual assessors were completed prior to the RN coordinator's signature, certifying overall completion of the MDS assessment, for 15 of 15 sample residents (#3, #10, #14, #16, #19, #26, #35, #37, #38, #41, #42, #47, #58, #76, #77). Specific evidence where signatures would either have to be dated after the completion date or backdated included residents #19 and #26. The findings were: 1. Review of the 1/17/12 quarterly MDS assessment for resident #26 showed the signature date of the RN coordinator at Z0500B was pre-printed by the computer as 1/17/12. However, the coordinator's signature was lacking, as were the signatures of the other assessors. Therefore, when signed, the signatures would be backdated, an unacceptable practice per the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0, October 2011, or dated after the completion date. 2. According to the face sheet, resident #19 was admitted on 1/18/12, thus requiring that the admission MDS assessment be completed by 1/31/12. When the MDS was requested on 2/1/12 at 9:30 AM, unit secretary #1 immediately called the MDS coordinator. The secretary reported the coordinator had the MDS assessment in her office awaiting signatures from all the assessors.	F 278	4. A QI/PI indicator will be developed to monitor the final signature of the MDS Coordinator certifying that the MDS is complete. A representative sampling of the MDS's completed each month will be reviewed by the Director of Nursing, and the results reported to the Medicine/Critical Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 5. The Director of Nursing will monitor.	

2/18/12

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	535027	A. BUILDING _____ B. WING _____	02/02/2012

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F 278	Continued From page 12 When the assessment was later produced, the coordinator's signature signifying completion was dated 1/31/12 at Z0500B; however, signatures of those assessors completing various sections were lacking. 3. During an interview on 2/2/12 at 9:45 AM, the MDS coordinator stated the computer automatically generated the date the MDS was printed, and she signed each assessment that day. However, the other assessors had not yet signed the assessment and might not do so for several days. The coordinator stated they either dated their signature when signed or backdated it. She was unaware that her dated signature indicated the entire assessment was complete and that late or backdated signatures were not acceptable. The MDS coordinator further stated this process was utilized for signing every resident's assessments.	F 278		
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	F 279	1. The facility will continue to ensure that the results of required assessments are used to develop, review and revise the resident's comprehensive plan of care. 2. The care plan for Resident #38 will be revised to address a comprehensive plan of care for the resident's dental needs. 3. The care plan for Resident # 42 will be revised to address a comprehensive plan of care for communication and comfort care. 4. The care plan for Resident #47 will be revised to address a comprehensive plan of care for the resident's depression, anxiety, and aggressive behaviors.	03/18/2012

3/8/12

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F 279	Continued From page 13 §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 medical record review and staff interview, the facility failed to develop comprehensive care plans in various problematic areas for 3 of 15 sample residents (#38, #42, #47). The findings were: 1. Review of Section V of the 12/2/11 significant change MDS assessment for resident #38 showed a comprehensive care plan was to be developed for dental care. Review of the care plan last reviewed on 12/1/11 showed only that the resident was "not wearing my dentures very much." After review of the care plan with the with the MDS coordinator on 2/2/12 at 10 AM, she acknowledged there was not a comprehensive care plan for dental care. 2. Review of Section V of the 12/8/11 annual MDS assessment showed a comprehensive care plan was to be developed for communications for resident #42. Review of the care plan that was last updated on 1/13/12 only showed under behaviors, "It takes me a long time to say what I'm thinking." In addition, review of the 11/24/11 physician orders showed the resident was on comfort care. Review of the care plan did not show the resident was on comfort care. During review of the resident's care plan with the MDS coordinator on 2/2/12 at 10 AM, she	F 279	5. Each resident's care plan will be reviewed on at least a quarterly basis and revised with any change in the resident's needs or significant change in condition to assure there is a comprehensive plan of care that accurately reflects each resident's status. 6. A QI/PI indicator will be developed to monitor the accuracy of care plans to meet the resident's needs based on the comprehensive assessment. A representative sampling of the care plans will be reviewed on a monthly basis, and the results of the monitoring will be reported to the Medicine/Critical Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 7. The Director of Nursing will monitor.	

3/8/12

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F 279	Continued From page 14 acknowledged there was not a comprehensive care plan for communication or comfort care. 3. Review of the 1/4/12 admission MDS assessment and care plan, revised 1/26/12, showed resident #47 was assessed as having depression, anxiety, and aggressive behaviors. Further review showed the only care planned interventions for these problems were to administer Haldol, Lexapro, Ambien and Klonopin, and "drug and behavior and medication review team schedule set up." On 2/2/12 at 10:35 AM the MDS coordinator stated the interventions did not adequately address the identified problem.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	1. The facility will continue to ensure that each resident's care plan is reviewed and revised to accurately reflect the resident's status. 2. The care plan for resident #19 will be reviewed and revised to include interventions for staff to provide to assist in meeting the resident's needs, including bed elevation, depression, and activities. 3. The care plan for resident #26 will be reviewed and revised to include an intervention for pet therapy and any other activities determined appropriate by assessment. 4. The care plan for resident #38 will be reviewed and revised to reflect the resident's current medication regimen. 5. The care plan for resident #42 will be reviewed and revised to reflect the resident's current medication regimen.	03/18/2012

