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Healthcare Licensing and Surveys

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

PRINTED: 06/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE 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: CDM: Certified Dietary Manager CNA: certified nursing assistant DON: director of nursing MAR: medication administration record MDS: Minimum Data Set RN: registered nurse RD: registered dietitian Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	**F 156** **Residents will be properly informed, both orally and in writing of rights, rules, services and charges. This will be. This will be accomplished by:** **1. Unable to implement immediate correction for Resident # 45.** **2. Revised Policy and Procedure for non-traditional signatures was implemented.** **3. All resident non-traditional signatures on legal or facility documents will be reviewed to assure the necessary 2 witnesses are affixed.**	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	**4. In-service to the deficiency for Social Services, Admissions and Nursing leadership will be conducted.** **5. Random Audits of resident consent driven documents will be conducted over the next 90 days by Admissions Director.** Corrective action will be taken as indicated klr **6. The Admissions Director and/or Social Services Director will report results to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.** monthly klr 6/12/12	

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

Administrator | June 8, 2012

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.

The POC was accepted & revised & revised on 6/15/12 by Gill Hunt (Admin) Kathy Slate Survey changes made were accepted by Gill

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F 156	Continued From page 1	F 156		

other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a

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F 156	Continued From page 2 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and review of policies and procedures, the facility failed to comply with policy and procedures related to advance directives for 1 of 24 sample	F 156		

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F 156	Continued From page 3 residents (#45). The findings were: Review of the advance directive dated 2/25/11 for resident #45 showed the area selected "Do Not Resuscitate" had a hand-written statement: "Verbal OK by resident-unable to sign." The signature block had the same hand-written statement. The document was witnessed by one staff member. Interview with social services staff #1 on 4/25/12 at 4:25 PM could not confirm one witness was adequate when the resident gave verbal consent only. Review of the policy and procedures for admissions, reviewed August 2011, showed: "All paperwork is to be signed by the resident or representative to the resident. If resident is own person and cannot write name, a verbal consent or a written " X " may be used as long as these methods are witnessed by two individuals."	F 156	F176 An individual resident may self-administer drugs if the IDT as determined this practice is safe. This will be accomplished by: 1. Corrective Action: a. Resident #145 self administration was assessed by the ID Team for safe self-administration of medications. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for assessing residents for self-administration of medications was reviewed and remains current. b. All residents who have physician orders for self-administration or indicate a desire to self-administrate medications will be reviewed to assure they have the necessary ID Team assessment in place. c. An Inservice on self administration Policy and Procedure which includes an ID Team assessment will be held for the ID Team. 3. Random chart audits will be conducted by DON/Designee for 90 days on residents who are self-administering medications to assure they have a current ID Team assessment.	
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 medical record review and staff interview, the facility failed to ensure 1 of 1 sample resident (#145) who self administered medications was evaluated to be safe to self-medicate. The findings were: Review of the physician orders report for April 2012 showed resident #145 self administered	F 176		

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F 176	Continued From page 4 Humulin N and Humulin R insulin. Review of the 2/24/12 resident care plan showed the resident monitored his/her own blood sugars as well as self-administered the insulin. The goal was for the resident to report this information to the nursing staff so the MAR could be completed. Further review of the medical record showed there was no evaluation completed by the interdisciplinary team (IDT) to determine if the resident could safely perform these tasks. Interview with the DON on 4/25/12 at 10:15 AM confirmed there was no evaluation by the IDT. The DON provided a copy of a medication list, which the physician noted on 2/15/12 the resident may self administer medications.	F 176	4. DON/Designee will report the results of these audits to QA Committee for review and recommendations.	6/12/12
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide adequate maintenance to ensure resident rooms and hallways on 3 of 4 nursing units were in good repair. The findings were: During observation on 4/26/12 from 8 AM through 9:15 AM the following issues related to building maintenance were found: a. The 50-inch heat radiators, located next to the floor, had scuffed areas across in the following resident bathrooms: rooms 16, 18, 20, 27, 29, 34, 37, 45, and 68.	F 253		

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F 253	Continued From page 5 b. The front door frames for the following resident rooms were scuffed from the floor to 3 feet up on each side: rooms 107, 127, 201, 202, 203, 204, 206, 207, 208, 209, 210, 211, 212, and 214. c. The 2 custodian room doors by resident rooms 122 and 123 had multiple scuffs from the floor to 4 feet and across the 33 inch width. In addition, the double exit doors by the social services office were scuffed across the bottom of both doors to two feet high. d. In resident room 208, duct tape was placed across the floor under the bathroom door. The tape was pulling up at the edges and collecting dust. e. In resident room 120, there was a 4.5 inch by 2.5 inch hole in the wall just to the right upon entrance. f. In the central dining area, the left wall had 4 areas with the wallpaper detached from the wall; the largest area measured 4 inches by 2.5 inches. g. The baseboard is missing on 3 of 4 walls in resident room 220 exposing white uneven plastered walls. During an interview on 4/26/12 at 9:30 AM, the maintenance director confirmed that the facility needed paint and repair in various areas. However, the facility failed to have a specific plan with a timeframe to address these issues.	F 253	**F 253** **The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This will be accomplished by:** **1. The scuffs on the bathroom radiators in rooms 16, 18, 20,27,29,34,45 & 68, will be scraped and repainted.** **2. The door frames for rooms 107,127,201,202,203,204,206,207,208,209,210,211,212,214 and 2 custodian rooms doors by rooms 122 and 123 and East exit doors by Social Services will be scraped and repainted.** **3. The duct tape in room 208 will be replaced. Flooring in this room will be repaired.** **4. The hole in room 120 will be repaired.** **5. Peeling wallpaper in Central Dining room will be repaired or replaced.** **6. Mission baseboard in room 220 will be repaired.**	
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	F 280	**7. The Maintenance department will be in serviced to the deficiciency.** **8. Maintenance Department will audit the physical plant interior ~~routinely~~ monthly KR to identify areas of ill-repair and develop a written plan to address the areas.** and correct KR identified KR	

