APR 16 2010 PO: CAM Vers. Med. Care Ref. 4/16/10 between Karen Jones, DON and Tony Madden. The changed POC Completion Date agreed to is 5/9/10.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING ______ B. WING ______	03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY CARE CENTER	60 MAGNOLIA CASPER, WY 82604

(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: CDC: Centers for Disease Control & Prevention CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set MRSA: methicillin-resistant Staphylococcus aureus RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	F164 The facility will ensure each resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personnel privacy includes medical treatment and during personal cares. This will accomplished by:	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164	1. Staff will knock on door and await permission to enter before entering resident #127 room. 2. All staff will be in-serviced to deficiency. 3. All residents will be ensured privacy by staff knocking on door and awaiting permission to enter. 4. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for six months. 5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO / Administrator (X6) DATE 4-16-10

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.

This POC accepted without changes on 4/26/10 between Karen Jones, DON and Tony Madden

APR 16 2010

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F 164	Continued From page 1 and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure personal privacy for 1 of 23 sample residents (#127). The findings were: 1. Observation on 3/23/10 at 9:50 AM showed staff were providing personal care for resident #127. The resident's genital area was exposed during this care when physical therapist #1 knocked on the door and entered without waiting for permission. Interview with the resident on 3/24/10 at 2:15 PM revealed s/he was unaware the therapist entered the room. The resident stated that staff entering his/her room without permission "happens frequently." The resident also stated, "It's like they think it's okay to come in without waiting for an answer because they knocked." On 3/25/10 at 7:50 AM, the DON stated staff were expected to knock on closed doors and wait for permission to enter.	F 164		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		

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F 226	Continued From page 2 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of employees' records and facility policy, the facility failed to ensure 1 of 7 new employees (#4) whose records were reviewed was screened for prior findings of abuse and neglect. The findings were: Review of the facility policy "Background Screening Investigations," revised 7/23/02, documented: "Our facility will not knowingly hire any individual who has a history of abuse other persons. This facility will conduct background checks through either their professional licensing agency or Department of Family Services." Review of employee records showed employee #4 was a licensed practical nurse hired on 11/30/09. According to that review, as of 3/24/10, there was no evidence that the facility completed the screening process to ensure the employee's background was free of abuse and neglect to residents. During an interview on 3/24/10 at 4:15 PM and again on 3/30/10 at 2:30 PM, the DON stated she was unable to locate any evidence this had been done.	F 226	F226 The facility will ensure policies and procedures that prohibit mistreatment neglect, abuse of residents and misappropriation of resident property is reported immediately to the Administrator, Director of Nursing and to other officials in accordance with state law. The Director of Nursing will submit a written report of the results of all investigations to the administrator and to others in accordance with state law within 5 working days of the incident and if the alleged violation is verified appropriate corrective action must be taken. This will be accomplished by: 1. A DFS background check has been completed by employee #4 and forwarded to DFS office. 2. HR department will be in-serviced to deficiency. 3. HR department will utilize a checklist for all new hire employees to include background check to ensure all employees have a background check completed upon hire. 4. HR department will keep a copy of all background checks sent to DFS until completed original is received from DFS. 5. The DON or designee audit three personnel files monthly for three month and report to the QA team.	~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility dining policy, medical record review, and staff, resident, and family interview, the facility failed to maintain dignity for 6 of 23 sample residents (#2, #11, #16, #17, #43, #161) and 10 non-sample residents (#1, #3, #5, #6, #7, #20, #26, #32, #36, #165). The findings were: Concerns with dignity during dining: 1. Confidential interview with a resident's family member revealed s/he routinely visited the facility four to five times a week and noted that staff frequently placed the more dependent residents in the dining room for one to two hours before they served them. 2. Observation during the breakfast meal on 3/23/10 at 7:20 AM revealed resident #16 was seated at an assisted dining room table. The resident had his/her head down. The resident was not served his/her meal until 8:11 AM (51 minutes later). 3. Observation during the lunch meal in the south dining room on 3/24/10 revealed the following concerns: a. At 11:18 AM, CNA #2 brought resident #20 into the dining room, and placed him/her at an assisted dining table. The resident was not served his/her meal until 12:17 PM (59 minutes later). b. At 11:20 AM, CNAs #1 and #2 seated resident #7 at an assisted dining table. The resident was not served until 12:17 PM (57 minutes later).	F 241	F241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This will be accomplished by: 1. Resident's #20, 7, 32, 5, 1, 6, 11, 2, 165 and 161 will not be placed in the dining room until they are ready to be served a meal. 2. Nursing staff will acknowledge resident #17 and #43 comments and concerns and provide care or treatment as needed. 3. Nursing staff will be in-serviced to deficiency. 4. All residents will receive meals in a manner that maintains or enhances their dignity and respect. 5. All residents will be acknowledged and receive care as requested in a manner that maintains or enhances their dignity and respect. 6. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for six months. 7. The DON or designee will report audit results the QA team no less than quarterly for six months.	6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10