3/16/12

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F 280	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure staff reviewed and revised the care plan to accurately reflect each resident's status for 4 of 15 sample residents (#19, #26, #38, #42). The findings were: 1. Observation on 1/31/12 at 9:15 AM showed CNA #3 assisted resident #19 to bed. The head of the resident's bed was elevated thirty degrees, and a sign over the bed instructed staff to keep the head of the bed at that angle. However, according to the resident's care plan, staff were to keep the head of the bed at a ninety degree angle. In addition, further review of the care plan showed interventions for depression and activities were lacking. On 2/2/12 at 9:45 AM the MDS coordinator stated she forgot to add "when eating" after the instructions to keep the bed elevated at ninety degrees. She confirmed the care plan needed to be revised to include interventions for staff to provide to assist in meeting the resident's needs. 2. Intermittent observation on 2/1/12, but specifically at 11 AM and 5:18 PM, showed resident #26 seated in a wheelchair in the corridor outside his/her room. Review of the care plan showed the resident was "used to living alone" but did "like to visit." The care plan also indicated the resident had a pet dog. Interventions to address the residents possible need to visit or see animals, particularly dogs, were lacking. Interview with the activity director on 2/2/12 at 8:15 AM revealed the activity staff	F 280	6. Each resident's care plan will be reviewed on at least a quarterly basis and revised with any change in the resident's needs or significant change in condition to assure there is a comprehensive plan of care that includes interventions required for staff to meet the resident's needs. 7. A QI/PI indicator will be developed to monitor that care plans include appropriate interventions to meet the resident's needs. A representative sampling of the care plans will be reviewed on a monthly basis, and the results of the monitoring will be reported to the Medicine/Critical Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 8. The Director of Nursing will monitor.	

3/8/12

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F 280	Continued From page 16 stopped to visit a couple of times a week, otherwise, there was "not much" for activities. She acknowledged the care plan could be improved. 3. Random observations on 1/31/12 and 2/1/12 showed resident #38 drooled after eating or drinking. Review of a nurse/physician communication note dated 1/9/12 showed the medication Levsin was ordered to control the resident's drooling and the nurse requested the medication to be given twice a day. Review of the 1/10/12 physician's orders showed Levsin was ordered as requested by the nursing staff. The resident's care plan was not updated to reflect the new treatment for his/her drooling. Further, the resident's care plan showed the resident was on the medication Namenda (used for Alzheimer's dementia). Review of the active medication schedule dated 2/1/12 showed the resident was not currently receiving Namenda. An interview with the MDS coordinator on 2/2/12 at 10 AM confirmed the resident's care plan was not updated to show the current medication regimen. 4. Review of the care plan last updated on 1/13/12 for resident #42, showed the resident was taking Valium and Paxil daily for behaviors. In addition, the care plan for pain showed the resident had chronic pain due to arthritis and previous fractures and had Vicodin ordered routinely and as needed. Further review of the care plan for special needs/treatments showed the following medications were discontinued: Paxil, Vicodin, Valium and Duonebs. During an interview with the MDS coordinator on 2/2/12 at 10 AM, she acknowledged medications that were no longer in use needed to be indicated	F 280		

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F 280	Continued From page 17 throughout the care plan to remove inconsistencies in the resident's plan of care.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and resident interviews, the facility failed to ensure the coordination of care for 1 of 1 sample residents (#38) receiving hospice care. In addition, the facility failed to monitor the effectiveness of pain medication for 1 of 1 sample resident (#47) treated for pain. The findings were: 1. Review of the medical record for resident #38 showed s/he had diagnoses to include chronic obstructive pulmonary disease and thoracic malignancy (cancer). Review of the 11/17/11 physician's orders for the resident showed s/he was referred to hospice for comfort care. Review of the 1/23/12 hospice nursing notes showed the resident required assistance with meals. Further, DuoDerm was placed on the resident's toes due to redness caused by his/her shoes. The nursing staff was to assess the resident's toes for redness to determine if the DuoDerm was effective in protecting the skin. Review of the resident's care plan last updated on 12/1/11,	F 309	1. The facility will continue to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 2. The care plan for resident #38 will be reviewed and revised to address needs identified by the hospice service, to ensure there is a coordinated plan of care for the resident. 3. The care plan for resident #47 will be reviewed and revised to address pain management needs, an intervention added to ensure that the resident's pain is regularly assessed and that the effectiveness of pain medication is documented in the resident's electronic medical record. 4. The nursing staff will be educated regarding the requirement to document on each resident's care plan and in the electronic medical record all interventions required to meet the resident's care needs, and the resident's response to those interventions.	03/18/2012

