STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING _____ B. WING _____	11/15/2012

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PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA Certified Nurse Aide DON Director of Nursing LPN Licensed Practical Nurse MAR Medication Administration Record MDS Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided 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	F 279	F279 - Resident #38's care plan and floor staff daily care worksheet have been revised to reflect his/her current weight bearing status. Care plans for all residents that have been readmitted to our facility within the last 3 months will be reviewed to ensure all changes in status are reflected appropriately. These reviews will be completed by 12/30/12. Charge nurses will update the plan of care within 12 hours of	12/30/12

The DON will provide education to nursing staff regarding updating care plans KR

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

Administrator 12/7/12

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.

The POC was accepted with corrections reviewed & the DON and administrator on 20Dec12 at 1130AM KMay Surveyor

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F 279	Continued From page 1 by: Based on observation, medical record review, and resident and staff interview, the facility failed to review and revise the care plan for 1 of 10 sample residents (#38) that needed correction based on physician orders. The findings were: Review of the physician progress notes dated 11/5/12 showed resident #38 had a right hip pinning on 10/7/12. Further, the resident was not to bear weight on the right lower extremity for six weeks. Physician orders dated 11/5/12 showed the resident was not to full weight bear until 11/19/12. The following concerns were identified: a. Observation on 11/13/12 at 11:35 AM showed CNA #1 stood the resident in the bathroom for 5 minutes to complete perineum care. The resident stood with both feet equally placed on the floor and was not reminded to avoid putting full weight on his/her right lower extremity. Interview with the CNA on 11/14/12 at 1:55 PM revealed the resident beared weight according to how s/he was doing during transfers and was not aware of the restriction. b. Review of the care plan dated 10/12/12 showed the resident was weight bearing, and toe touch weight bearing. c. Interview with the resident on 11/13/12 at 5 PM revealed s/he was aware of the weight restriction but sometimes forgot which lower extremity not to put full weight on. d. Review of the resident's care plan with the DON on 11/15/12 at 10:10 AM confirmed it should not show the resident was both toe touch weight bearing and weight bearing. The DON also verified the care plan needed to show the resident was not to bear full weight until 11/19/12 as the physician had ordered.	F 279	changes in condition. Care plan coordinator will be notified by front line staff via voice mail with any changes and will review the updates within 72 hrs of notification. DON, Administrator and/or designee will review 2 charts weekly to ensure care plans are updated to reflect current status. Charts will be chosen based on change of status and randomly if indicated (ie. no status changes in a given week). If no significant deficiencies are noted in the next 6 months; June 30th, 2013, reviews will be decreased to an as needed basis. All results will be taken to QA&A for further review and analysis. Reeducation will be provided to staff if not compliant RN using QA tool RN	

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview the facility failed to ensure that the plan of care for 2 of 10 residents (#9, #14) represented an updated, revised assessment of the resident's current condition and medical plan of care. The findings were: Observation of residents #9 and #14 on 11/13/12 from 10:55 AM through 12:18 PM and 1:15 PM through 3 PM showed that wound care was done on a scheduled basis for pressure ulcers located on the coccyx for both residents. Review of the	F 280	F280 - Residents #14 and #9 care plans have been updated to reflect his/her current condition including current wound care treatments. The wound care nurse will ensure all residents currently treated for wound care will have the care plans updated to reflect the current wound status and treatment. This will be completed by 12/30/12. Charge nurses will update the Plan of care within 12 hrs for all residents when new treatments are initiated. The wound care nurse and/or designee will review the plan of care during weekly wound rounds to ensure the current status is reflected appropriately. This will continue as part of weekly wound rounds to ensure compliance. All results will be taken to QA&A for further review and analysis. The DON will provide education to nursing staff related to updating Plans of care KR Staff will be re-educated if not compliant KR this will be documented on an auditing tool to ensure compliance KR	12/30/12

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F 280	Continued From page 3 medical record revealed that the prescribed wound care was not documented on the care plan for either resident. Interview with the DON on 11/15/12 at 8:45 AM verified that the care plans for residents #9 and #14 did not represent the resident's current condition and the prescribed wound care was not documented in the care plans.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the facility's policy and procedures, the facility failed to adequately monitor and evaluate 4 of 10 sample residents (#2, #9, #24, #38) for pain intervention effectiveness. The findings were: 1. Review of the medical record for resident #24 showed s/he had diagnoses to include osteoporosis. Review of the care plan dated 11/22/11 showed the resident had shoulder and low back pain. Further his/her pain goal was "four." Review of the October 2012 MAR showed the resident received Percocet for pain 38 times. Review of the Long Term Care Pain Assessment showed s/he was not evaluated for effectiveness	F 309	F309 - Residents #24, #38, #9 and #2 will be re-assessed per policy after receiving pain interventions. All residents will be asked if their pain is under control by CNAs during weekly vitals to identify any residents who require pain management interventions. Any residents reporting pain will be assessed by the charge nurse. Any residents requiring frequent interventions for pain will be re-evaluated for the need of updated/new pain control regimen and referred to the physician if indicated. Charge nurses will follow up appropriately after implementing pain interventions to ensure pain is controlled using the facility pain protocol. Charge nurses will be re- Staff will be re-educated if not compliant	12/30/12