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F 241	Continued From page 4 c. At 11:21 AM, CNA #2 brought resident #32 into the dining room and placed him/her at an assisted dining table. The resident was not served his/her meal until 12:21 PM (1 hour later). d. At 11:25 AM, CNA #2 placed resident #5 at an assisted dining table. The resident was not served until 12:23 PM (58 minutes later). e. At 11:26 AM, CNA #2 brought resident #1 into the dining room and placed him/her at an assisted table. The resident was not served his/her meal until 12:21 PM (55 minutes later). f. At 11:42 AM, NA #1 brought resident #6 into the dining room and placed him/her at an assisted dining table. The resident was not served until 12:27 PM (45 minutes later). g. At 11:45 AM, CNA #3 brought resident #11 into the dining room and placed him/her at an assisted dining table. The resident was not served until 12:25 PM (40 minutes later). h. At 11:18 AM resident #2 was brought into the dining room by CNA #1. The resident was seated at the table sleeping on and off for 48 minutes before s/he was served a meal at 12:30 PM (1 hr 12 minutes later). 4. According to the 1/21/10 MDS assessment and corresponding care plan for resident #165, the resident required extensive assistance with eating and total dependence with locomotion due to cognitive impairment and limited range of motion. Observation on 3/23/10 at 7:30 AM showed the resident had been placed at the dining room table with three other residents who were eating their breakfast while s/he stared at a glass of water. The resident dozed intermittently and staff did not serve and assist the resident with his/her breakfast until an hour later at 8:30 AM.	F 241		

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F 241	Continued From page 5 5. Observation on 3/25/10 from 7:45 AM until 8:25 AM (40 minutes), showed resident #161 sat at the dining room table without food service or assistance. During that time the other residents in the dining room, including the residents that shared his/her table, had been served and were eating their breakfast. 6. Review of the open dining policy 2.2 revised on 3/5/10 showed, "Residents requiring feeding assistance or with special needs will continue to eat at set meal times out lined below:" The times were listed as 8 AM for breakfast, 12:30 PM for lunch, and 6 PM for supper. 7. During an interview on 3/24/10 at 3:50 PM, the DON stated there was no reason why the residents should be brought into the dining room that early. Other dignity concerns: 1. During an interview on 3/24/10 at 3:30 PM, resident #17 stated his/her concerns were frequently ignored by staff and that s/he had to repeat requests for care or information several times before something was done. The resident stated this made him/her feel "unimportant." During the interview, licensed practical nurse (LPN) #1 entered the room at 3:40 PM and asked how the resident was feeling. The resident's response was "...crappy." The nurse ignored the comment, making no reply to the resident and continued with her task of testing the resident's	F 241		

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F 241	Continued From page 6 blood sugar. When the surveyor asked the resident to define "crappy" the resident complained of pain in his/her back and sides and of generally "not feeling well." Again the nurse made no response at all to the resident's comment and continued with her work. When the surveyor asked the resident if s/he needed pain medication, the resident declined. During the entire procedure, the nurse never acknowledged the resident's comments or feelings. At 5 PM that day the DON stated she expected staff to respond to residents' comments, acknowledge their feelings, ask about pain, and provide treatment if they could.	F 241		
	2. Observation on 3/23/10 at 9 AM showed resident #43 wheeled him/herself up to a surveyor and stated s/he needed to go to the bathroom, and it was urgent. CNA #4 was working with another resident, and was standing close enough to overhear the request. CNA #4 acknowledged to the surveyor that she was aware, and then proceeded to tell RN # 1 that the resident needed to use the bathroom. During this exchange, the resident continued to say "Hurry, hurry." Neither the RN or CNA #4 took the resident at that time. Instead, the RN passed along the resident's request to CNA (#1), who was working with another resident. CNA #1 was heard to say, "I'll be right there." While waiting, the resident wheeled him/herself down the hallway where s/he told another staff member (activities staff) that s/he needed help getting to the bathroom. The activity staff pushed the resident back down the hall and relayed the resident's needs to the staff. At that time (9:07 AM), CNA #1 took the resident into the bathroom. Observation and interview with			

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F 241	Continued From page 7 CNA #1 as she helped the resident revealed the resident made it without an accident. However, the resident could be overheard in the bathroom crying and expressing to the CNA her worry about making a mess and a concern that his/her clothes were soiled. Interview with the DON on 3/24/10 at 3:58 PM revealed the resident's needs should have been addressed quickly, without being passed around to several staff members.	F 241	F248 The facility will provide an ongoing program of activities designed to meet the interests and physical, mental and psychosocial well-being of each resident. This will be accomplished by: 1. Resident #137 will be offered activities per her general preferences by activity staff to include weekends.	6/20/10 5/9/10
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.	F 248	2. Activity staff to be in-serviced to deficiency. 3. All residents will benefit from Activity staff scheduling change to increase coverage on afternoons and weekends. 4. Activity Director will explore alternatives to current activities calendar with all residents input as applicable for a wider variety of activities available to residents. 5. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for six months. 6. Activities Director or designee will submit activities calendars and report on activities to the QA team no less than quarterly.	6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10

This REQUIREMENT is not met as evidenced by:
Based on medical record and activity calendar review, observation, and resident and staff interviews, the facility failed to provide an adequate amount of activities to meet the needs for 1 of 23 sample residents (#137). In addition, confidential interviews with at least six residents revealed the amount of activities in the afternoon and on weekends was inadequate. The findings were:

1. According to the 1/22/10 significant change MDS assessment for resident #137, the resident's general activity preferences included playing cards and listening to music. During an interview on 3/24/10 at 10:50 AM, the resident stated, "On weekends I get bored because there is nothing going on because the activity person isn't here." The resident further stated that s/he