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F 280	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure resident care plans were updated to address all identified areas of concern for 1 of 24 sample residents (#43). The findings were: Review of the medical record for resident #43 showed s/he was admitted to a local hospital on 4/10/12 with diagnoses which included severe dehydration. The resident returned to the facility on 4/16/12. The following concerns were noted: a. Review of the care plan showed the facility failed to address a plan to ensure the resident's fluid intake was adequate. The only information in the care plan related to the resident's intake was, "Staff will record my consumption following each meal." b. Interview with the DON on 4/25/12 at 5:15	F 280	**9. Results of these audits will be reported (monthly) to the QA Committee on an ongoing basis.**	6/12/12

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F 280	Continued From page 7 PM confirmed the facility failed to updated the care plan to address the resident's hydration needs.	F 280	F280 Resident care plans will be updated to ensure all identified areas of concern are addressed. This will be accomplished by:	
F 282 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure care was provided in accordance with the written plan of care for 2 of 24 sample residents (#7, #95). The findings were: 1. According to the care plan for nutritional status, initiated 1/9/12, staff were instructed to request additional supplementation if the weight of resident #7 dropped below 98 pounds (lbs). Review of the weight record showed on 2/2/12 the resident's weight dropped below 98 lbs, to 97.2 lbs. Further review of the weight record showed the resident's weight continued to drop, and stayed below 98 lbs. The most recent weight was 87.6 lbs on 4/24/12. However, there was no evidence staff requested additional supplementation when the resident's weight dropped below 98 lbs. During an interview on 4/25/12 at 5:15 PM, the RD stated she was not informed of the resident's weight loss until the day before (4/24/12), and she was going to add additional Ensure supplements at meals.	F 282	1. Corrective Action: a. Resident #43 Care Plan was updated to indicate the hydration needs for this resident. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for updating Care Plans was reviewed and remains current. b. All residents at risk of dehydration will have their Care Plans reviewed to assure their hydration needs are indicated. c. An Inservice on updating Care Plans will be held for nurses. 3. Random chart audits on different units will be conducted by DON/Designee weekly for 90 days to assure hydration needs are indicated for residents with risk of dehydration. corrective action will be taken as indicated kk 4. DON/Designee will report results of these audits to QA Committee for monthly kk review and recommendations. 6/12/12	

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F 282	Continued From page 8 2. Review of the care plan, updated on 2/17/12, showed interventions for incontinence for resident #95 included check/change before/after meals, and at bedtime and when necessary. Staff failure to follow the care plan was identified during the following continuous observations on 4/24/12: From 8 AM until 9:15 AM the resident ate breakfast. From 9:15 AM to 9:45 AM s/he sat at the dining room table taking sips of water after the breakfast tray was removed. At 9:45 AM, CNA #3 wheeled the resident to the TV area where s/he remained until 11:25 AM when CNA#4 wheeled him/her to his/her room. The resident sat in his/her room from that time until 11:40 AM. Observation at 11:40 AM revealed CNA#3 and a second CNA went into the resident's room. Interview with CNA#3 at 11:50 AM revealed the CNAs provided incontinence care for the resident at 11:40 AM. Interview with unit manager #1 on 4/26/12 at 11:40 AM revealed it was important for staff to check and change the resident before and after meals because s/he received daily doses of a diuretic. The unit manager also stated she was on duty on 4/24/12 but she did not know the resident wasn't checked or changed for the prolonged period of time.	F 282	F282 Care will be provided in accordance with the written plan of care. This will be accomplished by: 1. Corrective Action: a. Nutritional need interventions were added for resident #7 b. Staff caring for resident #95 were counseled on the need to follow the incontinence care plan. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for providing incontinence care was reviewed and remains current. b. The facility has begun weekly nutritional meetings to discuss residents at nutritional risk which includes assuring appropriate interventions are in place. Dietary leadership as well as nursing leadership are in attendance. c. An Inservice on providing incontinence care and nutritional interventions will be held.	
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:	F 312	3. a. Random audits of incontinence care provided according to care plan will be completed weekly by DON/Designee on different units at different times for 90 days. corrective action will be taken as indicated b. Care interventions for residents at nutritional risk will be reviewed weekly by the Nutrition Risk committee. This will be an ongoing process to assure all residents at nutrition risk have the ~~necessary interventions care planned.~~	

