STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0042	A. BUILDING _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

(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	F 000		

The following common abbreviations are used throughout this document:

CDM Certified Dietary Manager
DON Director of Nursing
MDS Minimum Data Set
RN Registered Nurse

Less commonly used abbreviations will be annotated in each deficiency where used.

Definitions:

Shahbaz: Direct care staff who are certified nurse aides. They provide housekeeping and cooking services in addition to nursing care.

Shahbazim: plural of shahbaz

F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	F 176		7/13/12

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of policies and procedures, medical record review and staff interview, the facility failed to ensure one non-sample resident (#9) who self administered medications during a random observation was evaluated to be safe to self medicate. The findings were:

Green House Living for Sheridan will ensure that any Elder wishing to self-administer medications is safe to do so. This will be accomplished by:
1. GHLS policy Self-Administration of Drugs has been changed to read:
a. In addition to general

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Szymanski	Administrator	7/16/12

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.

7/23/12 PoC accepted.

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F 176	Continued From page 1	F 176		

Observation on 5/7/12 at 5:55 PM revealed RN #2 placed a cup of pills on the dining room table for resident #19. At that time the resident took only one of the pills and placed the cup with the remaining pills on the table. Continued observation revealed the RN departed from the area without observing whether resident #9 took the remaining pills. Interview that day at 6:05 PM with the RN revealed staff routinely left medications on the table for the resident to take at a later time. Review of the policies and procedures for self-medication administration revealed residents "may self-administer their own medications only if the attending physician in conjunction with the Interdisciplinary Care Planning Team [IDT] has determined that they have the decision making capacity to do so safely." Review of the medical record showed the attending physician and IDT had not completed an evaluation to determine whether the resident could safely self medicate. During an interview on 5/9/12 at 1:30 PM the DON confirmed the determination had not been completed for this resident.

evaluation of decision-making capacity, the nursing staff will administer a more specific skill assessment, the Self Med Admin assessment in ECS, which includes (but is not limited to) the Elder's:

i. Ability to read and understand medication labels;

ii. Comprehension of the purpose and proper dosage and administration time for his or her medications;

iii. Ability to remove medications from a container and to ingest and swallow (or otherwise administer them; and

iv. Ability to recognize risks and major adverse consequences of his or her medications.

2. After the medication self-administration is done by nursing staff, then the Interdisciplinary team will meet to determine that the elder can safely administer their own medications, and that the environment will support it. If it is determined that this is appropriate, then the interdisciplinary team will develop a process that will allow the elder to gain access to their medications (which will be locked up).

3. If it is determined through the quarterly MDS review or sooner through direct observation or DON monitoring that an elder can no longer safely self-administer medications, then he/she will be administered medications directly by the nursing personnel.

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F 176	Continued From page 2	F 176		

4. All nursing personnel will be trained regarding the new policy by July 13, 2012.

5. Elder #9 has a completed assessment in the record and a signed order from the physician that he is able to self-administer his medications. There are no other Elders at GHLS who self-administer medications.

6. The DON will develop a weekly monitoring tool from the MAR of all self-med elders to ensure proper documentation. Results from this monitoring tool will be reported to the Pharmacy Review Committee monthly. Actions taken as a result of this review will be reported to the QA committee quarterly.

F 225 SS=E 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS — F 225 — 7/13/12

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations

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F 225	Continued From page 3 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to check the State nurse aide registry for findings of abuse, neglect, or misappropriation of resident property for 3 of 3 shahbazim (#1, #2. #3) reviewed. The findings were: Review of the personnel files for the following employees revealed no evidence the Healthcare Licensing and Surveys (HLS) nurse aide registry was checked: a. Shahbaz #1 hired 1/20/12. b. Shahbaz #2 hired 3/12/12.	F 225	Update has been made to policy to include conducting investigations to check the State CNA Abuse Registry. Update has been made to policy to include conducting investigations to check the State CNA Abuse Registry. This policy includes statements that any CNA candidate(s) with an abuse or neglect report will be subject to investigations and potential follow-up disciplinary action, up to and including termination of employment.	

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F 225	Continued From page 4 c. Shahbaz #3 hired 1/20/12. An interview on 5/9/12 at 4:05 PM with the administrator, DON, and human resources director revealed they had not checked the State nurse aide registry because they were not aware that was required.	F 225	A comprehensive review of the current employees, including Shahbazim 1, 2 and 3, against the online registry was completed on 5-29-12. No employees were found with reported abuse or neglect findings. Printed copies of online checks were posted in the Employee's Personnel Records. As part of ongoing quality assurance monitoring, a new Inprocessing Checklist for new employees has been added to include the State CNA Abuse Registry check changes in hiring procedures to assist with eliminating future occurrences. A quarterly audit of Employee Personnel Records will further assist in correct registry verifications. Also a records review audit tool will be developed to check the accuracy of Personnel Records. Annual registry verification will be conducted on all current employees. This record will include CNA abuse registry verification. Regarding continuous quality implementation, any employee found with an abuse or neglect report will be subject to investigation and potential follow-up disciplinary action, up to and including termination of employment. The results of the registry verification and investigation monitoring will be reported quarterly to the QA committee.	