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F 248	Continued From page 8 would enjoy participation in a musical activity, playing cards or watching a movie to reduce the boredom during the weekend. Review of the activity calendar showed only two activities scheduled on Saturdays (Bingo and church visits) and one on Sundays (church services). 2. Periodic observations on the afternoons of 3/22/10 and 3/23/10 in the central unit revealed numerous (at least ten) residents seated in the television viewing area. The residents were not watching the television, nor engaged in any other type of activity. Review of the posted facility activity calendar revealed the primary resident activity in the afternoon was either Bingo (scheduled on average three times per week at 1:30 PM) or 1:1 activities. 3. Confidential interviews during the course of the survey from 3/22/10 through 3/25/10 revealed at least six residents did not think there were enough activities to keep them busy, primarily in the afternoon and on weekends. The residents verbalized ideas for activities they would like to see, such as facility outings, gardening, and dances. 4. During an interview on 3/25/10 at 9:30 AM the activity director acknowledged there were not enough group activities in the afternoon to keep the residents busy. She also stated the activities staff only worked thirty-two hours per week, and a large amount of that time was spent on paper work.	F 248		
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	F 279		

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F 279	Continued From page 9 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop comprehensive care plans for 2 of 23 sample residents (#17, #127). The findings were: 1. Review of the medication administration record revealed resident #17 received treatment for autonomic dysreflexia (a complication of spinal cord injuries resulting in high blood pressure brought on by pain or discomfort) on 3/19/10 and 3/23/10. An interview with RN #2 on 3/24/10 at 3:12 PM confirmed the resident received treatment on those days. However, review of the resident's care plan showed autonomic dysreflexia was not addressed. On 3/24/10, RN #2 reviewed the care plan at 3:25 PM and verified information related to autonomic dysreflexia was	F 279	F279 The facility will develop a comprehensive care plan for each resident that includes measurable objective and timetables to meet a resident's medical, nursing, mental and psycho-social needs that are identified in the comprehensive assessment. This will be accomplished by: 1. Resident #17 and #127 comprehensive care plan will include sign/symptoms of autonomic dysreflexia also to include interventions. 2. Nursing staff will be in-serviced to deficiency. 3. MDS team will assess all residents' quarterly and prn. The assessment will include a comprehensive care plan for identified needs. 4. MDS Coordinators will audit three charts for six months to monitor this process with immediate in servicing to follow as needed. 5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10

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F 279	Continued From page 10 lacking on the residents care plan. 2. Review of the medical record showed resident #127 had diagnoses that included autonomic dysreflexia. Refer to F309 for details related to lack of a care plan for this concern.	F 279	F280 The facility will ensure a comprehensive care plan will be developed within seven days after the completion of the comprehensive assessments, reviewed and revised by qualified persons after each assessment. This will be accomplished by:	
F 280 SS=D	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.	F 280	1. Resident #77 care plan will be reviewed and revised by Occupational Therapy. 2. Nursing staff will implement resident #77 care plan as directed by Occupational Therapy.	6/20/10 5/19/10 6/20/10 5/19/10
	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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to revise and implement the care plan as needed for 1 of 23 sample residents (#77). The findings were: Review of occupational therapy (OT)		3. MDS team will be in-serviced to deficiency. 4. MDS team will review and revise residents care plans after each assessment. 5. MDS coordinators will audit three care plans for review and revision after assessments complete for three months. 6. MDS team will perform five audits monthly for six months to ensure implementation of care plan to monitor this process with immediate in servicing to follow as needed. 7. The DON or designee will report audit results to the QA team no less than quarterly for six months.	6/20/10 5/19/10 6/20/10 5/19/10 6/20/10 5/19/10 6/20/10 5/19/10 6/20/10 5/19/10

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	535042	A. BUILDING _____ B. WING _____	03/25/2010

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F 280	Continued From page 11 documentation showed OT evaluated resident #77 to determine techniques to help him/her increase independence with eating. Refer to F311 for information related to failure to revise the care plan and implement the therapist's recommendations.	F 280	F282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. This will be accomplished by:	~~6/20/10~~ 5/9/10
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	1. A. Staff will assist resident #16 to toilet every two to three hours as per care plan. B. RNA staff will provide ROM to residents #33, 42, 17 per each residents care plan. C. Resident #77 will have spenco booties and TED hose on as per care plan. D. Resident #77 will receive oral care twice daily as per care plan. E. Resident #43 will be ambulated as per care plan.	
	This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care in accordance with the written plan of care for 6 of 23 sample residents (#16, #17, #33, #42, #43, #77). The findings were: 1. Refer to F309 for details regarding the facility's failure to follow the plan of care related to bowel incontinence for resident #16. In addition, refer to F311 for details on the facility's failure to follow the care plan related to ambulation for this same resident. 2. Refer to F318 for details regarding the facility's failure to follow the plan of care for range of motion (ROM) services for resident #33. 3. Refer to F318 for details regarding the facility's failure to follow the care plan for ROM services for resident #42. 4. Review of the 3/19/10 care plan for resident		2. Nursing staff will be in-serviced to deficiency. 3. All residents will benefit from the staff nurses monitoring for care being provided per care plan. Failure to follow the plan of care will result in immediate in servicing and corrective action will be taken. 4. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for six months. 5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10