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F 309	Continued From page 4 of the pain medication 15 times (40%) between the dates of 10/1/12 and 10/31/12. Those times the resident was evaluated only showed s/he was "sleeping", or "better." Review of the November 2012 MAR showed the resident received 12 doses of Percocet and was not assessed 5 times after the pain medication was administered (42%) between the dates of 11/1/12 and 11/12/12. The assessments did not include a numeric pain rating to determine if the the resident reached his/her acceptable pain goal. Review of the resident's care plan showed only pharmacological interventions were used to control pain. Further review showed the facility failed to address non-pharmacological interventions to address the resident's pain. 2. Review of the care plan last updated on 10/12/12 for resident #38 showed s/he had diagnoses to include degenerative joint disease and chronic pain due to Polymyalgia Rheumatica. In addition, the resident had a right hip fracture on 10/7/12. Review of the October 2012 MAR showed the resident received Norco 36 times for pain. Review of the Long Term Care Pain Assessment showed s/he was not evaluated for pain medication effectiveness 20 times (55.5%) between the dates of 10/2/12 and 10/23/12. On those occasions the pain medication was evaluated for effectiveness and comments included "sleeping" and "better." The assessment did not include a pain rating. Review of the November 2012 MAR showed the resident received 3 doses of pain medication and was not assessed for effectiveness 2 times (66%). Review of the resident's care plan showed the facility failed to address non-pharmacological interventions to address the resident's pain.	F 309	educated on pain ~~medication~~ management policy during our annual skills fair December 10th, 2012 through December 13th, 2012. DON and/or designee will audit MAR to ensure proper pain intervention follow up is completed. Audits will be completed on three residents weekly using audit tool. Residents to be audited will be chosen based on known PRN pain intervention need and/or randomly as needed. If 100% compliance is achieved by March 30, 2013 audits will be decreased to four audits each month. Pharmacist responsible for MAR review in a given month will complete medication audits monthly using audit tool to include but not limited to proper pain intervention follow-up. All results will be taken to QA&A for further review and analysis. staff will be re-educated if not compliant KL	

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F 309	Continued From page 5 3. Review of the medical record for resident #9 showed s/he received pain medications for flank and back pain. The resident received the pain medications Vicodin, hydrocodone and Flexeril. Review of the October 2012 MAR showed the resident received 30 doses of pain medications and was not evaluated for effectiveness 7 times (23.3%) between the dates of 10/22/12 and 10/30/12. Review of the November 2012 MAR showed the resident received 24 doses of pain medication and was not evaluated for effectiveness 4 times (16.6%) between the dates of 11/1/12 and 11/8/12. Review of the resident's care plan showed the facility failed to address non-pharmacological interventions to address the resident's pain. 4. Review of the medical record for resident #2 showed s/he received as needed medications which included a 5/30/12 order for acetaminophen 500-1000 mg (non-narcotic analgesic) by mouth every eight hours as needed. Review of the resident's Long Term Care Pain Assessment Record showed s/he received acetaminophen 1000 mg on 9/16/12 and 10/1/12 for pain. The form had an area for follow-up to determine pain relief effectiveness. However, those areas were left blank. Review of the entire medical record showed the facility failed to evaluate the effectiveness of pain relief on 9/16/12 or 10/1/12 after administration of acetaminophen. Review of the undated policy and procedure for pain management showed the staff was; "To obtain a subjective description of pain from the verbal and cognitively-intact resident use the 0-10	F 309		