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F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		7/13/12

The facility must develop and implement written 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 review of policies and procedures, staff interview, and review of personnel files, the facility failed to develop policies to ensure the State nurse aide registry was checked as part of the screening process. In addition, the facility failed to ensure the reporting requirements were consistent with the regulations. The findings were:

1. Review of the facility's "Elder Abuse and Neglect Policy" (12/11) showed the licensing boards for RNs, licensed practical nurses, and certified nursing assistants would be checked; however, the policy did not state that the State nurse aide registry would be checked for findings of abuse, neglect, or misappropriation of resident property. Review of the personnel files for shahbaz #1, #2, and #3 showed no evidence the State nurse aide registry was checked. An interview on 5/9/12 at 4:05 PM with the administrator, DON, and human resources director revealed they had not checked the State nurse aide registry because they were not aware that was required.

2. Review of the facility's policy "Reporting Abuse to State Agencies and Other Entities/Individuals" (undated) revealed agencies, including the State

F226 #1
Update completed on 5-25-12 to the "Elder Abuse and Neglect" policy to include verifications of employees on the State CNA Abuse Registry. Shahbazim 1, 2, and 3, as well as all Shahbazim, were checked against the State CNA Abuse Registry with no negative findings. Printed copies of the online checks were posted in Employee Personnel Records.

As part of ongoing quality assurance monitoring, a new Inprocessing Checklist for new employees has been added to include the State CNA Abuse Registry check changes in hiring procedures to assist with eliminating future occurrences. A quarterly audit of Employee Personnel Records will further assist in correct registry verifications. Also, records review audit tool will be developed to check the accuracy of Personnel Records. Annual registry verification will be conducted on all current employees. This record will include CNA abuse registry verification.

Regarding continuous quality implementation, any employee found with

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F 226	Continued From page 6 licensing/certification agency, Adult Protective Services, and law enforcement, would be notified of allegations. Specifically, "...Verbal/written notices to agencies will be made within forty-eight (48) hours of the occurrence." An interview on 5/9/12 at 4:05 PM with the administrator, DON, and human resources director revealed they were aware allegations were to be reported immediately, which was defined by CMS (Centers for Medicare and Medicaid Services) as within 24 hours. 3. According to the facility's policy "Abuse Investigations" (12/11), written reports of the results of abuse investigations would be given to the State survey and certification agency and others within ten (10) working days of the reported incident. During an interview on 5/9/12 at 4:05 PM, the administrator, DON, and human resources director stated they were aware the timeframe for reporting the written results was five working days, not ten.	F 226	an abuse or neglect report will be subject to investigation and potential follow-up disciplinary action, up to and including termination of employment. The results of the registry verification and investigation monitoring will be reported quarterly to the QA committee. F-226 #2 Update has been made to "Reporting Abuse to State Agencies and Other Entities/Individuals" policy to correct that notices to agencies will be made in 24 hours versus the previously stated 48 hours. All GHLS staff will receive notification of this policy change via in-service education tool. F-226 #3 Update has been made to "Abuse Investigations" policy to state that the results of abuse investigations would be provided to the State survey and certification agency and others within 5 working days versus the previously stated 10 working days. All GHLS staff will receive notification of this policy change via in-service education tool.	
F 279 SS=E	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		7/13/12

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F 279	Continued From page 7 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop a comprehensive care plan for 3 of 7 sample residents (#8, #12, #16). The findings were: 1. Observation on 5/8/12 at 10:45 AM revealed shahbaz #2 provided incontinence care for resident #12, who was incontinent of bladder. Review of the 4/17/12 admission MDS assessment revealed the resident was frequently incontinent of bowel and bladder. Review of the care plan for incontinence, dated 3/31/12, showed staff were instructed to "toilet per scheduled toileting plan." However, further review of the care plan showed the scheduled toileting plan was not defined. On 5/9/12 at 8:55 AM, the	F 279	Green House Living for Sheridan will ensure that all Elders living in our cottages will have a comprehensive Care Plan, based on a thorough assessment. This will be accomplished by: 1. DON will utilize the (ECS) care plan assessment tool for continuous quality assurance monitoring, implementation and evaluation for ongoing corrective action. 2. DON Will meet weekly with Care Coordinators in each cottage to ensure that care plans are being updated and entered into ECS according to the care plan assessment tool. If toileting changes	