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F 309	Continued From page 18 showed it did not reflect the needs of the resident identified by the hospice nurse. This review showed s/he was to be assisted with meals as needed. Further review showed the resident "may wear a reg [regular] shoe on R [right] foot" per podiatry, the entry was dated 3/25/11. The care plan review also showed there was no coordinated plan of care developed to identify the care and services the facility and hospice would each provide. During an interview with the MDS coordinator on 2/2/12 at 10 AM, she stated she was not aware that a care plan needed to be developed for residents who were transferred to hospice. 2. Review of the 1/4/12 physician's admission orders for resident #47 showed orders for one to two Vicodin every four hours as needed for pain. Review of the 1/10/12 admission MDS assessment showed the resident had pain frequently, making it hard to sleep and limiting daily activities. Review of the January and February 2012 MAR showed the resident received one to two Vicodin, two to three times daily. According to the policies and procedures, entitled "Pain Management", revised 11/1/00, staff were to record pain intensity and response to interventions on the MAR- Pain Assessment sheet. Review of the January and February 2012 nursing nursing showed the nurses did not consistently assess the resident's pain prior to administering the medication and documented follow up assessments of effectiveness were lacking. Interview on 2/1/12 at 6 PM with RN #1 revealed the nurses did not document pain medication effectiveness for residents who had chronic pain like resident #47. During an interview on 2/1/12 at 6:10 PM, RN #4 stated the nurses	F 309	5. A QI/PI indicator will be developed to monitor that care plans include appropriate interventions to meet the resident's needs, and that the resident's response to interventions are documented in the electronic medical record. A representative sampling of the care plans and nursing documentation will be reviewed on a monthly basis to ensure they are consistent with each other. The results of the monitoring will be reported to the Medicine/Critical Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 6. The Director of Nursing will monitor.	

3/8/12

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F 309	Continued From page 19 were expected to perform the pre and post assessments for residents with chronic pain as they did for residents with acute pain. Interview with the resident on 2/1/12 at 4:30 PM revealed sometimes the pain medications effectively relieved his/her pain and sometimes it didn't, but the nurses never returned to see whether or not the medication helped.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 and staff interview, the facility failed to ensure 2 of 2 sample residents (#10 and #14) who required ADL assistance received assistance to perform hand hygiene prior to eating during 2 of 2 meal observations. The findings were: 1. Observation on 1/31/12 at 8 AM and 11:50 AM showed resident #14 self-propelled his/her wheelchair to the dining room. The resident used one foot to move forward and the right hand to guide the wheelchair tire when changing directions. On 2/1/12 at 5:15 PM the resident was again observed while self-propelling him/herself to the dining room utilizing the same technique. Further observation showed the resident was not provided with any type of hand hygiene prior to the meal.	F 312	1. The facility will continue to ensure that a resident who is unable to carry out activities of daily living (ADL's) receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 2. Resident #14 will be provided hand hygiene prior to and after meals. 3. Resident #10 will be provided hand hygiene prior to and after meals. 4. All residents will be offered hand hygiene prior to and after meals. 5. All staff will be educated regarding the requirement that all residents who are unable to perform their own ADL's are provided with assistance to perform hand hygiene prior to and after meals.	03/18/2012

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F 312	Continued From page 20 2. Observation on 1/31/12 at 7:50 AM during the breakfast meal and again at 5:45 PM at the dinner meal showed resident #10 rolled his/her wheelchair from the unit to the East dining room. The resident propelled his/her chair with his/her left arm, placing his/her left hand in contact with the tire and pushing it forward. Once at his/her table position, the resident was served food by facility staff and assisted in positioning his/her clothing protector, napkin, and utensils. However, on neither occasion did staff offered to wash the resident's hands prior to eating or after s/he completed his meal. 3. Observation on 1/31/12 at 8 AM and again at 11:50 AM showed resident #14 self-propelled his/her wheelchair to the dining room. The resident used one foot to move forward and the right hand to guide the wheelchair tire when changing directions. On 2/1/12 at 5:15 PM the resident was again observed while self-propelling him/herself to the dining room utilizing the same technique. Further observation showed the resident was not provided with any type of hand hygiene prior to any of the meals. 4. Further observation from 5:15 PM through 6:10 PM on 2/1/12 showed none of the residents in the East dining room were provided with hand hygiene prior to, or during, the evening meal. 5. The Infection preventionist acknowledged in interview on 2/1/12 at 10:45 AM that hand hygiene prior to eating was important and required of staff. She added that hand hygiene for residents was supposed to be done after each meal, but hand washing prior to eating had been	F 312	6. A QI/PI indicator will be developed to monitor the provision of hand hygiene to dependent residents prior to and after meals. The Director of Nursing and/or Staff Development Coordinator – RN will observe at least five (5) dining times each week, and the results of the monitoring will be reported to the Infection Control Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 7. The Director of Nursing will monitor.	