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F 282	Continued From page 12 #17 showed CNAs were to perform "passive range of motion [ROM] in all cardinal planes" to both lower extremities on Saturdays and Sundays. Refer to F318 for details related to the facility's failure to follow the care plan for this resident. 5. According to the care plan, last updated on 3/11/10, resident #77 was to have "Spenco bootles" on both feet when in bed, wear thrombo embolic deterrent (TED) hose when up, and have staff assistance with oral care twice daily. Failure to follow the care plan was noted in the following instances: a. Observations on 3/23/10 at 8:45 AM and 3/24/10 at 11:10 AM showed the resident was in bed without "Spenco booties." b. Observation of morning care on 3/23/10 at 8:45 AM revealed staff did not put TED hose on the resident. Further observation showed the resident was bathed at 11 AM, but remained up without TED hose through 12:45 PM. On 3/12/10 at 11:05 AM, the care plan coordinator, RN #3, confirmed the CNA care plan was current. At 11:10 AM she observed the resident in bed and confirmed s/he was wearing neither "Spenco booties" nor TED hose. c. Refer to F312 for information related to failure to provide oral care. 6. Refer to F282 for details related to the failure to follow the ambulation care plan for resident #43.	F 282		
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	F 309		

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F 309	Continued From page 13 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care to promote bowel continence for 1 of 12 sample residents (#16) who were incontinent of bowel. In addition, the facility failed to provide the necessary care for 1 of 3 sample residents (#127) who were at risk for autonomic dysreflexia. The findings were: 1. Review of the 3/11/10 quarterly MDS assessment revealed resident #16 was incontinent of bowel. According to the 3/11/10 care plan, staff were instructed to offer or assist the resident to use the toilet every two to three hours and as needed. On 3/23/10, observation from 7:20 AM until 10:30 AM revealed the resident was neither offered an opportunity to use the toilet, nor physically assisted to the toilet. At 10:30 AM, CNA #3 and CNA #5 assisted the resident to the toilet. When the CNAs stood the resident up from the wheelchair, the resident's pants were visibly soiled from bowel incontinence. When asked when the resident was last assisted to the toilet, CNA #5 replied, "I assume when they got [him/her] up this morning." The CNA stated she came in at 7 AM, and had not assisted the resident to the toilet before this observation. 2. According to "Paralyzed Veterans of America/Consortium for Spinal Cord Medicine. Acute management of autonomic dysreflexia: individuals with spinal cord injury presenting to health-care facilities. Washington (DC): Paralyzed Veterans of America (PVA); 2001 Jul.: autonomic	F 309	F309 The facility will ensure each resident will receive 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 will be accomplished by: 1. Staff will assist resident #16 to toilet every two to three hours as per care plan. 2. Resident #127 comprehensive care plan will include signs/symptoms of autonomic dysreflexia also to include interventions. 3. Nursing staff to document in resident #127 medical record assessment and interventions regarding any autonomic dysreflexia episodes. 4. Nursing staff to be in-serviced to deficiency. 5. All residents will benefit from the staff nurses monitoring for signs/symptoms of diagnoses with appropriate documentation of interventions in medical record. 6. MDS Coordinators and Nursing management team will audit three charts for six months to monitor this process with immediate in servicing to follow as needed.	~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10

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F 309	Continued From page 14 dysreflexia is a sudden, severe rise in blood pressure (BP) caused by pain or discomfort. The most common cause(s) are bowel and bladder distention. Autonomic Dysreflexia is potentially life threatening and can occur in anyone with a spinal cord injury at or above thoracic level six. It requires quick and decisive treatment for resolution. The treatment is to lower the BP and then determine the cause(s) of pain or discomfort. Further review showed that a rise of 20 millimeters (mm) to 40 mm of mercury above the resident's baseline BP "may be a sign of autonomic dysreflexia." Medical record review showed resident #127 had diagnoses that included autonomic dysreflexia. Review of the vital signs flow sheets for January, February, and March 2010 showed the resident's BPs normally ranged from 92/62 to 120/72. On 3/23/10 at 7:20 AM the resident stated s/he had an episode of autonomic dysreflexia on 3/15/10. Review of the March 2010 medication administration record showed the resident received Clonidine for elevated BPs on the 13th at 8:15 AM and on the 15th at 3 PM (179/100 and 180/110, respectively). The following concerns were identified: a. Review of the nursing documentation showed no further assessment or attempt to determine the cause(s) of the resident's elevated BPs. Further, there was no evidence of additional monitoring of the resident to determine if the resident's baseline BPs were reached and maintained after administration of the Clonidine. b. Review of the care plan revealed there were no interventions interventions to address autonomic dysreflexia for this resident. c. Review of all documentation for 3/13/10 through 3/15/10 showed no evidence the facility	F 309	7. The DON or designee will report audit results to the QA team no less than quarterly for six months.	~~6/20/10~~ 8/9/10

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F 309	Continued From page 15 attempted to determine the cause of the resident's elevated BPs or had monitored this resident's BP after medication was administered in order to determine that a normal BP was reached and maintained. On 3/25/10 at 7:50 AM the DON confirmed the lack of an assessment, care plan, monitoring of BPs, and determination of cause(s) of the resident's elevated BPs.	F 309	F311 The facility will ensure the residents' receives the appropriate treatment and services to maintain or improve his or her abilities. This will be accomplished by: 1. A. Resident's # 16 and 43 will be ambulated by nursing staff and RNA as per care plan. B. Resident # 77 will be assisted at meals per care plan.	~~6/20/10~~ 5/9/10
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure services to promote increased ability to ambulate or eat were provided for 3 of 23 sample residents (#16, #43, #77) who required a program to maintain or improve abilities related to activities of daily living (ADLs). The findings were: 1. Review of the 3/11/10 care plan showed CNAs were instructed to ambulate resident #16 every shift each day. In addition, restorative nurse aides (RNAs) were supposed to assist the resident with ambulation two to three times per week. The following concerns were identified: a. Review of the March 2010 unit ambulation flowsheet (through 3/23/10) showed that ambulation was only attempted eleven times. Review of the February 2010 flowsheet showed	F 311	2. Nursing staff will be in-serviced to deficiency. 3. All residents will benefit from the staff nurses monitoring for care being provided per care plan. Failure to follow the plan of care will result in immediate in servicing and corrective action will be taken. 4. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for six months. 5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10