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F 279	Continued From page 8 DON stated the scheduled toileting plan should be in the shahbaz computer program, but was not for this resident. The DON stated the scheduled toileting plan had not been developed yet. 2. Review of the 4/23/12 admission MDS and care area assessment for resident #8 revealed s/he frequently had urinary incontinence and required extensive assistance with toileting due to cognitive impairment. Review of the care plan showed interventions that addressed urinary incontinence included: toilet per scheduled toileting plan. On 5/9/12 at 9:42 AM the private caregiver (#1) assigned to provide care for the resident was observed providing urinary and fecal incontinence care for him/her. At that time the caregiver stated a toileting schedule/plan had not been implemented. She also stated most of the time staff just tried to guess about the resident's elimination needs, but s/he was usually incontinent. During an interview with the DON on 5/9/12 at 1:45 PM she acknowledged the resident needed a toileting plan, but it had not been developed. 3. Observation on 5/8/12 at 10:45 AM revealed shahbaz #5 removed resident #16 from the breakfast table and transported the resident to his/her room where incontinence care was provided. Review of the 2/14/12 admission MDS assessment showed resident #16 was assessed for frequent bladder incontinence. Review of the resident's care plan for all ADL's including toileting showed only a generic statement: "I am Dependent and I need 1-2 assist." On 5/9/12 at 8:55 AM, the DON stated the scheduled toileting plan should be in the shahbaz computer program, but had not been developed yet.	F 279	need to be made, they will be evaluated and corrected in the Care Plan. Results of these monitoring meetings will be summarized and reported quarterly to the Quality of Care QA Committee. 3. MDS Coordinator will ensure that each triggered CAA is thoroughly addressed in the Care Plan every 90 days or more frequently as needed. 4. Scheduled toileting plan for resident #12 and #16 has been defined, is in the care plan, and on the Shahbaz assignment card. 5. Scheduled toileting plan for resident #8 has been defined, is in the care plan, and on the Shahbaz assignment cared. Private caregivers for resident #8 have been in-serviced regarding her toileting schedule.	

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F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI. RESTORE BLADDER	F 315		7/13/12

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 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 3 of 4 sample residents (#8, #12, #16) with bladder incontinence. The findings were:

1. Observation on 5/8/12 from 7:40 AM until 10:45 AM revealed resident #12 was not toileted or checked for incontinence. At 10:45 AM (3 hours 5 minutes after the start of observation) the resident put on his/her call light, which was answered by shahbaz #2. The resident said "I think I'm wet." The shahbaz provided incontinence care and confirmed the resident was wet. When asked what the toileting schedule was for the resident, the shahbaz stated when the resident got up for lunch, or when the resident requested. However, the shahbaz stated the resident did not always know when s/he needed to go. Review of the 4/17/12 admission MDS assessment revealed the resident was frequently

F315
Green House Living for Sheridan will ensure that all Elders who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This will be accomplished by:
1. All Elders who are incontinent of bladder will have a toileting schedule in place. All Shahbazim will be trained on appropriate care of those who are incontinent and the Guide, DON or designee will randomly observe Elders to ensure that their individual schedule is being adhered to. This observation will be completed weekly in each cottage and reported quarterly at the QA meeting.
2. All Shahbazim will be in-serviced by the DON on how ECS is used to ensure adherence to toileting schedule and documentation of scheduled toileting and

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F 315	Continued From page 10 incontinent of bowel and bladder. Review of the care plan for incontinence, dated 3/31/12, showed staff were instructed to "toilet per scheduled toileting plan." However, further review of the care plan showed the scheduled toileting plan was not defined. On 5/9/12 at 8:55 AM, the DON stated the scheduled toileting plan should be in the shahbaz computer program, but was not for this resident. The DON stated the scheduled toileting plan had not been developed yet. She further stated the toileting plans were "basically every two hours." 2. Observation on 5/8/12 from 7:30 AM until 10:45 AM (3 hours and 15 minutes) revealed resident #16 sitting at the table for the breakfast meal. At no time during the observation did staff ask the resident about toileting needs, or offer to take the resident to the bathroom. After taking the resident to his/her room at 10:45 AM, shahbaz #5 stated the resident "needed to be changed". Review of the 2/14/12 admission MDS assessment showed the resident triggered for urinary incontinence and was coded as being frequently incontinent. Review of the 4/16/12 care plan for bladder showed "Shahbazim - TOILETING: I am Dependent, and I need 1-2 assist". On 5/9/12 at 8:55 AM, the DON stated the scheduled toileting plan should be in the shahbaz computer program, but had not been developed yet. 3. Review of the 4/23/12 admission MDS and care area assessment for resident #8 revealed s/he frequently had urinary incontinence and required extensive assistance with toileting due to cognitive impairment. Review of the care plan showed interventions that addressed urinary	F 315	incontinence of bladder events. ECS documentation of toileting will be monitored by the Guide weekly and reported to the DON as part of quality monitoring and the implementation process. Statistics on toileting schedule compliance and incontinence of bladder events will be reviewed on a quarterly basis or more frequently, as needed by Quality of Care QA committee. 3. Elders #12, 8, and 16 all have a defined toileting schedule that is addressed in their care plan, and is on the Shahbaz Assignment Card.	