2/8/12

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F 312	Continued From page 21 overlooked.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM 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 consistently evaluate and monitor medications for unnecessary drug use for 1 of 13 sample residents (#47). The findings were:	F 329	1. The facility will continue to ensure that medications are consistently evaluated and monitored so that each resident's drug regimen is free from unnecessary drugs. 2. The Registered Pharmacist will conduct a comprehensive drug regimen review of resident #47 and make recommendations to the resident's attending physician regarding a warranting diagnosis for each medication, therapeutic outcomes for each medication, recommended ways to reduce medications to lowest therapeutic dose, and adverse reactions and/or side effects of the medications. 3. All residents' medication regimens will be reviewed by the Registered Pharmacist on a monthly basis and recommendations made to the attending physician as outlined in item #2 above for this tag. 4. A daily intervention will be entered into the electronic medical record by the nursing staff for resident #47 to include the response to medications and any noted side effects. 5. The care plan for each resident being reviewed by the monthly Medication Review Team (MRT) will be reviewed at the meeting and updated to reflect any additional interventions related to diagnoses being treated with psychoactive medication.	03/18/2012

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F 329	Continued From page 22 Review of the 1/4/12 physician's admission orders for resident #47 showed orders for Haldol (antipsychotic medication) two milligrams (mg) at bedtime, Lexapro (antidepressant) twenty mg daily, Ambien (medication for sleep) ten mg at bedtime when necessary, and Klonopin (anxiolytic medication) one mg at bedtime when necessary. Review of the 1/4/12 physician's orders, 1/4/12 admission MDS assessment, and 1/26/12 revised care plan showed the resident's diagnoses included depression with anxiety and aggressive behavior. Review of the care plan also showed the only interventions for these problems were to administer Haldol, Lexapro, Ambien and Klonopin, and "drug and behavior and MRT [medication review team] schedule set up". Review of the January 2012 MAR showed the resident received the prescribed doses of Haldol, Lexapro, Ambien, and Klonopin everyday. Review of the policies and procedures #358, revised April 2000, showed the following: The DON will monitor the use and side effects of psychoactive medications and the reason for use. Upon recognizing a specific behavior that does/or could adversely affect the resident, staff will start a behavior monitor form and place it in the MAR notebook. The nurse assigned to the patient will be responsible for knowing and documenting each resident's behavior on the behavior monitor form each shift. The pharmacist will monitor and document the use of psychoactive drugs and the reason for their use in the monthly consulting review. Review of the nursing notes revealed the following information: On 1/6/12, the resident was restless during the night and activated the motion	F 329	6. All residents on psychoactive medications will have an intervention entered into their electronic medical record to monitor for response, complications, or adverse consequences, to support decisions for continuing, modifying, or discontinuing the medications. 7. A QI/PI indicator will be developed by the Registered Pharmacist to monitor the drug regimens of each resident, and the results reported to the organization-wide QI/PI Committee on a quarterly basis. 8. The Director of Pharmacy will monitor.	

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F 329	Continued From page 23 sensor countless times by leaning up in bed. Documentation on 1/10/12," review of situations surrounding multiple falls...has been taking Haldol at HS [bedtime] scheduled and Klonopin and Ambien at HS, PRN... also on Lexapro. There is concern that [s/he] may not need all three products at HS...sleeping too much and had been observed to be lethargic." On 1/11/11 staff "advised resident of possibility of continued inappropriate behaviors, i.e.: calling the staff for mere pleasure of seeing them run could lead to a transfer to another facility and/or discharge from this facility." On 1/13/12 the CNA reported the resident had been verbally abusive and demanding. On 2/1/12 the documentation showed "...[the resident] sleeps most of the day and the night...family reports resident says staff are conspiring against [him/her]..." The following concerns regarding the lack of ongoing monitoring and assessment for unnecessary drug use were identified: a. Review of the medical record showed no evidence of a psychiatric diagnosis to support the use of the Haldol. On 2/1/12 at 5:30 PM, the MDS coordinator confirmed the lack of a psychiatric diagnosis. b. Interview with the DON on 2/1/12 at 4 PM revealed the resident's medications had not been reviewed by the medication review team because the next meeting was not scheduled until February 2012. c. Interview with pharmacist #1 on 2/2/12 at 10:50 AM revealed the monthly consulting review that he completed on 1/10/12 had not been completed as it should have been. He stated the review did not include a warranting diagnosis for each medication, therapeutic outcomes for each medication, recommended ways to reduce	F 329		

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F 329	Continued From page 24 medications to lowest therapeutic dose, adverse reactions and/or side effects of the medications. Review of the 1/10/12 monthly consulting review confirmed the pharmacist's statement. d. Review of the January and February 2012 drug and behavior monitoring documentation showed staff were collectively monitoring antipsychotic, antidepressant and antianxiety medications for anxiety, delusions, verbal abuse, insomnia and irritability. Further review of this documentation showed the identified behaviors were "not displayed" on seven days in January 2012, but documentation was lacking for 1/5, 1/7, 1/8, 1/9, 1/10, and 1/12 -1/25/12. This review showed no evidence staff were monitoring the Haldol, Lexapro, Ambien and Klonopin for response, complications, or adverse consequences to support decisions for continuing, modifying, or discontinuing the medications. e. Interview with the MDS coordinator on 2/1/12 at 5:30 PM revealed the facility's drug and behavior monitoring system consisted of drug categories and identified behaviors, but did not identify or link specific behaviors with Haldol, Lexapro, Ambien and Klonopin. She stated staff did not know when or why the medications were started prior to admission to the facility. She also stated staff had not developed plans for reducing psychoactive medication use or implemented approaches for behavior management for this resident.	F 329		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356	1. The facility will continue to ensure that the required nurse staffing is posted at the beginning of each shift on a daily basis	03/18/2012