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F 311	Continued From page 16 that CNAs only ambulated the resident fourteen times during that month. Interview with the DON on 3/25/10 at 8:50 AM revealed she checked with the CNAs and found out that the ambulation was "hit and miss." She stated some of the CNAs did not ambulate the resident, and some CNAs stated they did, but did not document. b. Review of the March 2010 restorative flowsheet showed the resident did not receive ambulation at least two times during the second week in March. A note written by the RNA on 3/8/10 stated "pulled to the floor." Review of the January 2010 flowsheet showed the resident only received restorative services once during the first fourteen days of the month. Notes written by the RNA on 1/3, 1/5, 1/6, 1/11, and 1/12 read "pulled to the floor" and "orientation." During an interview on 3/24/10 at 3:05 PM, the restorative nurse confirmed that the RNAs were sometimes pulled from restorative duties to work on the floor as a CNA. 2. Review of occupational therapy (OT) documentation showed OT evaluated resident #77 to determine if the resident could increase his/her independence with eating. On 1/29/10, OT recommended that nursing use a "hand over hand" technique during the first fifteen minutes of each meal to increase the resident's knowledge and independence with eating. Observations on 3/23/10 at 9:15 AM and 3/24/10 at 12:15 PM showed this technique was not utilized; instead, the resident received total assistance from staff. Review of the care plan last updated on 3/11/10 showed the instructions were not listed. On 3/24/10 at 2 PM the unit's charge nurse, RN #4, confirmed the technique was not included in the plan of care. The RN confirmed the technique was not currently being used. Furthermore, she	F 311		

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F 311	Continued From page 17 stated she did not know if it was ever implemented. 3. Review of the 3/1/10 significant change MDS assessment for resident #43 showed s/he needed limited assistance with ambulation. Review of the unit ambulation flowsheet for February 2010 showed CNAs were to ambulate the resident with a front wheel walker up to 150 feet 2-3 times per week. This plan for ambulation by the CNA was also noted on the resident's care plan dated 3/1/10 under the problem of self-care deficit. During February 2010, the sheet showed the resident was ambulated four times, once on 2/1, 2/21, 2/22, and 2/23. No reasons were documented as to why the ambulation was not done as planned. Interview with the DON on 3/24/10 at 3:58 PM verified the CNAs should follow the plan of care.	F 311	F312 The facility will ensure 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 will be accomplished by: 1. Resident #77 will receive oral care twice daily as per care plan. 2. Nursing staff will be in-serviced to deficiency. 3. All residents will benefit from the staff nurses monitoring for care being provided per care plan. Failure to follow the plan of care will result in immediate in servicing and corrective action will be taken. 4. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for six months. 5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10
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, medical record review, and staff interview, the facility failed to ensure oral care was provided during 1 of 4 observations (#77) of oral care. The findings were: According to the care plan for resident #77, last updated on 3/11/10, staff were to provide oral care for this resident twice daily. Morning care	F 312		

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F 312	Continued From page 18 provided by CNAs #6 and #7 was observed on 3/23/10 at 8:45 AM. After stating she was finished providing care, CNA #7 pushed the resident's wheelchair to the door to take the resident to breakfast. When asked what time oral care was provided, CNA #7 stated it should have been provided with morning care, but she "forgot" it.	F 312	F318 Based on the comprehensive assessment of a resident, the facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion. This will be accomplished by:	
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide services to prevent further decline in range of motion (ROM) for 3 of 13 sample residents (#17, #33, #42) with range of motion limitations. The findings were: 1. Review of the 1/14/10 quarterly MDS assessment showed resident #42 had ROM limitations to both arms, one hand, and one leg and foot. According to the 1/14/10 care plan, the resident was to receive restorative AA-AROM [active assisted-active range of motion] to the lower extremities and lower extremity exercises two to three times per week. Review of restorative flowsheets revealed the following concerns: a. In January 2010, the resident did not receive restorative services during the first week.	F 318	1. RNA staff will provide ROM to residents #33, 42, 17 per each residents care plan. 2. Restorative staff will be in-serviced to deficiency. 3. Restorative Director will monitor for care being provided by RNA staff. Failure to follow the plan of care will result in immediate in servicing and corrective action will be taken. 4. The DON or designee will report results to the QA team no less than quarterly for six months.	~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10

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F 318	Continued From page 19 Notes written by the RNA on 1/4/10, 1/5/10, and 1/6/10 read "pulled to the floor" and "orientation." b. In February 2010, the resident only received restorative once during the last week of the month. The RNA documented "pulled to the floor" on 2/23/10. c. In March 2010, the resident did not receive any restorative during the second week, and only received it once during the third week. The RNA documented "pulled to the floor" on 3/8/10 and "RNA program was down a restorative aide during 3/9-3/16. Tried to fill in the best we could..." During an interview on 3/24/10 at 3:05 PM, the restorative nurse confirmed that the RNAs were sometimes pulled from restorative duties to work on the floor as a CNA. 2. Review of the 12/31/10 quarterly MDS assessment revealed resident #33 had ROM limitations to the neck, both hands, both arms, both feet and both legs. According to the 3/25/10 care plan, the resident was to receive restorative services 3 to 4 times per week for passive ROM to the arms, legs and neck. Review of the restorative flowsheets revealed the following concerns: a. During January 2010, the resident only received restorative services once during the first week, and twice the second week. The RNA documented "pulled to the floor" or "orientation" on 1/4/10, 1/5/10, and 1/11/10. b. During March 2010, the resident only received restorative twice per week for the first three weeks of the month. On 3/8/10, the RNA documented "pulled to the floor." During an interview on 3/24/10 at 3:05 PM, the restorative nurse confirmed that the RNAs were sometimes pulled from restorative duties to work	F 318		

