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

PRINTED: 12/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535849		C 11/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

ID PREFIX TAG	(X4) 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)	COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. For the purposes of any allegation the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations manual.	

The following common abbreviations are used throughout this document:

CNA	Certified Nurse Aide
DON	Director of Nursing
LPN	Licensed Practical Nurse
MDS	Minimum Data Set
RN	Registered Nurse
MAR	Medication Administration Record
TAR	Treatment Administration Record

Less commonly used abbreviations will be annotated in each deficiency.

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview, and review of resident group meeting minutes, the facility failed to provide a dignified dining experience for 5 of 15 sample residents (#36, #38, #51, #52, #87) and one non-sample resident (#45) during one of two meal observations. In addition, the facility failed to ensure one non-sample resident (#45) was treated with with dignity related to the temperature control in the resident's room. This affects

* Observation of the evening meal dining service

F 241	The facility will ensure residents are provided a dignified dining experience and will ensure residents are treated with dignity related to temperature control in his/her rooms. This will be accomplished by:	1/3/13

A) Resident # 36 and Resident # 51 are now seated at a four person table, each on either side of a CNA seated between the two residents to assist in a more attentive and timely meal service.

Resident # 87 is at an assisted dining table and is being assisted to eat at the time the meal is placed before him/her.

Resident # 52 is allowed to enter the dining room before the posted meal service. The expectation is that he/she will be served their meal in a timely manner.

The expectation is that Resident #38 will be served his/her meal in a timely manner.
The private room temperature related to Resident #45's request will not be adjusted by staff unless discussed first with the resident.

Jennifer Crouse Executive Director 12/21/12

POC accepted. Called to Jennifer Crouse, ED on 1/3/13 @ 10:35pm
Janice Collins 1/7/13

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F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	F241 The facility will ensure residents are provided a dignified dining experience and will ensure residents are treated with dignity related to temperature control in his/her rooms. This will be accomplished by:	1/13/13

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview, and review of resident group meeting minutes, the facility failed to provide a dignified dining experience for 5 of 18 sample residents (#36, #38, #41, #52, #87) and one non-sample resident (#51) during one of two meal observations. In addition, the facility failed to ensure one non-sample resident (#45) was treated with with dignity related to the temperature control in the resident's room. The findings were:

1. Observation of the evening meal dining service

A) Resident # 36 and Resident # 51 are now seated at a four person table, each on either side of a CNA seated between the two residents to assist in a more attentive and timely meal service.

Resident # 87 is at an assisted dining table and is being assisted to eat at the time the meal is placed before him/her.

Resident # 52 is allowed to enter the dining room before the posted meal service. The expectation is that he/she will be served their meal in a timely manner.

The expectation is that Resident #38 will be served his/her meal in a timely manner.
The private room temperature related to Resident #45's request will not be adjusted by staff unless discussed first with the resident.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	12/21/12

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.

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F 241	Continued From page 1 on 11/26/12 from 4:55 PM to 5:45 PM showed CNA #1 was attempting to assist residents #36 and #51 with eating and drinking. The residents required extensive assistance, and did not attempt to take any bites without assistance. CNA #1 who was seated on a movable chair, would give one resident a bite, and then move herself to the other residents by wheeling around and giving one bite at a time. On several occasions the CNA was pulled away from this table to help other residents. At one point resident #51 and #36 waited for 7 minutes from 5:28 PM to 5:35 PM for another bite of food. At that time, resident #36 became increasing agitated and was heard to say "hurry up" and "help me" repeatedly Observation on 11/26/12 at 5:18 PM showed resident #57 was sleeping as his/her uncovered meal was placed on the table. There was no attempt to wake the resident or provide any assistance until 5:28 PM when CNA #1 assisted the resident to drink the health shake. The resident was not offered any bites of food from the plate until 5:40 PM (22 minutes after it was served) and then the food provided from the plate was not re-heated Interview with CNA #1 on 11/26/12 at 5:30 PM revealed s/he was a restorative aide and helped where needed. She stated when the CNAs on the units were done they usually come to the dining room to help assist. Review of the 9/5/12, 10/8/12 and the 11/15/12 resident council meeting minutes showed a continued concern for residents who needed help eating and there not being enough help for those who need assistance with dining	F 241	B) The dining room evening meal service has been revised to serve independent diners first, allowing the CNA's time to assist all residents to the dining room. Licensed and dietary staff will assist in delivering meal trays to independent diners. Assisted diners will be seated after the independent diners have been seated. The placement of assisted diners has been reevaluated to assure that there are no more than two assisted diners and two residents requiring cuing to eat at each four top dining room table that is to be assisted by one CNA. As the CNA's enter the dining room with the assisted diners, they will obtain meal trays and immediately sit to assisted residents. Licensed and dietary staff will continue to assist in delivering meal trays to the assisted diners. After all dining room resident meals are served, licensed and dietary will continue with their other dining room tasks. An interview of alert and oriented resident was completed by Social Services related to their private room temperatures preferences. C) Licensed staff was in-serviced by January 13, 2013 by the Staff Development Coordinator or designee to pass medications before and after meals have been served to assure residents are assisted with dining in a timely manner. Nursing and dietary staff was in-serviced regarding the timeliness of delivering meal trays in the dining room as well as the timeliness of assisting residents with eating. CNA's were in-serviced to place meal trays before assisted diners with the intention of immediately sitting down to begin assisting the resident to eat. Licensed staff was in-serviced not to change resident private room thermostats without first discussing it with the resident. The Resident Council will be informed of these new changes in the dining process and the education provided to staff regarding the thermostats.	