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F 312	Continued From page 9 Based on observation, staff interview and medical record review, the facility failed to ensure oral care was provided for 2 non-sample residents (#55, #118) during 2 of 3 random observations of bedtime care. The findings were: 1. Observation on 4/24/12 at 8 PM showed nurse aide (NA) #1 and NA #2 did not provide oral hygiene for resident #118 before or after transferring the resident to bed. Review of the 4/11/12 annual MDS assessment and corresponding care plan showed the resident required total assistance with oral hygiene and personal care. 2. According to the 1/25/12 annual MDS assessment and corresponding care plan, resident #55 was totally dependent on staff for provision of oral hygiene and personal care. Observation on 4/24/12 at 8:30 PM revealed NA #2 did not provide oral hygiene before or after transferring the resident to bed. Interview with unit manager #1 on 4/26/12 at 11:40 AM revealed staff were expected to provide oral hygiene for all residents at bedtime.	F 312	4. DON/Designee/Dietician will report results of these visual audits to QA Committee for review and recommendations. → monthly F 312 Residents who are unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming, personal care and oral hygiene. This will be accomplished by: 1. The staff providing care for residents #55 and #118 were counseled on the need to include offering oral care at hs. 2.Corrective Action as a. The Policy and Procedure for providing hs cares was reviewed and remains current. b. An Inservice on providing oral care will be held. 3. Random visual audits will be conducted by DON /Designee weekly on different units for 90 days to assure oral cares are being provided as care planned. corrective action will be taken as indicated KR 4. DON/Designee will report results of these audits to QA Committee for review and recommendation. → monthly 6.12.12 KR	6/12/12 6/12/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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F 315	Continued From page 10 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate care and services to address urinary incontinence was provided for 1 of 11 sample residents (#95) with bladder incontinence. The findings were: Review of the 1/25/12 quarterly MDS assessment for resident #95 showed the resident was always incontinent of urine, and required total assistance with toileting. Review of the care plan, updated on 2/17/12, showed interventions for incontinence included the following: use disposable briefs, check/change before/after meals, at bedtime and when necessary. Staff failure to provide incontinence care in a timely manner was identified during the following continuous observations on 4/24/12; From 8 AM until 9:15 AM the resident ate breakfast. From 9:15 AM to 9:45 AM s/he sat at the dining room table taking sips of water after the breakfast tray was removed. At 9:45 AM, CNA #3 wheeled the resident to the TV area where s/he remained until 11:25 AM when CNA #4 wheeled him/her to his/her room. The resident sat in his/her room from that time until 11:40 AM. Observation at 11:40 AM revealed CNA #3 and a second CNA went into the resident's room. Interview with CNA #3 at 11:50 AM revealed the CNAs provided incontinence care for the resident at 11:40 AM, and confirmed the resident was wet. Interview with unit manager #1 on 4/26/12 at	F 315	F 315 Residents who enter the facility will receive appropriate care and services to address urinary incontinence. This will be accomplished by: 1. Corrective Action: a. The staff assigned to resident #95 care on 4/12/12 am were counseled on the need to provide incontinence care according to the care plan. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for providing incontinence care was reviewed and remains current. b. An Inservice on providing incontinence care as planned will be held KLN 3. Random visual audits will be completed by DON/Designee weekly on different units for 90 days to assure incontinence care is being provided as care planned. corrective action will be taken as indicated KLN 4. DON/Designee will report the results of these audits to QA Committee review → monthly KLN and recommendation. 6/12/12	

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F 315	Continued From page 11 11:40 AM revealed it was important for staff to check and change the resident before and after meals because s/he received daily doses of a diuretic. The unit manager also stated she was on duty on 4/24/12 but she did not know the resident wasn't checked or changed for the prolonged period of time.	F 315	**F 323** **The facility must ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance to prevent accidents. This will be accomplished by:**	
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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that 2 of 5 nursing units (Ellbogen, East) were free from accident hazards. The findings were: 1. Observation on 4/23/12 at 3:30 PM showed the steam table in the "Ellbogen" kitchen/dining area was turned on in preparation of the evening meal. Two of the four wells were covered with lids and were hot and steaming. There was nothing in place to warn of the hot surface and potential danger of being burned, and the steam table was accessible to any resident who came into the kitchen/dining area. Additional observation on 4/26/12 at 11:33 AM showed the steam table was hot and there were no precautions provided for warning residents. Review of a list provided of	F 323	**1. The steam table will be moved to limit resident access.** **2. The East Station Activity Stove was electrically manipulated with addition of safety switch to prevent it from being turned on without staff supervision.** **3. An in-service for activity and nursing personnel will be conducted to heighten awareness of deficient practice.** **4. Random visual Audits of Ellbogen Steam Table and East Activity stove will be conducted over the next 90 days.** by Safety Director Corrective Action will be reviewed as indicated monthly KLH **5. The Safety Committee Director will report results to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.** 6/12/12	

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F 323	Continued From page 12 residents who wander revealed three residents on this unit were known wanderers (#34, #73, #111). Interview with dietary aide #1 on 4/26/12 at 11:33 AM revealed the steam table was turned on 30 minutes to an hour prior to meals, and staff were not always in the area. She then verified the hot steam table presented a danger to anyone who may touch it. Observation on 4/26/12 at 11:33 AM showed a temperature of one of the surface wells was 115.4 degrees F. The temperature was taken with an infrared laser thermometer. 2. Observation on 4/24/12 at 3:30 PM in the activity area by the east nursing station revealed a stove with four burners on top and an oven. There were residents ambulating in the area and in the adjacent hallway. The following concerns were noted: a. The stove had no secure features and could be heated with a simple adjustment of the control knobs. b. No staff was in the area to monitor for safety during the 4/24/12 observation at 3:30 PM. c. The following residents with wanderguards (electronic protection for wandering/confusion) were living in the east nursing station area: #28, #27, #33, #46, #48, #68, #100, #116, #117, #119, #121, #129, #138, # 139, #156, #147, #167, #168, and #172. d. Interview with the maintenance director on 4/26/12 at 11:35 AM confirmed the stove in the east nursing station activity area had no safety features to protect residents who were confused from heating the stove.			
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 323	**F 325** **The facility will maintain resident nutritional status unless unavoidable. This will be accomplished by:** **1. Residents # 7, 109, 140 will be reassessed by RD with identified interventions for nutritional needs implemented.** **2. Revised procedures for identifying and addressing weight loss for all other residents will be implemented through a Nutrition Risk committee.** **3. An in-service discussing the deficient practice and plan of correction will be conducted for nursing and dietary staff.** **4. Dietary Manager or designee will conduct chart audits to assure that at risk residents are identified and appropriate interventions implemented.** weekly/KBa **5. Results of these audits will be reported to the QA Committee for a minimum of 90 days at which point the team will determine appropriate reporting until compliance is achieved.** monthly KB 6/12/12	