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F 315	Continued From page 11 incontinence included: toilet per scheduled toileting plan. On 5/9/12 at 9:42 AM the private caregiver (#1) assigned to provide care for the resident was observed providing urinary and fecal incontinence care for him/her. At that time the caregiver stated a toileting schedule/plan had not been implemented. She also stated most of the time staff "just tried to guess" about the resident's elimination needs, but s/he was usually incontinent. During an interview with the DON on 5/9/12 at 1:45 PM she acknowledged the resident needed a toileting plan, but it had not been developed.	F 315		
F 318 SS=D	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 observation, medical record review and staff interview, the facility failed to ensure restorative services were consistently provided for 1 of 3 sample residents (#4) who needed range of motion exercises. The findings were: Review of the medical record for resident #4 showed the resident received twenty-five physical therapy visits for muscle weakness, difficulty walking and joint pain. Review of the 5/3/12 physical therapy notes showed the resident was	F 318	Green House Living for Sheridan will ensure that all residents with limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This will be accomplished by: 1. On admission, each elder will be assessed by the RN/LPN for their ROM under the muscular/skeletal section of the Nursing Admission Assessment form In	7/13/12

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F 318	Continued From page 12 discharged from physical therapy on 5/3/12 because his/her functional goals were achieved and skilled therapy was no longer needed. During an interview on 5/9/12 at 10:30 AM, physical therapist #1 revealed the resident's strength and mobility had improved with therapy, but a daily restorative program that included range of motion exercises was needed for continued progress in these areas. Review of the shahbaz documentation showed the resident received range of motion on three of six days after the physical therapy was discontinued. Periodic observations on 5/7, 5/8 and 5/9/12 revealed range of motion exercises were not provided for this resident. On 5/8/12 at 9:55 AM an interview with shahbaz #2 revealed she did not know who was responsible for providing range of motion for the residents because she had not been directed to do this. During an interview on 5/9/12 at 2:30 PM, the DON stated the facility did not have a formal restorative program, nor had she developed a system for identifying the residents who needed this service and ensuring services were consistently provided.	F 318	ECS. Those elders requiring further assessment will receive the Restorative Assessment in ECS. 2. All current elder initial assessment records will be reviewed to determine if there are other elders for whom ROM exercises are appropriate. Anyone flagged through the initial nursing assessment will receive a specific ROM program. 3. GHLS has designated a current nurse to oversee our Restorative care program as Restorative Care Coordinator. She/he provides initial and ongoing assessment of Elders, implements a specific program for each identified elder, and monitors the CNAs' restorative care practices, competency and documentation thereof as the restorative plan. 4. The effectiveness of ongoing assessment, implementation, monitoring and evaluation of restorative care practices and related monitoring procedures will be reviewed monthly by the DON and reported to Quality of Care QA committee on a quarterly basis. 5. Nursing staff and Shahbazim will receive in-service education related to restorative care as needs are identified through ongoing QA activities. Resident #4 has been assessed and a ROM plan is in place, which is addressed in her Care Plan, and is on the Shahbaz assignment sheet.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		7/13/12

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F 323	Continued From page 13 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure a safe environment in 2 of 2 resident houses. The findings were:

1. Observations on 5/9/12 between 11:48 AM and 1:14 PM and throughout the survey revealed the following concerns:

a. Mechanical closets in both houses, each measuring 2.5 feet (ft) x 10 ft, had door lock latches attached to the outside of the sliding doors. The closets were large enough for a resident or other individual to get inside. The latches automatically engaged when the doors were closed and could not be opened from the inside.

b. Exit patio doors from each house were locked from the outside; therefore, if a resident exited out the patio doors, the locked doors would prevent him/her from getting back inside. Interview on 5/10/12 at 8:46 AM with the maintenance director revealed the contractor was aware of the permanently locked patio doors and verified this was a safety concern and was in the process of fixing them.