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F 356	Continued From page 25 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the required nurse staffing data at the beginning of each shift in 1 of 1 locations where the information was posted. The findings were: Observation on 2/1/12 at 3 PM showed staffing data was already posted for all three shifts.	F 356	2. Any changes that occur after the nurse staffing is posted will be documented on the posting during the shift affected, or prior to the beginning of the next shift if applicable. During hours that the administrative office is not open, these revisions will be made by a charge nurse 3. Charge nurses will be educated by the Director of Nursing regarding the requirements for revising the nurse staffing posting when appropriate to reflect the actual staffing on each shift. 4. A QI/PI indicator will be developed to monitor the accuracy of the required nurse staffing posting, and the results reported to the organization-wide QI/PI Committee on a quarterly basis. 5. The Administrator will monitor.	

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F 356	Continued From page 26 Interview with the administrative assistant at that time confirmed she posted the information. When asked if the night staff revised the information for their shift if the data changed, the administrative assistant reported that she changed it the next day. She reiterated that the night staff did not revise the posted information prior to the beginning of the shift.	F 356		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of policies and procedures, and CNA worksheets, the facility failed to ensure snacks were offered to residents for 7 of 8 days reviewed. The findings were: On 1/31/12 at 2:10 PM in a resident group	F 368	1. The facility will continue to ensure that snacks are offered to all residents at bedtime on a daily basis, and that the snacks will be documented as given or refused per the resident's preference. 2. Nursing staff will be educated by the Director of Nursing regarding the requirement to provide and document bedtime snacks on a daily basis. 3. The Registered Dietitian will review the documentation of snacks on a weekly basis and report the results of the review to the Director of Nursing. 4. A QI/PI indicator will be developed to monitor the provision of bedtime snacks and the results will be reported to the Medicine/Critical Care Committee on a quarterly basis with oversight by the organization-wide QI/PI Committee. 5. The Director of Nursing will monitor.	03/18/2012

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F 368	Continued From page 27 interview, 2 of 9 residents stated snacks were not routinely passed in the evening; these same residents further stated they would like an evening snack. On 2/1/12 at 1:40 PM, CNA worksheets used to record resident snack services were reviewed. For first floor residents, documents were available for the period 12/24/11 through 1/31/12 (8 days) and each day was divided into 3 sections: AM, PM, HS [bedtime]. Of 24 opportunities to provide snacks to 27 residents on the first floor, only 1 (1/25/12, PM) contained entries to document the provision of snacks. Staff were unable to locate similar records for residents on the second floor when requested by a surveyor. Interview with CNA #4 on 2/1/12 at 3:50 PM revealed she was one of the individuals responsible for passing snacks on the first floor. The CNA confirmed her duties included providing snacks to residents, but added she had recently been on vacation. She acknowledged the available worksheets were blank for all days except 1/25/12 and stated this usually happened when staff forgot to take snacks out to the residents. Interview with CNA #5 on 2/1/12 at 4:05 PM identified her as an individual that passed snacks to first floor residents. She stated that residents did not want an evening snack and "...so we don't always offer it [snack] at night." She further stated that missing documentation meant "...someone forgot to give out snacks or didn't write it down." The CNA acknowledged she had not discussed with her supervisor or dietary personnel her	F 368		

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F 368	Continued From page 28 perception that residents did not want evening snacks. Interview with CNA # 6 on 2/1/12 at 4:35 PM identified her as an individual who passed snacks to second floor residents. She stated that staff were supposed to document attempts to give snacks to residents, even when refused, and that missing entries could either be undocumented refusals or no snacks were passed. Interview with RD #2 on 2/1/12 at 3:40 PM identified facility policies and procedures that required staff to pass nutritional snacks to residents three times each day: 10 AM, 2 PM, and 8 PM. The RD stated snacks were to be offered to each resident and documented if accepted or refused. The policy statement further required staff to notify the RD or dietary technician if a resident repeatedly refused the evening snack; this information would be added to the resident's care plan. The RD added she was not aware of residents routinely refusing snacks.	F 368		
F 371 SS=E	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	F 371	1. The facility will continue to ensure that food is stored, prepared, distributed and served under sanitary conditions. 2. The water drain line from the ice machine in the East dining room was modified on 02/17/12 to provide the appropriate air gap from the drain grate. 3. The stainless steel cart in the East dining room was moved away from the alcohol hand rub dispenser on 02/01/12, and the dispenser was relocated on 02/17/12.	03/18/2012