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F 309	Continued From page 6 Pain Scale." For the resident who is cognitively impaired, the staff were to use the FLACC (Face, Legs, Activity, Cry, Consolability scale) or 0-5 scale to rate pain. Further review showed the facility was to include both pharmacological and non-pharmacological interventions for pain on the residents care plan. During an interview with the DON on 11/15/12 at 10:10 AM she acknowledged pain assessments were not complete.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide safe assistive devices and supervision for 1 of 1 sample resident (#35) observed using a sit-to-stand lift. The findings were: Review of the history and physical exam dated 7/18/12 for resident #35 showed s/he had osteoporosis and a history of a cerebral vascular accident resulting in "profound left arm and left leg paralysis..." The following concerns were identified: a. Observation on 11/13/12 at 2:45 PM	F 323	F323 - Resident #35 was re-evaluated on 11/19/12 by the occupational therapist for use of the sit to stand lift. All residents currently a mechanical lift will be re-evaluated for appropriateness of such lifts by the physical or occupational therapist by 12/30/12. All residents using a mechanical lift will be re-evaluated on an annual basis and or on change of condition to ensure safety and appropriate for the residents current condition. The MDS coordinator will ensure this is complete within 30 days of the annual MDS assessment. All results will be taken to QA&A for further review and analysis. The DON will provide education to the staff on the proper use of lifts KLu using QA auditing tool KLu	12/30/12

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F 323	Continued From page 7 showed CNA #2 transferred the resident from his/her wheel chair to the bathroom using a sit-to-stand lift. The CNA completed perineum care while the resident remained in the lift. While in the lift, the resident complained of left arm pain and verbalized the strap was too tight around his/her chest. During the transfer the resident did not show s/he was supporting his/her own weight. The resident's buttock was extended out away from the lift and the lift strap was tight against his/her arm pits. b. Review of the physical therapy progress notes dated 5/10/11 showed the resident was evaluated for the use of a sit-to-stand lift. At that time the resident was able to "weight-bear appropriately through-out the lower extremities.." c. Interview with the DON on 11/15/12 at 10:10 AM revealed the resident did not have a more recent physical therapy evaluation. She further stated the resident needed to be reevaluated for appropriate lift use.	F 323		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428		

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F 428	Continued From page 8 Based on observation, medical record review and staff interview the facility failed to ensure irregularities found during the drug regimen review was reported to the director of nursing and the physician for 1 of 10 sample residents (#35). The findings were: Observation during the medication pass on 11/14/12 at 5:15 PM showed LPN #1 administered Tylenol 1000 mg to resident #35. Review of the 5/31/12 physician orders showed the resident had asked for Tylenol 1000 mg by mouth daily to be given at suppertime. The nursing staff informed the physician and requested an order for Tylenol 500-1000 mg daily to be given at suppertime and it was approved as requested. Review of the September, October and November 2012 MARs showed the order for Tylenol 500-1000 mg by mouth daily to be given during the evening meal but failed to indicate how much of the medication was given. Interview with the DON on 11/15/12 at 10:10 AM revealed she would have expected the nursing staff to clarify the physician's order. Interview with pharmacist #1 on 11/14/12 at 11:37 AM showed she should have informed the nursing staff they needed to document the dose of Tylenol given to the resident.	F 428	F428 - Resident #35's order have been clarified by the physician to reflect the dosage of medication the resident is receiving. Pharmacists will notify the DON and Physician of any drug irregularities as they are found on a monthly basis. Nursing staff will be re-educated regarding appropriate documentation of medication dosage during the December 10th, 2012 through December 13th, 2012 skills fair. Nursing staff will be re-educated regarding order clarification requirements during the December 10th, 2012 through December 13th, 2012 skills fair. Pharmacist and DON will monitor MAR for irregularities during the end of month MAR reviews and refer to the physician for clarification and/or changes as indicated. All results will be taken to QA&A for further review and analysis.	12/30/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		

Staff will be re-educated if not compliant. KR

nursing audit tool KR

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F 431	Continued From page 9 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications were labeled appropriately with an expiration date in 2 of 2 medication carts. In addition, expired medications available for use were stored in 1 of 2 medication carts. The findings were: Observation of the front hall medication cart with	F 431	F431 - All identified medications on carts without expiration date have been labeled with the correct date of expiration. Medication carts will be audited by DON and/or designee to identify expired medications by December 30, 2012. Any expired medications will be removed and disposed of per facility protocol. Charge nurses will be re-educated on the 6 rights of medication administration to check expiration dates prior to administering medications. Pharmacist responsible for MAR review in a given month will complete one medication audit to include all medication carts and medication room monthly using audit tool to include but not limited to proper labeling including expiration dates. Re-education of staff will be provided if not compliant RL All results will be taken to QAI for further review and analysis RL	12/30/12