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F 325	Continued From page 13 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the accuracy of nutritional assessments and failed to implement interventions in a timely manner to maintain nutritional status for 3 of 9 sample residents (#7, #109, #140) with unplanned weight loss. The findings were: 1. Review of the vital signs and weight records for resident #109 revealed s/he weighed 138 pounds (lbs) on 1/6/12 and 105.9 lbs on 4/24/12. Review of the 2/2/12 CDM nutritional review showed the resident was 95 years old, 67 inches tall, weighed 132 pounds, and experienced an unplanned weight loss of 10.8% in ninety days and 19.8% in one hundred eighty days. This review indicated a referral to the RD was needed. However, further review of the medical record showed no evidence the RD was notified of the weight loss. Interview with the RD on 4/25/12 at 5:15 PM revealed she had not been able to follow up on the dietary manager's referral made on 2/2/12 related to the weight loss.	F 325		

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2. Review of the 1/16/12 annual MDS assessment revealed resident #7 was 51 inches tall and weighed 101 lbs. Review of the care plan dated 1/9/12 revealed the resident had an elevated body mass index (BMI) of 27.3, but was at risk for weight loss due to poor oral intake. The goal was for the resident to maintain his/her weight above 98 lbs. The resident received super cereal with breakfast and a shake at lunch. The care plan directed staff to request additional supplementation if the resident's weight dropped below 98 lbs. The following concerns were identified:

a. Review of the weight record showed the resident's weight dropped below 98 lbs on 2/2/12, at 97.2 lbs. Further review showed the following weights: 94 lbs on 2/16/12, 89.7 lbs on 2/28/12, 91.5 lbs on 3/6/12, and 88.7 lbs on 3/22/12. There was no evidence staff requested additional supplementation after the resident's weight dropped below 98 lbs. The resident's most recent weight on 4/24/12 was 87.6 lbs.

b. Review of the CDM nutritional review dated 3/25/12 revealed the resident weighed 89 lbs and had a BMI of 16.9 (underweight). The review indicated the resident had a significant unplanned weight decline in 3 months of 11.9%, and the resident was under his/her IBW (ideal body weight). However, the review indicated that a referral to the RD was not made. During an interview on 4/25/12 at 5:15 PM, the RD stated she was not notified of the resident's weight loss until the day before, 4/24/12 (after the surveyor requested information on the resident's weight status). After the notification, the RD updated the care plan to reflect the unplanned significant weight loss, and added additional

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F 325	Continued From page 16 supplementation at the breakfast and supper meals. c. Review of the consumption flow record for March and April 2012 revealed staff did not consistently document whether or not the resident consumed the supplements (shakes). On 4/26/12 at 8:21 AM, CDM #1 stated the dietary aides were supposed to document the supplements on the consumption record for each meal. 3. Review of the 3/2/12 significant change MDS assessment showed resident #140 was 67 inches tall and weighed 136 lbs. The associated care plan dated 3/2/12 showed a goal for the resident to maintain his/her weight at 130 lbs or more. According to the subsequent 4/24/12 quarterly MDS assessment, the resident weighed 126 lbs and had an unplanned weight loss. The following concerns were identified: a. Review of the 3/16/12 CDM nutritional review showed the resident weighed 127 lbs. The review indicated the resident experienced a significant unplanned weight loss of 6.6% in 30 days, and 12.4% in 180 days. The review indicated a referral to the RD was made. However, continued review revealed no evidence the RD was made aware of the resident's weight loss. b. During an interview on 4/25/12 at 5:15 PM the RD stated she had not changed interventions with the resident, and had no additional information. She further stated she was on vacation during part of that time. 4. During an interview on 4/25/12 at 5:15 PM, the RD stated there was not enough time to track residents closely who had weight loss. She further stated the facility no longer had a nutrition	F 325		

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F 325	Continued From page 16 at risk committee to follow residents with weight loss. On 4/26/12 at 8:21 AM, CDM #1 stated there was not a good process in place for nursing staff to inform her of weight loss with residents. She further stated there was no system in place to identify weight loss between the RD's annual assessment and her quarterly assessments. 5. According to the "Dietary Guidelines for Americans 2010" Evidence based nutritional guidance published by the U.S. Department of Agriculture and U.S. Department of Health and Human Services, estimated calorie needs per day are based on age, gender, and physical activity level. The detailed chart in Appendix 6 of these guidelines showed sedentary men 76+ years old need an estimated 2200 calories/day, and sedentary women 76+ years old need an estimated 1600 calories/day to maintain calorie balance. The following concerns were identified: a. The 3/25/12 CDM nutritional review showed resident #7 was 92 years old, was 51 inches tall, weighed 89 pounds, and had experienced a significant weight decline. The resident's estimated nutritional needs were calculated at 908 calories. b. According to the 3/16/12 CDM nutritional review, resident #140 was 82 years old, 67 inches tall, weighed 127 pounds, and had experienced a significant weight loss. The resident's estimated nutritional needs were calculated at 1157 calories. c. Review of the 2/2/12 CDM nutritional review showed resident #109 was 95 years old, was 67 inches tall and weighed 132 pounds. The estimated nutritional needs was calculated at 1109 calories. d. Interview with the RD on 4/25/12 at 5:15 PM revealed she was not aware how the	F 325		