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F 371	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the drain line from 1 of 5 ice machines had an air gap. The facility further failed to ensure 1 of 1 snack carts was maintained in a sanitary location. The findings were: 1. Tour of the facility with the environmental services director on 2/2/12 at 11:05 AM revealed a cooper waste water drain from an ice machine located in the food preparation area of the East dining room emptied beneath a floor grate. The water drain line entered the drain grate and continued below the surface of the floor. The environmental services director acknowledged during the observation that the drain should have an air gap to minimize the risk of waste water being aspirated back into the ice machine. Four other ice machines were observed on tour; each had either an air gap or anti-siphon mechanism in place; the environmental services director stated the ice machine in the East kitchen area was the oldest of the machines still in service and the drain pipe had not been updated with an air gap. 2. Observations on 1/30/12 at 7:15 PM showed a stainless steel cart placed directly beneath a hand hygiene dispenser adjacent to a doorway leading from the food serving area of the East dining room. The top shelf of the cart was loaded with uncovered plates, a white cup holding plastic utensils, and individual serving packages of peanut butter and jelly. The lowest of three shelves held two opened bags of potato chips; neither bag was closed or sealed.	F 371	4. The staff has been advised to not place carts with food products or clean dishes under any hand hygiene stations, and a sign will be posted in that area as a reminder. 5. The drain lines for all ice machines will be checked during environmental rounds on a quarterly basis by the Director of Plant Operations to ensure that each machine has the required air gap or anti-siphon device to prevent backflow of waste water. 6. The location of all carts containing food products or clean dishes will be monitored on a monthly basis by the food service supervisor to ensure that no such carts are placed beneath a hand hygiene station. 7. QI/PI indicators will be developed to monitor the ice machines and location of carts, and the results will be reported to the Environment of Care Committee on a quarterly basis, with oversight by the organization-wide QI/PI Committee. 8. The Director of Plant Operations will monitor.	

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F 371	Continued From page 30 A second observation was made with the long-term care center registered dietitian (RD) #2 on 1/31/12 at 3:10 PM. The cart was still located beneath the hand hygiene dispenser. The RD acknowledged that staff using the hand hygiene product could contact food items on the cart with dirty hands and potentially drip the hand rub product onto plates and open food items. Repeat observations on 1/31/12 and 2/1/12 revealed facility staff continued to place the cart beneath the hand hygiene dispenser. On 2/1/12 at 11:50 AM, two unidentified staff members were observed to use the hand hygiene dispenser; a third individual used the dispenser at 12:10 PM and dripped gel onto the cart surface, a plate, and into a basket holding peanut butter packages. The RD #1 stated in interview on 2/1/12 at 2:20 PM the cart should be moved; she wheeled the cart into the food preparation area. According to Food Code 2009, U.S. Public Health Service: 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.	F 371		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.	F 387	1. The facility will continue to ensure that residents are seen by a physician at least once every 30 days for the first 90 days after admission, and at once every 60 days thereafter.	03/18/2012

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F 387	Continued From page 31 A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a physician assessed 1 of 13 sample residents (#42) every sixty days as required. The findings were: Review of the physician progress notes for resident #42 showed s/he was not seen or examined by a physician from 3/15/11-6/7/11 (76 days), 7/6/11-9/30/11 (112 days) and 9/30/11-12/30/11 (90 days). In an interview with the administrator on 2/2/12 at 2:15 PM, she stated the physician had seen the resident more frequently, but he failed to document his visits in the medical record.	F 387	2. The attending physician for resident #42 has been advised of the requirement for completion and documentation of regular visits to the resident not to exceed 70 days from the previous visit. 3. The facility's Medical Director will remind the medical staff regarding the requirement for documentation of regular 30 or 60 day visits to each resident. 4. Each attending physician will be provided with a monthly report listing the date their resident was last seen and the due date for the next visit. 5. A QI/PI indicator will be developed to monitor the timeliness of physician visits, and the results reported to the organization-wide QI/PI Committee on a quarterly basis. 6. The Administrator will monitor.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 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:	F 428	1. The facility will continue to ensure that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. 2. The drug regimen of resident #47 will have a comprehensive review conducted by a licensed pharmacist and recommendations made to the physician regarding warranting diagnoses for each medication, recommended ways to reduce medications to the lowest therapeutic dose, adverse reactions and/or side effects of the medications.	03/18/2012

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F 428	Continued From page 32 Based on medical reocrd review and staff interview, the facility failed to ensure monthly medication regimen reviews were appropriately completed for 1 of 13 sample residents (#47). The findings were: Review of the 1/4/12 physician's admission orders for resident #47 showed orders for Haldol (antipychotic) two milligrams (mg) at bedtime, Lexapro (antidepressant) twenty mg daily, Ambien (medication for sleep) ten mg at bedtime when necessary, and Klonopin (anxiolytic) one mg at bedtime when necessary. Further review of the 1/4/12 physician's orders showed diagnoses included depression with anxiety and aggressive behavior. Review of the January 2012 MAR showed the resident received the prescribed doses of Haldol, Lexapro, Ambien, and Klonopin everyday. Interview with pharmacist #1 on 2/2/12 at 10:50 AM revealed the monthly consulting review that he completed on 1/10/12 had not been completed as it should have been. He stated the review did not include a warranting diagnosis for each medication, therapeutic outcomes for each medication, recommended ways to reduce medications to lowest therapeutic dose, adverse reactions and/or side effects of the medications. Review of the 1/10/12 monthly consulting review confirmed the above statement.	F 428	3. Each resident will have a drug regimen review conducted by a licensed pharmacist on a monthly basis, and any recommendations for modifications or monitoring will be reported to the resident's attending physician. 4. A QI/PI indicator will be developed to monitor the monthly drug regimen reviews, and the results will be reported to the organization-wide QI/PI Committee on a quarterly basis. 5. The Director of Pharmacy will monitor.	
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	F 431	1. The facility will continue to assure that only authorized personnel will have access to keys for any medication storage areas, and that all drugs and biologicals will have a clearly legible expiration date. 2. Unit secretary #1 was advised that she cannot enter the medication rooms unless directly supervised by a licensed nurse or pharmacist.	03/18/2012