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F 431	Continued From page 10 LPN #1 on 11/14/12 at 4:30 PM showed the following medications were not labeled with an expiration date and were available for use; alprazolam 0.25 mg; 20 tablets, hydrocodone/acetaminophen 5/25 mg; 30 tablets, and Oxycodone 10 mg. Interview with the LPN at that time confirmed the medications were not labeled with an expiration date. Observation of the back hall medication cart with LPN #3 on 11/14/12 at 4:30 PM showed the following medication was not labeled with an expiration date and was available for use; Dilacor XR 180 mg. In addition the following medications were expired and available for use; Lisinopril expired on 5/12, omeprazole expired on 7/12, two containers of ondansetron expired on 4/12 and fluoxetine expired on 10/12. The LPN at the time confirmed the medications were both labeled incorrectly and expired. According to Smith Duell and Martin, in "Clinical Nursing Skills, Basic to Advanced Skills" seventh edition, 2008, page 669, "The Six Rights" of medication administration include checking for the expiration dates of medications administered to clients.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	Continued From page 11 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 infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy and procedures, the facility failed to ensure staff understood and were adequately trained to properly handle and dispose of contaminated trash and soiled linens. In addition, the facility failed to ensure policies that addressed contaminated trash and soiled linens were	F 441	F441 - All staff will be evaluated for proper hand washing procedures at the December 10th, 2012 through December 13th, 2012 annual skills fair. ICN and/or designee will audit 1 random staff member 5 days per week through 1/30/13 to ensure compliance with proper hand washing techniques. ICN and/or designee will complete one random hand washing audit per week to maintain compliance for three months after 1/30/13 and then quarterly thereafter. All results will be taken to QA&A for further review and analysis. General infection control policy will be reviewed and revised by the ICN and DON using current infection control standards of practice recommendations. The review and revision will include specific guidelines for soiled and contaminated linens as well as contaminated trash disposal. The policies will be reviewed, researched and revised by 12/30/12. All staff will be corrective action will be taken if staff are not in compliance with proper hand washing techniques ICN	12/30/12

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	535053	A. BUILDING _____ B. WING _____	11/15/2012

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F 441	Continued From page 12 complete. Further, the facility failed to ensure proper handwashing was implemented during 2 random observations. The findings were: Trash disposal, soiled linens, and related policies: 1. Neither the maintenance supervisor, administrator, DON, housekeeping supervisor, RN #1, or laundry aide #1 were aware of current procedures for transportation and disposition of contaminated waste or soiled linens. This evidence was gained from interviews with the housekeeping supervisor on 11/14/12 at 10:50 AM, the maintenance supervisor on 11/14/12 at 11:20 AM, RN #1 on 11/14/12 at 11:30 AM, the administrator and DON on 11/14/12 at 11:45 AM, and laundry aide #1 on 11/15/12 at 8:20 AM. 2. During an interview with the ICP (infection control practitioner) on 11/14/12 at 11 AM, she stated she did not know the procedure for the disposal of contaminated trash and linen, but she would review the facility policies and procedures. During an interview with the ICP on 11/15/12 at 9 AM, she stated the acceptable method for disposal of contaminated trash in the facility was to dispose of contaminated trash in the regular trash without any differentiation. She also stated that staff should take contaminated linen to the adjacent contracted laundry in a separate bag. 3. According to the facility policy titled, "General Infection Control Guidelines", the "Handling of soiled linen: i. All soiled linen will be bagged in a clear plastic bag and transported to soiled utility room or placed directly into laundry container." In addition, the following information in the policy addressed spills, "I. All blood and/or body fluid	F 441	educated regarding the infection control policy, proper handling of linens and contaminated trash by 12/30/12. ICN will perform 1 random audit on the infection control policy per week to ensure compliance if compliance is maintained after two months – February 28, 2013 then audits will be decreased to 2 random staff members monthly to ensure compliance. Re-education of infection control policies will occur annually. All results will be taken to QA&A for further review and analysis.	

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F 441	Continued From page 13 spills will be cleaned right away using the facility approved 2 step procedure. See policy attached. a. Each soiled utility room will have facility approved disinfectant spray bottles, clear trash bags, red trash bags and PPE available for staff use." According to the facility policy titled, "Departmental (Environmental Services)-Laundry and Linen", revised November 2011, " 5. All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture. Place any linen saturated with blood or body fluids into a bag before placing it into the hamper. b. The following concerns with handling trash and linens, and the related policies and procedures were noted: i. The policies failed to state that a separate laundry container would be provided for soiled linens. ii. The policies failed to state that contaminated trash would be disposed of separately from the regular trash. iii. The ICP confirmed on 11/15/12 at 9 AM the facility failed to educate staff concerning acceptable standards for disposing of contaminated trash and soiled linens. Handwashing: Observation on 11/13/12 at 2:45 PM showed CNA #2 complete perineum care for sample resident #35 with gloved hands. After completing incontinence care, the CNA removed her gloves and donned a second pair without first washing her hands. The CNA adjusted the resident's pillow and placed a blanket around the resident. Interview with the CNA on 11/14/12 at 5:10 PM revealed she should have washed her hands	F 441		