2. Observation in the Watt House kitchen on 5/7/12 at 4:30 PM revealed a bottom drawer that contained two food processor blades. The drawer

F-323
GHLS will ensure that the resident environment remains as free from accident hazards as is possible; and provide each resident adequate supervision and assistance devices to prevent accidents. This will be accomplished by:
1. Contractor will provide single-action egress hardware to meet code requirements on the inside of the coat and computer room closet doors to allow someone to safely exit from the inside.
2. Assure that exit patio doors are unlocked so that people can get back into the cottage.
3. Food processor blades have been moved to a secured storage in the kitchen. Education has been provided to Shahbazim on the rationale for securing blades.
4. A quality improvement monthly monitoring tool will be implemented by the CDM to include that food processor blades are stored appropriately. In addition, the Maintenance Technician will implement a monthly quality improvement tool to include that corridor door latches

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F 323	Continued From page 14 did not have a lock and was accessible to any resident who opened it. Interview with the CDM at that time revealed residents were not prohibited from entering the kitchen area. Observation on 5/9/12 at 10:25 AM showed the two blades remained in the unlocked kitchen drawer.	F 323	are working effectively and that patio doors are unlocked from the outside. Any safety findings will be corrected and reported monthly to the Safety Committee and quarterly to the QA Committee for ongoing evaluation and assessment, and to determine further staff education needs.	
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 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of education files, the facility failed to ensure food was stored safely, that fingernail brushes were labeled, that hair restraints were effective when food was prepared and served, and finally that wet wiping clothes were stored appropriately. The findings were: 1. Observation on 5/9/12 at 10:15 AM showed the pantry refrigerator in the Watt house contained raw and cooked meats being stored in the same container. The plastic container had packaged raw ground beef stored with packaged cooked turkey slices and packaged cooked barbeque	F 371	F-371 1. The facility will store, prepare, distribute and serve food under sanitary conditions. This will be accomplished by: a. A refrigerated food storage system will be employed that effectively divides raw meat, cooked and cooled meat (ready for reheat), and RTE meats. a. The CDM will provide education for Shahbazim on implementation of the refrigerated food strorage system and rationale behind separation of raw, cooked, and RTE meats. b. A quality improvement monitoring	6/15/12

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F 371	Continued From page 15 pork. Interview with shahbaz #3 at that time revealed she did not know that was not allowable. Interview with the CDM on 5/9/12 at 10:25 AM verified the raw and cooked items needed to be separated and although the turkey and the BBQ pork were planned to be re-heated, she discard these items rather than serve them to the elders. Interview with the human resources director and review of education files on 5/10/12 at 8:30 AM revealed shahbaz #3 had not been through food safety training. According to Food Code 2009, U.S. Public Health Service, 3-302.11: Packaged and Unpackaged Food-Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD...(b) Cooked READY-TO-EAT FOOD..." 2. Observation in the Scott house on 5/7/12 at 5:30 PM showed shahbaz #2 prepared steamed carrots. She wore a hat, but about three to four inches of her hair was uncovered. Shahbaz #4 was observed on 5/9/12 at 4:30 PM during meal preparation and three inches of hair was not covered by the hat she wore. Observation in the Watt house on 5/8/12 at 8:10 AM showed shahbaz #5 was preparing toast for residents. The shahbaz wore a hat however, it was not effective in restraining all of her hair. According to Food Code 2009, U.S. Public Health Service, 2-402.11: "(A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD;	F 371	tool will be implemented by the CDM to ensure proper food storage. The Shahbaz food coordinator in each home will inspect the refrigerated food storage system weekly to ensure compliance. The CDM will monitor the refrigerated food storage system weekly to ensure compliance. 2. Fingernail brushes will be discarded and no longer utilized at the facility. a. The CDM has provided formal communication to Shahbazim on terminating the use of fingernail brushes. 3. Hair restraints will be employed that effectively restrain hair. a. The CDM has provided education for Shahbazim on acceptable hair restraints. b. A quality improvement monitoring tool will be implemented by the CDM to monitor hair restraints. This monitor will be completed weekly by the CDM. 4. Wet wiping cloths will be stored appropriately in quaternary sanitizing solution in a red plastic pail. a. The CDM will provide education for Shahbazim on appropriate storage of wet wiping cloths. b. A quality improvement monitoring tool will be implemented by the CDM to ensure wet wiping cloths are stored appropriately. The Shahbaz food coordinator in each home will inspect the storage of wet wiping cloths weekly to ensure compliance. The CDM will monitor the storage of wet wiping cloths weekly to ensure compliance. 5. Upon continuous monitoring of all safe	