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F 325	Continued From page 17 estimated nutritional intake for each resident was being determined or calculated. The RD stated the estimated needs were calculated by the computer program the CDMs used when inputting their data on residents, and she was uncertain if these calculation were reasonable. The RD stated she and the CDM had discussed concerns with the calculations when they first started using the computer program, but that no further action was taken because the emphasis was on care plans, not the estimated caloric needs.	F 325	F 327 The facility must provide each resident with sufficient fluid intake to maintain proper hydration. This will be accomplished by: 1. Corrective Action: a. Residents #43, 95 and 113 were reassessed for hydration needs and appropriate interventions put into place. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for assessing nutritional needs, including hydration, was reviewed and revised. b. All resident at hydration risk will be reviewed to assure they have a plan in place to address their hydration needs. c. An Inservice on assessing and providing hydration needs will be held. 3. Random chart audits will be conducted by Dietician/Designee weekly on different units for 90 days to assure hydration needs have been assessed and appropriate interventions in place. 4. Dietician/Designee will report the results of these to QA Committee for review and recommendations.	monthly 6/12/12
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 3 of 24 sample residents (#43, #95, #113) received sufficient fluid intake to maintain proper hydration. The findings were: According to Geriatric Nursing Resource for Care of Older Adults, "Hydration Management", evidence based content updated March 2008, by Janet Mentes: Dehydration risk factors include the following: ADL dependencies, dementia, infections, certain medications, and prior episodes of dehydration. 1. Review of the medical record for resident #43 showed s/he was admitted to the facility on	F 327		

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3/27/12 with diagnosis which included dementia. Review of the resident's 4/3/12 admission MDS assessment showed s/he did not trigger for dehydration or fluid maintenance. Review of the resident's 4/10/12 history and physical showed s/he had a 4/10/12 hospitalization with a diagnoses of severe dehydration and severe hypernatremia. The following concerns were noted:

a. Review of the care plan showed the facility failed to develop a plan to ensure hydration needs after the resident's 4/10/12 hospitalization for severe dehydration.

b. Review of the resident consumption flow records (covering breakfast, lunch, and dinner), the only record of the resident's fluid intake from 3/28/12 through 4/24/12, showed a minimum fluid intake of 240 cubic centimeters (cc) on 4/20/12 and 4/21/12, and a maximum fluid intake of 940 cc on 4/23/12. The estimated fluid need for the resident was determined on the 4/23/12 nutritional review to be 2400 cc in 24 hours.

c. Interview with the DON on 4/25/12 at 5:15 PM confirmed the facility did not have a plan to address the resident's identified hydration needs; and the facility did not know how much fluid intake the resident had.

2. Review of the 1/25/12 quarterly MDS assessment for resident #95 showed s/he had dementia, required extensive and total assistance with most ADLs. Review of the medical record and April 2012 MAR showed the resident's current medications included Lasix (a diuretic) 80 milligrams twice a day and medication for Clostridium difficile infection. Review of the care plan, updated 2/17/12, showed staff were directed to provide prompting, cueing,

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encouragement, and reminding assistance at mealtime. Review of the 4/19/12 CDM nutritional review showed the resident had the following signs and symptoms of dehydration: edema, nine or more medications, infection, gastric reflux and dry lips. This review also showed the estimated daily fluid needs for the resident was 1118 cc. The following concerns were identified:

a. Review of the resident consumption flow record for March and April 2012 showed staff only documented the resident's fluid intake during meals. Review of the April 2012 resident consumption flow record for April 2012 was incomplete or blank for eight of twenty-four days.

b. Continuous observation on 4/24/12 after breakfast from 9:15 AM until 11:40 AM revealed staff did not offer or encourage resident to drink fluids while s/he sat in the TV area and his/her room.

3. Review of the 3/13/12 nutrition CAA (care area assessment) summary for resident #113 showed risk for dehydration related to use of diuretics, limited ability to self feed, and insufficient consumption with and between meals. Review of the medical record and April 2012 MAR showed the resident's current medications include Lasix and HCTZ (both are diuretics) and medication for Clostridium difficile infection. Review of the 3/6/12 CDM nutritional review showed the resident was at risk for dehydration and his/her daily fluid needs was 1118 cc. The review also showed the CDM documented the resident's "mouth very dry, gave a glass of water." Review of the 4/8/12 speech therapy progress report and discharge summary showed, the resident's current level of function required one to one assistance and maximum assist to effectively cue patient to

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F 327	Continued From page 20 utilize swallow intake of nectar thickened liquids. Observation on 4/24/12 at 9:30 AM and again at 11:10 AM revealed staff pushed the resident from the TV area to his/her room and provided toileting assistance then pushed him/her back to the TV area without offering or encouraging fluids. Review of the April 2012 resident consumption flow record showed it was incomplete. This review also showed documentation that the resident received more than 900 cc's only on 3 of 25 days. 4. Interview with CNA#5 on 4/26/12 at 8:15 AM revealed the CNAs had not been directed to provide increase fluids for residents #95 and #113. The CNA also stated in the past residents were given fluids between meals, but this was discontinued many months ago. During an interview on 4/26/12 at 8:20 AM, the nursing unit manager #2 confirmed fluids were not offered or encouraged between meals unless care was being provided. She stated residents #113 and #95 needed increased fluids due to recent infections and both resident had multiple risk factors for dehydration. She further stated the monitoring and assessment the residents needed had not been done because the facility did not have an effective system for ensuring residents' hydration needs were met.	F 327		
F 363 SS=F	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		