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	535042	A. BUILDING _____ B. WING _____	03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY CARE CENTER	60 MAGNOLIA CASPER, WY 82604

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F 318	Continued From page 20 on the floor as a CNA. 3. Review of the 3/18/10 significant change MDS assessment revealed resident #17 had limited ROM in the neck, arms, hands, legs, and feet. According to the medical record, the resident received physical therapy Monday through Friday during February and March 2010, with restorative nursing staff to pick up the ROM program on both days of the weekend in February. Review of restorative documentation for February 2010 showed the program was only provided on one day of the weekend during three out of four weekends. The program was not provided on the first weekend, and it was "Rolled to floor CNAs" on 2/28/10. Review of the care plan dated 3/19/10 showed the CNAs were to perform "passive ROM in all cardinal planes" to both lower extremities on Saturdays and Sundays. On 3/24/10 at 3:25 PM, review of the CNA documentation with the charge nurse, RN #2, revealed no evidence ROM was provided. RN #2 stated she thought restorative nursing was providing the program. Interview with the restorative nurse on 3/24/10 at 5:20 PM revealed restorative nursing was not providing ROM on the weekends. At 5:45 PM that day, the restorative nurse confirmed ROM was not being provided by the unit CNAs either.	F 318		
F 323 SS=E	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.	F 323		

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F 323	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment for residents in 3 of 8 hallways. The findings were: Periodic observation from 3/22/10 at 4:30 PM through 3/24/10 at 2:48 PM revealed the following concerns: 1. The metal radiator cover in the hallway next to the Krampert facility exit was not attached to the wall. The cover measured approximately four feet by 2 feet and weighed over 15 pounds. Interview with the facility DON on 3/24/10 at 10:10 AM verified the cover represented a potential hazard. 2. Part of the hard plastic end pieces on the hallway hand rails outside resident rooms #200 and #218 were shattered and had broken away. As a result, the end of the hand rails had very sharp edges. Interview with the facility housekeeping manager on 3/24/10 at 2:22 PM revealed replacement end pieces were on order but had not yet been received. 3. An 8 inch by 6 inch metal protective thermostat cover approximately 5 feet above the floor was not securely attached to the wall. The cover was between resident rooms #109 and #110. Interview with the facility DON on 3/25/10 at 8:30 AM revealed the cover represented a potential hazard.	F 323	F323 The facility will ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accents. This will be accomplished by: 1. The metal radiator in hallway by Krampert facility exit was secured to wall by maintenance department. 2. Hallway handrails outside resident rooms 200 and 218 will be replaced by maintenance department. 3. Metal protective thermostat outside resident rooms 109 and 110 was secured to wall by maintenance department. 4. Maintenance and housekeeping staff to be in-serviced to deficiency. 5. Maintenance department to perform monthly facility inspections to include covers secured to wall and hallway handrails. 6. The DON or designee will report audit results to the QA team no less than quarterly for six months.	3/24/10 ~~6/20/10~~ 5/9/10 3/25/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10
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	F 329		

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F 329	Continued From page 22 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 ensure the medication regimen for 1 of 23 sample residents (#127) was free from unnecessary drugs. The findings were: Medical record review showed resident #127 had been receiving the antidepressant, Zoloft, 200 milligrams (mg) since 1/27/09. Review of a request to the physician for a dose reduction showed it was dated 2/25/10. The physician's response was "Do not attempt to taper the dose of this drug because in my professional opinion to do so is clinically contraindicated. This patient's	F 329	F329 The facility will ensure each resident's drug regimen will be free from unnecessary drugs. This will be accomplished by: 1. Chemical restraint committee will request a dose reduction of Zoloft for resident #127. 2. Chemical restraint committee will be in-serviced to deficiency. 3. All residents receiving psychotropic medications will benefit from dosage reductions unless clinically contraindicated and appropriate diagnoses by the chemical restraint committee per federal guidelines. 4. Chemical restraint committee will perform five random audits monthly for six months to monitor this process. 5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10 6/20/10 5/9/10

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F 329	Continued From page 23 behaviors are due to the psychiatric diagnosis, and the prescribed medication at the current dose is the appropriate treatment." Review of the criteria for "clinically contraindicated" showed: a. "The resident's target symptoms returned or worsened after the most recent attempt at a tapering... b. The physician has documented the clinical rationale for why any additional attempted tapering at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder." There was no evidence the resident failed a previously attempted dose reduction, and there was no psychiatric diagnosis on record. Further, a physician's statement denoting the risks versus the benefits of continued treatment at the same dose was lacking. On 3/24/10 at 12:32 PM the DON verified a dosage reduction had not been attempted since 1/27/09. She also confirmed the resident did not have a psychiatric diagnosis and that a physician's statement defining the risks versus the benefits of continuing the antidepressant at the same dose was lacking.	F 329		
F 371 SS=F	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		