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F 431	Continued From page 33 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 1976 and other drugs subject to abuse, except when the facility uses single unit 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, staff interview, and review of policies and procedures, the facility failed to develop and implement policies and procedures that specified who was authorized to access 2 of 2 medication storage rooms and the medication keys. In addition, random observation showed the manufacturer's expiration dates were obscured on medications for resident #7. The findings	F 431	3. Both medication rooms in the facility were re-keyed on 02/15/12 and the new keys distributed only to authorized medical personnel in nursing and pharmacy. One additional key is stored in the locked narcotic cabinet in the locked East Wing medication room for access only by authorized personnel. 4. A policy will be developed to designate which personnel will be authorized to have access to medication storage areas. 5. Nursing staff will be educated by the Director of Nursing that non-medical personnel shall not be permitted access to medication storage areas without direct supervision by authorized personnel. 6. The labels for the Benefiber and Children's Tylenol for resident #7 will be replaced in a position that will not obscure the manufacturer's expiration dates. 7. Pharmacy staff will be educated by the Director of Pharmacy that all drugs and biologicals must include a clearly legible expiration date, and that any labels applied cannot obscure the expiration date. 8. A QI/PI indicator will be developed to monitor the access to medication storage areas, and the legibility of all expiration dates on medications and biologicals, and the results of the monitoring will be reported to the organization-wide QI/PI Committee on a quarterly basis. 9. The Director of Pharmacy will monitor.	

3/8/12

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	535027	A. BUILDING _____ B. WING _____	02/02/2012

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F 431	Continued From page 34 were: 1. Observation on 1/31/12 at 8:40 AM showed unit secretary #1 was in the East medication room with RN #2. At that time the RN left the room and closed the door, leaving the unit secretary alone in the medication room for ten minutes. During an interview on 2/1/12 at 10:33 AM, the DON stated a nurse had to supervise non-medical staff when they were in the medication rooms, either by physically being present or by leaving the door open for direct observation. The DON further stated charge nurses had keys to the medication rooms, but that the administrative assistant did have an extra key in case one was lost. Finally, the DON stated there were no policies and procedures specifying which personnel had access to the medication keys. On 2/2/12 at 11:05 AM the administrative assistant confirmed she did have access to the key, and at 2:05 PM that day, the administrator stated she also had access. Interview with the pharmacy director and pharmacist #1 and review of policies and procedures on 2/2/12 at 10:30 AM confirmed the lack of a policy specifying who was authorized to have access to the medication room and the keys. The pharmacy director stated this was considered a nursing responsibility as, per the State Board of Pharmacy, nursing staff were responsible for the medication room and the medication carts. Both pharmacists did confirm that it was not a standard of practice for non-medical personnel to have access to the medication room or the keys. 2. Observation on 2/2/12 at 8:55 AM showed new containers of medications stored in the east	F 431		

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F 431	Continued From page 35 medication storage room included Benefiber and Children's Tylenol for resident #7. Review of the labels showed expiration dates were missing as the pharmacy labels did not include those dates. At 9:10 AM that day, RN #2 verified the absence of expiration dates. However, he compared the containers with others by the same manufacturer and found that the labels applied by the facility's pharmacy covered the manufacturer's expiration dates. On 2/2/12 at 10:30 AM the pharmacy director confirmed their labels should not be applied so as to cover the manufacturer's expiration dates.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	1. The facility will continue to ensure that an Infection Control Program is in place to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 2. All facility personnel, including nursing, housekeeping, laundry, maintenance and dietary staff will complete a mandatory on-line education module by February 29, 2012 on hand hygiene, blood borne pathogens, personal protective equipment, and related infection control requirements. 3. The supervisors of housekeeping, laundry, maintenance and dietary staff, with the assistance of the Infection Control Practitioner will monitor staff infection control practices including hand hygiene, posted precautions, use of personal protective equipment, and other infection control practices.	03/18/2012