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F 363	Continued From page 21	F 363	**F 363**	

This REQUIREMENT is not met as evidenced by:
Based on review of the menu, observation, and staff interview, the facility failed to ensure the nutritional needs of residents were met when 1 of 1 menu was reviewed. The findings were:

Observation in the south kitchen on 4/25/12 at 11:30 AM of the mid day meal service showed the serving sizes shown on the menu, and served to the residents were 2 ounces (oz) instead of the standard 4 oz serving size for potatoes and vegetables (According to the Simplified Diet Manual, 9th Edition, Iowa Dietetic Association). Observation of the east unit kitchen on 4/25/12 at 11:40 AM, and the Central unit kitchen at 12:10 PM showed the same serving sizes were being used. Review of the weeks menu (4/22- 4/28) showed the potatoes and vegetables were consistently planned to be a 2 oz serving. Interview with CDM #1 on 4/25/12 at 11:45 AM verified the menu portion sizes had been made smaller to reduce the amount of wasted food. At that time, when the day's menu (4/25/12) was reviewed on the computer program for 4/25/12, the nutritional analysis showed the daily total for calories was 1642, there was no value for carbohydrates, and the protein total for the day was 77.6 grams. Continued discussion with the CDM revealed she wasn't sure what the requirements were for the nutrition of the menu.

According to the "Dietary Guidelines for Americans 2010" Evidence based nutritional guidance published by the U.S. Department of Agriculture and U.S. Department of Health and

Menus will meet the needs of residents in accordance with recommended alowances of th Food and Nutrition Board of the National Reserach Council, National Academy of Sciences. This will be accomplished by:

1. **The menu portions reflected were changed to meet the required daily allowances.**
2. **The policy and procedure for reviewing menus was revised to include review by the RD.**
3. **An inservice was held for the Dietary Department regarding the updated menus and the deficient practice.**
4. **RD will audit random meals to assure compliance with immediate corrective action in the event there is departure from the approved practice.** designee KLR — monthly for 90 days KLR
5. **Results of these audits will be reported to the QA Committee for a minimum of 90 days at which point the team will determine appropriate reporting until compliance is achieved.** monthly KLR — 6/12/12

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F 363	Continued From page 22 Human Services, estimated calorie needs per day are based on age, gender, and physical activity level. The detailed chart in Appendix 6 of these guidelines showed sedentary men 76+ years old need an estimated 2200 calories/day, and sedentary women 76+ years old need an estimated 1600 calories/day to maintain calorie balance. Interview with the RD on 4/25/12 at 5:15 PM revealed she was not involved with planning or approving of the menus. The RD stated she was aware that CDM #1 had made some changes to the menu portions in order to reduce waste; however, she had not reviewed the changes. In addition, she and CDM #1 thought residents desiring more food than was served could ask and have an additional serving, so they did not have concerns regarding the small portions being served to all residents.	F 363	F 368 The facility must offer snacks at bedtime daily. This will be accomplished by: Corrective Action: a. The practice of offering HS snacks for all residents was initiated as soon as the discrepancy was identified. 1. Corrective Action as it applies to other residents: a. The Policy and Procedure for offering HS snacks was reviewed and remains current. b. All residents will be offered an HS snack per policy. c. An In-service on providing HS snacks will be. held x4	
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	F 368	3. Random visual audits will be conducted by DON/Designee on different units weekly for 90 days to assure HS snacks are being offered per policy. corrective action will be taken as indicated x4 4. DON/Designee will report the results of these audits to QA Committee review monthly x4 and recommendations. 6/12/12	

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F 368	Continued From page 23 nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, and staff and resident interview, the facility failed to offer snacks at bedtime in 2 of 3 resident units observed for evening snacks. The findings were: 1. During a group interview on 4/24/12 at 3 PM, 11 of 11 residents stated evening snacks were not offered to residents. The residents stated that sometimes snacks were available at the nursing station, but residents would have to request a snack, or get it themselves. The residents also said that sometimes snacks were not even available at the nursing station. The residents resided on the east, central and south units. 2. Interview on 4/24/12 at 7:35 PM with resident #150 stated snacks were not offered prior to bed time. Interview on 4/24/12 at 8:30 PM with residents #16 and #87 stated evening snacks were not offered. Further, the residents stated food items were available but they had to ask for them. 3. Interview on 4/24/12 at 9 PM with CNA #1 stated residents needed to ask for snacks if they wanted something before going to bed. 4. Observation of the east and central nurses' stations showed a container of snacks to include popcorn, chips and juice was sitting on the nurses' desk. Random observations on 4/24/12 from 7:30 PM to 9 PM did not show the nursing	F 368		