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F 371	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to establish a system to monitor foods that were stored in individual resident refrigerators to ensure the food was safe to eat. The facility identified 19 individual refrigerators in use. In addition, wiping cloths were not stored or used in a sanitary manner in 3 of 4 kitchen/service areas observed. The findings were: 1. The following concerns were identified related to personal refrigerators: a. Observation on 3/23/10 at 7:15 AM, showed resident #135's personal refrigerator contained nine different undated sandwiches secured in plastic bags and five of ten containers of yogurt that had expired on or before 3/14/10. These items were positioned tightly among two unopened packages of cheese, a jar of pickles, nutritional supplements and various baked goods wrapped in napkins. Further observation showed dried food stains on the refrigerator shelves and interior door. During an interview on 3/25/10 at 8:55 AM, the resident stated s/he had not seen staff check or clean the refrigerator, but s/he thought that it was being done because cleaning and maintenance was the facility's responsibility. b. During an interview on 3/23/10 at 2:02 PM, resident #127 stated staff did not check his/her personal refrigerator for correct temperatures or for dated/outdated food. Observation on 3/24/10 at 2:15 PM revealed the resident's refrigerator and freezer were full of food; both compartments lacked a thermometer. All food items lacked either the date they were placed in the refrigerator/freezer or the expiration date.	F 371	F371 The facility will store, prepare, distribute and serve food under sanitary conditions. This will be accomplished by: 1. Residents #135, 100, 23 and 17 individual room refrigerators will be monitored for correct temperature and outdated food items. 2. Dietary staff will place and store wiping clothes in chemical sanitizing solution between uses. 3. All staff will be in-serviced to deficiency. 4. All residents with individual room refrigerators will benefit from monitoring temperature and outdated food items by housekeeping, dietary and nursing staff. 5. All residents will benefit for proper storing of wiping clothes between uses. 6. Dietary manager or designee will perform five random audits monthly to monitor these processes with immediate in servicing to follow as needed for three months. 7. The DON or designee will report audit results to the QA team no less than quarterly for three months.	~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10

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F 371	Continued From page 25 o. Interview with the director of housekeeping on 3/24/10 at 2:35 PM revealed there was no system to monitor or clean individual resident refrigerators. She stated the residents were expected to ensure refrigerators were clean and the food was not expired. d. Review of a list provided by the DON showed the following 19 residents had refrigerators in their rooms: 4 sample residents (#127, #100, #23, #17) and 15 non-sample residents (#28, #41, #56, #66, #95, #124, #131, #135, #138, #143, #144, #156, #163, #164, #175). 2. Observations on 3/23/10 at 12:20 PM in the central unit kitchenette, 3/23/10 at 12:30 PM in the east kitchenette, and 3/24/10 at 10:10 AM in the main kitchen showed wet wiping cloths were not stored in the chemical sanitizing solution. In all three areas, multiple wet cloths were laid on counters or the steam tables, and used by staff to wipe counters without being immersed into any sanitizing solution. According to Food Code 2009, U.S. Public Health Service: 3-304.14. "...(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;"	F 371		
F 431 SS=D	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	F 431		

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F 431	Continued From page 26 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 and staff interview, the facility failed to ensure medications stored in 1 of 5 medication carts were not expired. The findings were: During an observation of the medication cart at the east nursing station on 3/24/10 at 4 PM, two vials of Lovenox (an anticoagulant) were opened, but had not been dated, and were available for use. During an interview immediately after the	F 431	F431 Drugs and biological 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. This will be accomplished by: 1. Opened, undated vials of Lovenox in east station were discarded. 2. Nursing staff will be in-serviced to deficiency. 3. Nursing staff to check all vial medications for date when opened prior to administration to ensure resident receives no expired medications. 4. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for six months. 5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	3/25/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10 ~~6/20/10~~ 5/9/10

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F 431	Continued From page 27 observation, licensed practical nurse (LPN) #2 stated she could not find an open date for either of the two opened vials. Also, she could not determine how long the vials had been opened or if they were outdated; and she confirmed the vials were available for use. On 3/25/10 at 7:50 AM the DON stated that multiple dose vials were to be dated when they were opened. She further stated the contents were usually good for only thirty days after the vial was opened. According to "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, & Martin, Seventh Edition, page 605, "If multi-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials."	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	F 441		

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F 441	Continued From page 28 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 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 policies and procedures for infection control, manufacturer's instructions for cleaning glucose testing devices ("glucometers"), and nationally accepted standards for isolation & precautions, the facility failed to ensure staff followed guidelines for contact precautions for 1 of 1 residents (#149) with an epidemiologically significant infection. The facility further failed to ensure a glucometer was cleaned between residents for 1 of 5 glucose testing observations. In addition, facility staff failed to practice appropriate hand hygiene techniques during 1 random observation of resident care and during 1 of 2 meal observations. The findings were: 1. The initial tour of the facility on 3/22/10 at 3:30 PM showed a "Contact Precautions" sign posted	F 441	F441 The facility will 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. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This will be accomplished by: 1. A. Staff will follow contact precautions for resident #149 utilizing PPE's. B. Residents #166 and 142 will have glucometer cleaned with appropriate cleanser between uses. C. Staff will wash hands before performing personal cares to resident #77. D. Staff will not handle or touch the rim of glass or straws by drinking area for residents #132, 88 and 117. E. Staff will not touch their own face or hair when assisting resident #77, 92, 99 and 133. 2. Nursing staff will be in-serviced to deficiency.	6/20/10 5/5/10 6/20/10 5/5/10