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F 371	Continued From page 16 clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." 3. During the observations on 5/7/12 of the main food storage area at 4 PM, and of the Scott house kitchen at 4:10 PM, there were fingernail brushes located at the hand washing sinks in these areas. Both nail brushes were unlabeled and not of a single use variety. Interview with the CDM on 5/7/12 at 4:30 PM revealed she was not sure anyone used the nail brushes, and would discard them. 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 can achieve up to a 5-log reduction in microorganisms on the hands." 4. Observations in the Scott house on 5/7/12 at 4 PM showed there were two wet towels not held in a sanitizer solution. One wet towel was laying on the kitchen counter, the other was in an empty sink. Interview with the CDM on 5/7/12 at 4:30 PM verified the wet towels need to be stored appropriately. 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	food handling and storage practices as noted in this F-tag, individual performance review will reflect corrective action for failure to follow and adhere to established procedures and protocol. 6. All items reported in this POC and all related safe food handling and storage monitoring and implementation are documented by the CDM and reported to Quality Assurance quarterly for ongoing evaluation and assessment, and to determine further staff education needs.	
F 386 SS=B	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	F 386		7/13/12

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The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure physician progress notes were written and signed by the physician for 4 of 6 sample residents (#2, #4, #12, #16) who had physician visits. The findings were:

1. Review of the physician notes for resident #2 showed the physician made visits on 2/27/12, 4/20/12 and 5/8/12. The notes were transcribed into the electronic medical record by the DON; however, there was no evidence the physician signed the notes.

2. Review of the physician notes for resident #4 showed the physician made visits on 2/27/12, 4/20/12 and 5/8/12. The notes were transcribed into the electronic medical record by the DON; however, there was no evidence the physician signed the notes.

3. Review of the medical record for resident #12, who was admitted 3/29/12, revealed no physician progress notes. On 5/9/12 at 1:32 PM, the DON

Green House Living for Sheridan will ensure that all Elders will have their physician review their total program of care, including medications and treatments, at each visit; dictate or write a new progress note; sign the previous month's progress note; and sign and date all orders. This will be accomplished by:
1. Any physician with an unsigned Physician Visit entry will have a paper copy of that entry sent to them by the DON to be signed and placed in the paper chart.
2. All physicians credentialed with GHLS who desire to use ECS will be assigned passwords and trained in how to access and use ECS.
3. DON will train each each physician at their June 2012 monthly visit on how to access the physician screen and electronically sign all notes, orders, and review of care plans.
4. Elders 2, 4, 12, and 16 will have physician signed verification of progress

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F 386	Continued From page 18 stated that the physician did in fact visit the resident, but did not write a progress note because she didn't have access to the computer system. 4. Review of the physician notes for resident #16 showed the physician made visits on 2/27/12, 4/20/12 and 5/8/12. The notes were transcribed into the electronic medical record by the DON; however, there was no evidence the physician signed the notes. 5. Interview with the DON on 5/8/12 at 4:03 PM verified many of the physicians did not use the electronic medical record system. She stated the physicians would dictate their notes and she transcribed them into the system. The DON further revealed it was a system they needed to work on because the physicians were not electronically or otherwise signing these notes.	F 386	notes by 6/29/12. 5. Any physician who prefers a paper record will be given a copy of all medication and treatment orders, physician progress notes from the previous month, and Plan of Care to be signed. That paper copy with physician signature will then be maintained in the Elder's paper chart. 6. DON will monitor each Elder's record monthly to ensure all entries are signed by the attending physician. Dictated progress notes will be signed at the following monthly visit as per GHLS policy. 7. DON will report the results of the ongoing monitoring process to the Medical Director at the monthly Executive Review Committee meetings. This will also be reported quarterly to the Quality Assurance Committee for ongoing evaluation and assessment of attending physician duties.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428		7/13/12

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by:
Based on medical record review, staff interview, and review of the pharmacy consultant report, the facility failed to ensure the physician responded to the recommendations made by the pharmacist for 1 of 7 sample residents (#2) and one non-sample resident (#11). The findings were:

1. Review of the pharmacist recommendations for resident #2 showed on 3/23/12 the pharmacist made a recommendation for the physician to consider ordering a potassium level based on the combination of medications this resident was taking and their effects on potassium levels. Review of the medical record showed the physician had not yet acknowledged or acted on this recommendation. Interview with the DON on 5/9/12 at 1:35 PM revealed she had faxed this recommendation to the physician and there was not yet any response.

2. Review of the medication administration record for resident #11 showed daily doses of dihenoxylate/atroprine and Aricept were included in the resident's medication regime. Review of the 2/23/12 and 3/25/12 monthly pharmacy review showed a recommendation for a physician response regarding the following drug to drug interaction: The resident receives dihenoxylate/atroprine routinely which is an anticholinergic and may counteract the effectiveness of Aricept. Interview with the DON on 5/10/12 at 8:20 AM revealed she had not notified the physician regarding the identified irregularity until 5/8/12.