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F 441	Continued From page 36 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of surveillance activities, infection control records, and label information for a chemical disinfectant, the facility failed to establish a reliable system for monitoring non-nursing staff for compliance with infection control practices. The facility further failed to ensure staff effectively disinfected point-of-care glucometers for 5 of 5 observations of resident testing. In addition, facility staff failed to use sanitary techniques for preparing medication for injection in 1 of 4 observations and replacing nasal cannula during 1 of 1 random observations. The findings were: 1. Review of infection control activities on 2/1/12 at 10:30 AM showed the facility conducted active monitoring of nursing personnel and practices for compliance with hand hygiene and infection prevention standards. However, there were no comparable data to show non-nursing staff were monitored in a similar manner.	F 441	4. Nursing staff will be required to complete a competency module for glucometer use, to include proper disinfection time as per manufacturer's instructions for the product being used. 5. RN #3 will be educated regarding proper infection control technique for administration of medications in a syringe, and the administration of medications to Resident #12 will be monitored for proper administration technique. 6. Resident #19 will be monitored for proper infection control practice with regard to administration of the resident's oxygen. 7. All nurses will be educated regarding the proper technique for administering medications in a syringe, and all nursing staff will be educated regarding necessary disinfection of contaminated nasal cannulas prior to replacing the cannula on the resident's face. 8. Each area of service will develop a QI/PI indicator to monitor infection control practices of staff and the results will be reported on a quarterly basis to the Infection Control Committee with oversight by the organization-wide QI/PI Committee. 9. The Infection Control Practitioner (RN) will monitor.	

2/8/12

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F 441	Continued From page 37 The infection preventionist stated in interview on 2/1/12 at 11:10 AM that supervisors of non-direct care staff were responsible for assessing the infection control compliance of their employees. She acknowledged that monitoring of non-nursing employees was not conducted as systematically as that of nursing staff. Further review of infection control meeting minutes for the last two quarterly meetings failed to show evidence that housekeeping, laundry, maintenance, or dietary staff working in the long-term care facility were periodically assessed for compliance with hand hygiene, posted precautions, use of personal protective equipment, or other infection control practices. Registered dietician #1 stated in interview on 2/1/12 at 2:50 PM that the dietary department conducted a performance improvement study on hand hygiene in 2010. She further stated hand hygiene practices among her staff had not been thoroughly assessed since the 2010 study. Interview with the housekeeping supervisor on 2/2/12 at 10:50 AM revealed her staff received in-service training as part of orientation and on an annual basis. She acknowledged there was no documentation to show that compliance was regularly monitored and reported for the nursing home setting. 2. Independent observations on 1/31/12 revealed facility staff failed to use a disinfectant as required by the manufacturer; the following deficiencies were noted: a. Observation on 1/31/12 from 10:50 AM to 11:20 AM showed LPN #1 used PDI Sani-Cloth	F 441		

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F 441	Continued From page 38 Plus germicidal disposable wipes on a glucometer to clean the device between residents. She was further observed to wipe the exterior surface of the glucometer with a disposable disinfectant cloth between five residents; the wet contact time of the disinfectant varied from six to twelve seconds. The LPN stated in interview on 1/31/12 at 11:20 she was not aware of a required contact time to effectively disinfect the glucometer and, further, had not been instructed to do more than simply wipe the surface of the device between uses. b. Observation on 1/31/12 from 11:05 AM to 11:23 AM showed RN #3 used PDI Sani-Cloth Plus disinfectant wipes to clean a glucometer between residents. She was further observed to clean the exterior surface of the device on two occasions, wiping the glucometer for twelve seconds after one use and then for eighteen seconds after a subsequent use. The RN stated in interview on 1/31/12 at 11:35 AM that she was taught to wipe off the glucometer, she was not aware if the chemical disinfectant in the disposable wipes required a minimum exposure time to achieve effective disinfection. c. Review of the manufacturer's instructions for use as printed on the label of the PDI Sani-Cloth Plus container revealed the product had a required wet exposure time of three minutes for antibacterial activity and five minutes when used as a tuberculocide. A technical representative of PDI confirmed in a telephone interview on 2/6/12 at 1:40 PM the Sani-Cloth Plus product was only an effective disinfectant when used per the label instructions and minimum exposure times were observed. The technical representative further	F 441		

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F 441	Continued From page 39 stated additional wipes might need to be used if a single wipe did not achieve the minimum wet contact time. d. Guidelines published by the Association for Professionals in Infection Control & Epidemiology (APIC), Safe injection, infusion, and medical vial practices in health care, dated April 2010, recommend the exterior surface of glucometers be disinfected after each use. These same principles are endorsed by the Centers for Disease Control & Prevention. 3. On 1/31/12 RN #3 was observed while preparing an injection for resident #12 at 11:32 AM. During the observation, the RN had her fingers on the plunger of the syringe while drawing the medication into the syringe. After determining that there was a bubble in the liquid, the RN moved the plunger back and forth and then twice injected the medication back into the vial before removing the bubble. This action contaminated the syringe and the medication in the vial. At 11:38 AM the RN stated she always holds the plunger of the syringe to initially withdraw medication from the vial, but does not usually inject it back into the vial. She acknowledged this technique was a poor practice. 4. On 2/1/12 at 8 PM resident #19 was observed seated in the East dining room; the resident was receiving oxygen per a nasal cannula connected to a concentrator. At that time an unidentified CNA approached the resident to assist him/her to move closer to an electrical outlet so the oxygen tubing was not stretched across the floor. Prior to moving the resident, the CNA looped the nasal cannula and the oxygen tubing into a circle,	F 441		

3/19/12

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F 441	Continued From page 40 touching the nasal prongs of the cannula with the tubing. After reseating the resident, the CNA replaced the nasal cannula on the resident's face without first cleaning it.	F 441		

3/8/12