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F 441	Continued From page 29 at the entrance to resident #149's room. The infection control signage required staff to use appropriate personal protective equipment (PPE; gloves, masks, disposable gowns) and hand hygiene when entering and leaving the room. A cart containing PPE for staff was positioned immediately outside the room. Facility policies for contact precautions were reviewed. These policies referred to current CDC guidelines and required all staff and visitors to use PPE and hand hygiene when entering and leaving rooms posted with infection control precautions. The following concerns were identified related to actual facility practice: a. On 3/24/10 at 10:30 AM, CNA #8 entered the precaution-posted room. The CNA did not wear gloves, and she was observed to enter both resident areas of the room (resident #149 and his/her roommate). The CNA was not observed to wash her hands prior to leaving the posted room. b. Interview with the CNA immediately after the 3/24/10 observation revealed her expectation was to follow the contact precautions sign which showed staff were to "Wear gloves when entering room." The CNA further stated she did not always wear gloves upon entering the room of resident #149, but stated she should. c. Medical record review showed a positive culture report for MRSA dated 3/3/10. The positive culture report was cited in nurses' notes on 3/3/10. d. Interview with the DON on 3/24/10 at 3:20 PM confirmed resident #149 had a positive culture report for MRSA and his/her room was posted with "Contact Precautions" to minimize the risk of spreading MRSA to other residents or staff. The DON further confirmed all staff were expected to use appropriate PPE when entering the room, regardless of whether their care was	F 441	3. All residents will benefit from the staff following posted isolation precautions and universal precautions while providing cares for residents. Failure to follow isolation and universal precautions will result in immediate in servicing and corrective action will be taken. 4. All residents requiring glucometer monitoring will benefit from individual glucometers. 4. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for six months. 5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	6/20/10 5/9/10 5/3/10 6/20/10 5/9/10 6/20/10 5/9/10

4/20/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 30 restricted to resident #149 or his/her roommate. 2. Observation on 3/23/10 at 11:30 AM revealed RN #6 used the same glucometer to perform glucose tests for two residents #166 and #142. Further observation showed she did not clean the glucometer between resident use. 3. Observation on 3/23/10 at 8:45 AM showed a mat placed on the floor beside the bed for resident #77. CNA #6 entered the room, donned gloves, and picked up the mat. She handled both the top and bottom of the mat, and placed it behind the head of the bed. The CNA then changed the resident's disposable brief and performed incontinence care, handling the wipes with the same gloves that were in contact with the dirty floor mat. 4. Observation on 3/24/10 at 12:12 PM showed CNA #9 donned gloves to provide meal assistance for residents #132, #88, #117, and #128. For each resident, the CNA then handled the drinking glasses by the rim and the straws by the drinking area. Each of the residents drank from the glasses or straws during the meal. 5. On 3/24/10 at 12:12 PM, CNA #10 was observed to don gloves prior to assisting residents #77, #92, #99, and #133 with the lunch meal. Throughout the meal, the CNA frequently used both hands to brush her hair back from her face. Each time, the CNA continued assisting the residents without performing hand hygiene or removing the gloves.	F 441		
F 503 SS=E	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services,	F 503		

4/24/10

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F 503	Continued From page 31 the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of quality control data and product label information, the facility failed to ensure quality control procedures were properly performed and documented for glucometers on 2 of 4 resident units. The findings were: Quality control procedures for a glucometer at the central unit nurse's station were reviewed on 3/22/10 at 3:45 PM. Interview with the unit charge nurse, RN #6, at that time revealed she did not know if quality control procedures were performed for the glucometer or where the data might be documented. She further stated the "...night nurse	F 503	F503 The facility will ensure provided laboratory services meet the applicable requirements for laboratories. This will be accomplished by: 1. Quality control testing of resident individual glucometers will be performed when new bottle of test strips opened as per manufactures recommendations and documented. 2. Nursing staff will be in-serviced to deficiency. 3. All residents will benefit quality control testing of glucometers. Failure to follow the plan of care will result in immediate in servicing and corrective action will be taken. 4. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for six months. 5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	5/3/10 5/3/10 6/20/10 ~~5/5/10~~ 5/3/10 6/20/10 5/5/10

4/2/10

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F 503	Continued From page 32 probably took care of that..." Interview with the night nurse, RN #7, on 3/23/10 at 7 AM revealed quality control material was tested every night, but the results and interpretation of acceptable values was not documented. The label on the control materials she used expired in November 2009, 5 months prior to survey. It was further noted that the control materials were labeled for use on Assure 3 glucometers; the facility used Assure 4 glucometers. The night RN further acknowledged she had not noticed the statement on the glucose quality control material or on the reagent test strips that stipulated a 90-day expiration once the bottles were opened. She did not know when the products were first opened, nor the corrected expiration date. Interview with RN #8 on 3/23/10 at 11:10 AM revealed she did not know whether the east unit's glucometer performance had been verified with quality control material. She was unable to find any control material on the unit and stated the glucometer might have been tested on the west unit "...that's what we do when we run out [of control material]...". The DON stated in interview on 3/24/10 at 3:40 PM she expected staff to perform quality control as required by the manufacturer and, further, the results of testing should be documented. The DON added all testing products should be labeled to show the expiration date and annotated correctly if the expiration date changed after opening. Review of the manufacturer's instruction manual (Assure 4, Arkray USA, Inc.) showed a	F 503		

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F 503	Continued From page 33 requirement to test each glucometer with Assure 4 quality control material (page 14) and the results of testing must be compared to the acceptable range of values to confirm proper performance (pages 14-15).	F 503		

4/16/10