3. During an interview on 5/17/12 at 9:15 AM, the pharmacist who completed the monthly reviews

F428
Green House Living for Sheridan will ensure that the drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist and that the pharmacist will report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon. This will be accomplished by:
1. Resident #2 had a potassium level drawn and results are in the chart.
2. A response was received from Elder #11's physician regarding his Aricept and diphenoxylate/atropine and the response is in his chart.
3. DON was in-serviced by the consultant pharmacist on May 31, 2012 on the Drug Regimen Review (DRR) process.
4. Pharmacist will send DRR each month to DON. All correspondence/notes will be kept in Consultant Pharmacist Review notebook.
5. Any Note to Attending Physician will be faxed to the physician by DON. DON will follow-up after 7 days if no response is received from physician.
6. All other questions will be followed-up on by the nursing staff until resolved.

7. A review of the ongoing process of monitoring and assessing drug regimens and irregularies will be conducted by the Pharmacy and Executive Review Committees monthly to determine the need for education and further evaluation. Any concerns identified during the monthly review will be discussed during

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F 428	Continued From page 20 stated staff did not have a clear understanding of the purpose of the pharmacy reviews; and guidelines for how to address the recommendations have not been developed. He further stated the facility is new and unfamiliar with the process.	F 428	quarterly QA meetings.	
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.	F 441		7/13/12

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(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 review of infection control logs and policies and procedures, staff interview and medical record review, the facility failed to develop and implement an effective infection control program that included current infection control information for 2 sample residents (#8, #12) and 1 non-sample resident (#11). In addition, the facility failed to develop an effective program for screening healthcare workers for tuberculosis (TB) prior to resident contact. The findings were:

1. Review of the facility's infection control logs revealed the infection control preventionist (ICP) who is also the DON, did not consistently document infectious organisms identified by laboratory reports, there was incomplete documentation regarding resolutions, and data analysis was lacking. Further review revealed the following information regarding residents with infections had not been included in the infection control log:
a. Medical record review for resident #12 showed the resident received the last dose of Cipro (antibiotic) for a urinary tract infection on 4/28/12. Further review showed the same antibiotic was prescribed on 5/4/12 for the same diagnosis. Review of the 4/22/12 urine culture lab

F441 #1
Green House Living for Sheridan will ensure that its infection control program provides for a safe, sanitary, and comfortable environment and that it helps to prevent the development and transmission of disease and infection.
This will be accomplished by:
1. DON/ICP was trained by American Data/ECS personnel on the infection control portion of ECS on 5-15-2012.
2. New "button" added in ECS for nurses to "Notify DON of New Infection" which alerts DON/ICP of any new infection in the facility.
3. DON will chart pertinent infection information in the Chart of Infection (QA) folder of ECS, including site of infection, pathogen type, antibiotic use, and whether it's a repeat infection.
4. Infections will be monitored on an ongong basis and reported monthly to the Medical Director at the Executive Review Committee. This will also be reported quarterly to the Quality Assurance Committee for ongoing evaluation and assessment of infection control practices.
5. Residents #8 and #12 - urinary tract

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results showed positive findings for Escherichia coli and Cipro was listed in the sensitivity analysis. Review of the urine culture lab report dated 5/5/12 showed no organism growth. Review of the infection control data failed to include information regarding the need for the second phase of antibiotic therapy. Review of the infection control data showed a urine culture was obtained on 4/20/12, but the information regarding the identity of the organism and effectiveness of the antibiotic was lacking. Further review showed no information regarding the urine culture results on 5/5/12.

b. Medical record review for resident #8 showed antibiotic therapy for a urinary tract infection was initiated on 4/20/12. Review of the infection control log showed no information regarding this resident. During an interview on 3/10/12 at 8:15 AM, the ICP stated she did not know how this resident was missed.

c. Medical record review for resident #11 showed intramuscular injections of Invanz (an antibiotic) was started on 2/22/12 for cellulitis. Information regarding cultures, identity of the organism and resolution were lacking.

An interview with the ICP on 3/9/12 at 3:30 PM revealed the current infection control program needed to be revised because it did not include a systematic process for identifying and addressing infection prevention concerns.

2. According to the policies and procedures entitled, "Employee Screening for Tuberculosis," revised October 2010, each newly hired employee will be screened for TB infection and disease after an employment offer has been made and prior to the employee's duty

infection information has been entered into the Chart on Infection (QA) folder of ECS.

6. Information regarding the cellulitis of Elder #11 and the Invanz injections has been entered into the Chart on Infection (QA) folder of ECS

F441 #2

Changed "Employee Screening for Tuberculosis" policy. In accordance with "Employee Screening for Tuberculosis" policy, all new employees for GHLS will be tested upon hiring and then annually. Administration of the Tuberculin Skin Test (TST) will be accomplished by a licensed nurse at GHLS and all results will be reported to the Employee Health Manager or designee for documentation in the TB Test Summary Log. RN #1 and Shahbazim #1 and 2 will be tested immediately and results filed in their Employee Health Record and logged in the TB Test Summary Log.