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F 441	Continued From page 14 after removing her gloves and before donning a second pair. Observation on 11/15/12 at 11:35 AM showed LPN #2 completed a blood sugar finger stick for non-sample resident #5 with gloved hands. After completing the task she removed her gloves and continued to place medications in the medication cart and entered the locked medication room. Interview with the LPN on 11/15/12 at 11:45 AM acknowledged she needed to wash her hands after she removed her gloves. Review of the policy and procedure for Handwashing/Hand Hygiene last revised on 10/1/09 showed staff are to cleanse their hands; "After removing gloves."	F 441		
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of maintenance logs the facility failed to provide adequate ventilation in resident bathrooms in 1 of 2 resident hallways (rooms #102 through #115, called the front or grand hallway). The findings were: 1. Observation on 11/13/12 at 9:30 AM revealed a strong urine odor in the hallway outside resident rooms #100, #107, #109, and #111. Observation again on 11/14/12 at 8:45 AM revealed a strong	F 467	F467 – All resident bathroom exhaust vents have been cleaned as of 11/30/12. All bathroom exhaust vans will be put on a monthly cleaning schedule and cleaned by maintenance or designee. Bathroom exhaust fans will be audited monthly on a rotating basis to ensure the system is in proper working order. Audit will be conducted by Administrator or designee. All results will be taken to QA&A for further review and analysis. All maintenance personnel will be in-serviced on maintaining the exhaust fans etc. corrective actions will be taken if exhaust fans are found not to be in proper working order etc.	12/30/12

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F 467	Continued From page 15 urine odor in the hallway outside resident room #110. 2. On 11/13/12 at 1:20 PM the bathroom ceiling vents in all resident rooms in the hallway (#100, #101, #102, #103, #104, #105, #106, #107, #108, #109, #110, #111) were tested by the surveyor and none of the vents were exchanging air. The process was repeated on 11/14/12 at 10:30 AM with the same results. 3. Review of the Exhaust Fan Cleaning Log revealed that the bathroom vents in the hallway had not been cleaned since 5/9/12. 4. During an interview with the maintenance supervisor on 11/14/12 at 11:20 AM he stated he was not aware of any problems with the ventilation system in the resident bathrooms. The vent in room #102 was checked at this time with the maintenance supervisor and verified there was no air exchange. During the same interview the maintenance supervisor stated that the vent system was checked on a quarterly basis. In a subsequent interview with the maintenance supervisor on 11/14/12 at 11:45 AM he stated that the vents were clogged with dirt and debris and those already cleaned were exchanging air.	F 467		
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:	F 502	F502 - Resident #24 had INR completed on 11/14/12. Collaborative practice pharmacist has changed process to follow up with nursing staff if INR results are not received by the end of the business day of the order. All residents on the anticoagulation collaborative practice program will be audited by DON or designee and collaborative practice pharmacist for current INR status by 12/30/12. Any residents found to be out of compliance will have the INR checked immediately and results	12/30/12

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F 502	Continued From page 16 Based on medical record review and staff interview, the facility failed to ensure an order for a laboratory test was completed as ordered for 1 of 10 sample residents (#24). The findings were: Medical record review showed resident #24 had diagnoses to include atrial fibrillation. Review of a pharmacist order written 9/26/12 showed the resident was to have his/her INR (International Normalized Ratio used to monitor the effects of anticoagulant medications) checked on 10/24/12. Review of the October 2012 MAR showed the resident was receiving Coumadin (for chronic atrial fibrillation) daily. Review of the Anticoagulant Therapy flowsheet showed the last PT/INR completed was 9/26/12. During an interview, and review of the medical record with the DON on 11/15/12 at 10:10 AM, she acknowledged the order for the INR to be completed on 10/24/12 was missed by the nursing staff.	F 502	reported as per policy. All nurses will be re-educated on the INR collaborative practice policy and procedure by December 30, 2012. INR draws to be done by nursing staff will be written on the anti-coagulant flow sheet as well as the "labs due" book at the time the order is received by the charge nurse noting the order. DON and/or designee will audit all anticoagulation sheets weekly x 1 month to ensure compliance. If compliance is achieved at the end of 1 month audits will be decreased from weekly to 3 random residents (on the program) monthly. Collaborative practice pharmacist will audit 3 random residents on the program each month to ensure compliance is maintained. All results will be taken to QA&A for further review and analysis.	