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F 368	Continued From page 24 staff had asked residents if they wanted a snack prior to going to bed. 5. Interview on 4/24/12 at 8:30 PM with nurse aide (NA) #2 and at 9:05 PM with RN #2 revealed the staff on the east nursing unit did not routinely offer snacks to the residents. They further stated the snacks were available if the residents asked for them or awakened during the night and walked to the nurses desk to get a snack.			
F 371 SS=F	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food equipment was clean in 3 of 5 kitchens (main, east, central) and that fingernail brushes were labeled and used for a single use or person. The findings were: 1. Observation on 4/23/12 at 3:20 PM and on 4/25/12 at 10:55 AM showed the following items that needed to be cleaned: a. In the main kitchen, the electric meat slicer which was sitting on a counter covered with a	F 368	**F 371** **The facility will store, prepare and serve food under sanitary conditions. This will be accomplished by:** **1. The electric meat slicer and stand mixer in the main kitchen, two microwaves were cleaned as soon as the issue was identified. The fingernail brushes were discarded.** **2. The policy and procedure for utensil and equipment cleaning and use of fingernail brushes was revised.** **3. An in-service was held for the Dietary Department regarding equipment cleaning and single use fingernail brushes per the identified deficient practice.** **4. CDM or designee will will conduct weekly audits for 90 days to assure compliance with immediate corrective action in the event there is departure from the approved practice.** **5. Results of these audits will be reported monthly to the QA Committee for a minimum of 90 days at which point the team will determine appropriate reporting until compliance is achieved.**	6/12/12
F 371				

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F 371	Continued From page 25 white bag to show it was clean, was not clean. There were small bits of food stuck to the blade and the platform of the slicer. In addition, the counter below the slicer had dried pieces of food that had accumulated. b. The stand mixer in the main kitchen which was not in use showed it had dried splattered food underneath and on the mixing arm. c. Two microwaves, one in the south kitchen/dining room and the other in the central unit kitchen were in need of cleaning. They both had dried splattered food on the interior of the ovens. According to Food Code 2009, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch... (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 2. Observation on 4/23/12 at 3:20 PM showed two unlabeled fingernail brushes on the edge of the hand washing sink in the dish room of the main kitchen. Interview with CDM #1 on 4/26/12 at 8:40 AM revealed she didn't know if anyone ever used the nail brushes. According to Food Code 2009, U.S. Public Health Service, Annex 3- Public Health Reasons / Administrative Guidelines: 2-301.12 Cleaning Procedure. "...Fingernail brushes, if used properly, have been found to be effective tools in decontaminating this area of the hand. Proper use of single-use fingernail brushes, or designated individual fingernail brushes for each employee, during the hand washing procedure	F 371		

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F 371	Continued From page 26 can achieve up to a 5-log reduction in microorganisms on the hands."	F 371	F441 The facility must establish and maintain an Infection Control Progarm that will provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. This will be accomplished by:	
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 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	F 441	1. Corrective Action: a. Staff involved were counseled on the need to leave wound cleanser in room for any resident on contact isolation, the procedure of disinfecting the bathroom commode after use when resident is on contact precautions, the procedure of allowing hand sanitizer to evaporate and not wiping it dry after use, the appropriate use of gloves and handwashing b. Documentation was completed for resident #145 to indicate lack of compliance with MD order for stool specimen and MD notification. 2. Corrective Action as it applies to other residents: a. The facility Infection Control Policy and Procedure was reviewed and remains current. The Policy includes appropriate glove use, procedures for contact precautions, handwashing and use of hand sanitizer and tracking/trending and action plans for infections.. b. Data analysis will begin on resident infections to include clinical resolution and identification of infectious organisms. c. An Inservice on following the Infection Control Policy which includes	

Infection which includes

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F 441	Continued From page 27 infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures and infection control logs, the facility failed to ensure staff followed appropriate infection control practices during 4 random observations. In addition, the infection control program failed to ensure data collection and analysis was adequate to have an effective program. The findings were: 1. On 4/24/12 at 7:40 PM RN #3 was observed providing treatment to the skin tear area on resident #113's arm. Continuous observation revealed that although a contact isolation sign was posted on the resident's door, the RN took the wound cleaner into the room, used it to clean the bleeding wound, brought the bottle of solution out of the room and placed it on the treatment cart. Interview with the RN at 8:45 PM revealed she acknowledged the wound cleaning solution should have remained in the room, but at the time she "forgot to do that". At that time the RN discarded the wound cleaning solution to prevent further use. 2. On 4/24/12 at 9:30 AM and again at 11:10 AM staff were observed providing toileting assistance for resident #113 in the resident's room. At 9:30 AM CNAs #3 and #6 assisted the resident and donned the appropriate PPE (personal protective equipment) for contact isolation, but the CNAs did not disinfect the bathroom commode after completing the task. At 11:10 AM CNA #4 was	F 441	proper glove use, handwashing, tracking of infections, use of hand sanitizer and procedures for isolation precautions, including contact precautions will be held. 3. a. Random audits by DON/Designee to visually check handwashing and glove use, use of hand sanitizer, proper procedures for contact precautions and specimen collection will be done weekly on various units for 90 days. corrective action will be taken as indicated LRN b. Infectious organisms will be identified for residents on antibiotics as well as the clinical outcomes for these residents. This will be a part of the Infection Control Tracking Log and will be done on an ongoing basis. Reports of infection Control tracking will be reviewed at QA meeting. 4. DON/Designee will report the results of these audits to QA Committee review and recommendation. → monthly LRN 6/12/12	

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F 441	Continued From page 28	F 441		

observed assisting the resident in the same bathroom and disinfected the bathroom commode after use. Interview with the CNA at that at time revealed staff were expected to disinfect the bathroom commode after use and all the CNAs had received these instructions.