All employees health records will be reviewed to ensure TB testing was completed and logged. Any found not to have been compliant will be tested immediately. This correction will ensure policy compliance. Future employees will be required to obtain proof of testing within the past year or will have a TST administered at the time of hire and testing results posted in their Employee Health Records, and logged in the TB Test Summary Log. The requirement will be added to the "HR Inprocessing Checklist"required for all new employees

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F 441	Continued From page 23 assignment. Review of employee files and an interview on 5/10/12 at 8:25 AM with the human resources staff revealed the screening for the following employees had not been done prior to contact with the residents and at the time of the survey. a. Shahbaz #2 hired on 3/12/12 b. Shahbaz #1 hired on 1/20/12 c. RN #1 hired on 1/20/12.	F 441	to ensure testing is done at the time of hire. A new employee with a known positive TST conversion, or known reactions to PPD, must have a baseline negative chest x-ray documented. The "HR Inprocessing Checklist" will be used to monitor monthly that all employee TB tests are current and results will be reported to the QA Committee quarterly.	
F 498 SS=C	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to ensure nurse aides were competent in their duties for 3 of 3 shahbazim (#1, #2, #3) reviewed. The findings were: Review of personnel files for shahbaz #1, #2, and #3 revealed they were certified nurse aides (CNAs). Further review showed no evidence competency evaluations were completed to ensure they were competent in duties assigned. During an interview on 5/9/12 at 10:35 AM, the human resources director confirmed there were no competencies for any of the CNAs. She stated staff were asked to review their job description and confirm they could perform the tasks. She	F 498	F498 Individual Core Competencies are being developed for all new hires and will be evaluated annually as part of personnel performance evaluations. Administrative staff are currently identifying and creating Quality Assurance and Education specific core competencies to individually rate and verify levels of completion and competency for each employee at hire, annually and progressively. Evaluation of competencies for Shahbazim, 1,2, and 3, and all other Shahbazim are being conducted and core competencies will be verified, annotated and stored in the Employee Personnel Records for current	7/13/12

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F 498	Continued From page 24 further stated the facility was in the process of developing an annual competency for staff.	F 498	and future Shahbazim. To meet Quality of Care QA requirements, the competencies will be evaluated by the staff development coordinator to determine education needs, as well as performance evaluation review and improvement considerations. Findings from competency evaluations will be reported to QA quarterly. Competencies will be completed upon hire, annually, and on an as-needed basis for all Shahbazim.	
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory reports were filed in the medical record for 1 of 1 sample resident (#12) with laboratory reports. The findings were: Review of the medical record showed the laboratory reports for urinalysis ordered 4/20/12 and 5/3/12 for resident #12 were not filed in the medical record. On 5/9/12 at 10:25 AM, the DON and RN #1 confirmed the lab reports were not in the medical record. They stated the lab frequently just sent the reports to the physician, and did not	F 507	F507 Green House Living for Sheridan will ensure that all laboratory reports are filed in the elder's clinical record and that they are dated and contain the name and address of the testing facility. This will be accomplished by: 1. A copy of all lab order sheets will be kept in the nurse's office in a designated file folder until a final report has been received from the lab. This will ensure that we receive all lab correspondence in a timely manner.	7/13/12

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F 507	Continued From page 25 provide the facility a copy. At 10:35 AM RN #1 brought the surveyor the copies of the lab reports (dated 4/22/12 and 5/5/12) they had requested the lab to fax to them.	F 507	2. All final lab reports will be filed in the Elder's paper chart by the nurse receiving the report. A quality improvement monitoring tool will be implemented by the DON to ensure all labs are in the chart. Outcomes from monitoring of lab reports will be reported to the Medical Records QA committee quarterly, and as monthly Executive Review Committee..	
F 519 SS=C	483.75(n) TRANSFER AGREEMENT WITH HOSPITAL In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate, as determined by the attending physician; and medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions. The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.	F 519		6/5/12

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, the facility failed to have a written transfer agreement with a hospital. The findings were:

On 5/9/12 at 10:25 AM the administrator was asked for a copy of the written transfer agreement with a hospital. The administrator stated the facility did not have a written agreement with a hospital. She stated they were "in talks" with the hospital, but did not have an agreement.

F-519
A transfer Agreement with Sheridan Memorial Hospital is in place. The Agreement is effective 6-1-12 and shall remain in effect unless terminated by either party upon thirty (30) days' written notice and will be reviewed bi-annually by both parties.