3. Observation on 4/23/12 at 8:50 AM showed RN #1 gave resident #72 his/her medication. Following the medication pass, the RN cleansed her hands with the hand sanitizer and immediately wiped her hands dry with a paper towel. At 9 AM, the RN donned her gloves and administered eye drops to resident #119. Following the procedure, she removed her gloves and applied hand sanitizer then immediately dried her hands with a tissue. Review of the policy and procedure for "Hand Cleaner, Antiseptic" procedure #425, showed staff are to apply approximately 1 to 3 cc (cubic centimeter) of antiseptic cleanser into the palm of their hand. The hands are to be rubbed briskly until the cleanser has evaporated.

4. Observation on 4/23/12 at 8:15 AM showed CNA #2 donned her gloves to assist with incontinence care for resident #33. After completing incontinence care, the CNA removed her gloves and opened the resident's door to exit the room before washing her hands. At 8:30 AM the CNA donned her gloves to change the same resident's urine collection bag. After the CNA changed the bag, she removed her gloves and continued to provide personal care to include combing the resident's hair. The CNA did not cleanse her hands after removing her gloves. Review of the policy and procedure for handwashing, last reviewed August 2009, showed

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F 465	Continued From page 30 Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment in 3 of 5 kitchens (main, east, central). The findings were: 1. Observation on 4/23/12 at 3:20 PM showed the entrance to the walk-in freezer in the main kitchen had large amounts of accumulated ice around the door frame, on the floor and on the plastic curtain in the entrance. Interview with CDM #2 at that time revealed the ice had been an ongoing problem for more than a year. Interview with the maintenance director on 4/25/12 at 4:45 PM regarding the freezer and the ice problem verified it was an old problem, and had not been fixed due to cost. 2. Observation on 4/23/12 at 3:20 PM and on 4/25/12 at 10:55 AM revealed the condenser unit fan covers in each of the walk-in refrigerator units in the main kitchen had thick accumulation of dust. The food and beverages in the areas were covered; however, interview with CDM #1 on 4/26/12 at 8:40 AM verified the dirty fan covers should be kept clean. 3. Observation on 4/25/12 at 10:55 AM showed the partition wall located in the main kitchen near the produce sink was damaged and crumbling near the floor. The damaged area was measured to be 1.5 feet long by 4 inches high. 4. Observation on 4/25/12 at 11:43 AM showed a ceiling exhaust vent located in the east unit kitchen that was occluded more than 50 percent with dust. In the central unit kitchen there was also a ceiling exhaust vent occluded with dust. Interview with the maintenance director on	F 465		

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F 441	Continued From page 29 the nursing staff are to wash their hands "After removing gloves." 5. Review of the 4/10/12 physician orders for resident #145 showed "...stool for c. difficell toxin, giardia antigens and culture..." Further review of the medical record failed to show evidence the specimen was obtained or any laboratory services were provided. Interview with the DON on 4/25/12 at 10:15 AM verified the specimen had not been collected. She then stated according to the nurses, the resident was not being compliant in providing the specimen; however, there was no documentation to show this or what the plan was for further follow-up. Interview with the infection control nurse on 4/26/12 at 10:50 AM revealed she was not aware of this order. 6. Interview with the infection control practitioner (ICP) on 4/26/12 at 9:10 AM and review of the January to April 2012 infection control surveillance logs revealed the facility's infection control program lacked data analysis, failed to show the final clinical resolution for residents documented as receiving antibiotic therapy for an infection, and did not include the identity of infectious organisms.	F 441	**F 465** **The facility will provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. This will be accomplished by:** **1. The condenser unit fan covers in the walk-in refrigerators were cleaned by maintenance.** **2. The partician wall was repaired by maintenance.** **3. The ceiling exhaust vent in the East & Central Kitchen was cleaned.** **4. The policy and procedure for preventative maintenance and regular cleaning of vents and fan covers was revised.** **5. An in-service was held for the Dietary & Maintenance Department regarding the identified deficient practice.** **6. Maintenance Department will conduct weekly audits to assure compliance with immediate corrective action in the event there is departure from the approved practice.** **7. Results of these audits will be reported to the QA Committee for a minimum of 90 days at which point the team will determine appropriate reporting until compliance is achieved.** → monthly KeL	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 465		6/12/12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 31 4/25/12 at 4:45 PM verified the vents were for air exhaust and they were in need of cleaning.	F 465	F502 The facility will provide or obtain quality and timely laboratory services.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory services were obtained for 1 of 24 (#145) sample residents with laboratory orders. The findings were: Review of the 4/10/12 physician orders for resident #145 showed "...stool for c. difficell toxin, giardia antigens and culture..." Further review of the medical record failed to show evidence the specimen was obtained or any laboratory services were provided. Interview with the DON on 4/25/12 at 10:15 AM verified the specimen had not been collected. She then stated according to the nurses, the resident was not being compliant in providing the specimen; however, there was no documentation to show this or what the plan was for further follow-up. Interview with the infection control nurse on 4/26/12 at 10:50 AM revealed she was not aware of this order.	F 502	This will be accomplished by: 1. Corrective Action: a. Documentation to include physician notification regarding resident #145 non-compliance with obtaining a stool specimen and further plan of care was completed immediately after the concern was identified. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for following physician orders was reviewed and remains current. b. An In-service on necessary documentation if a resident is non-compliant with a physician order will be held. 3. Random chart audits will be conducted by DON/Designee on different units weekly for 90 days to assure any resident who is non-compliant with a physician's order has documentation to include physician notification and plan. 4. DON/Designee will report the results of these audits to QA Committee review and recommendations. monthly 6/12/12	