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F 241 Continued From page 2

2. Interview on 11/28/12 at 10 AM with non-sample resident #45 revealed s/he was unhappy with the staff adjusting the temperature of his/her private room based on their opinions. The resident stated s/he should have the right to keep his/her room warm even though the staff may be uncomfortable for a few minutes while working in the room. The resident was able to make him/herself understood and had written a note and hung it on the wall next to the thermostat. The note showed it was the resident's request to not have staff change the temperature. The resident stated this was a frequent problem. Interview with the interim DON on 11/28/12 at 10:45 AM verified she was not aware of the problem the resident was experiencing or the posted note. Review of the resident group meeting minutes from 10/18/12 showed concerns under the category of nursing. One of the concerns documented was related to not having staff change thermostats without permission from the residents.

F 243 SS=E 483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP

A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

F 241

D) Resident evening dining room meal service will be monitored daily for 1 week, weekly for 3 weeks, and monthly for an additional 2 months to assure resident receive their meal trays timely and that assisted diners are assisted in a timely manner.

Residents will be randomly interviewed by Social Services regarding the adjustments of their private room thermostats for the next 30 days.

The facility Performance Improvement Committee meets at least monthly to define and approve the scope of quality improvement for the facility. The Committee consists of the Executive Director, Director of Nursing, Medical Director, and several other managers and facility staff. The PI Committee facilitates the use of tracking tools, reviews findings, provides oversight as to effective utilization of the PI process, and assures that the facility's plans are followed, making adjustments as necessary. Negative trends noted during monitoring will be brought to the PI Committee where follow up interventions will be determined including additional training and/or creation of an action plan based on the data collection.

F 243

The results of the dining room and thermostat monitoring will be reported to the Performance Improvement Committee monthly by the SSD and DON or designee for the next 90 days or until the committee determines substantial compliance has been achieved.

F243 The facility will ensure the resident group is assisted, organized and functioning. This will be accomplished by: 1/13/13

A) The activity director met with the resident council and discussed the process for the election of officers and how the council wanted to have their concerns followed up on by the activities director. Resident Council officers have been elected.

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F 243 Continued From page 3

This REQUIREMENT is not met as evidenced by:
Based on review of resident group meeting minutes, resident and staff interview, and review of the policy and procedure, the facility failed to ensure the resident group was assisted with organizaton and effective functioning during 3 of 3 months reviewed. The findings were:

Confidential interview with a group of residents on 11/27/12 at 2 PM revealed 5 residents had concerns and concerns about life in the facility. The acting president of the group revealed a concern about not having any elected officers and how in the past few months, the group meetings were ineffective. The group of residents being interviewed agreed that an election for resident council officers was needed. Interview with the activity director on 11/26/12 at 3:50 PM revealed she was new to the position and had realized there was not a well organized or effective resident group in place. She verified in the past 3 months the group was not as strong due to the loss of a couple of active resident group members. She also said she needed to help the group have an election and/or re-organize the system for resident group meetings. She was not aware of the facility policy and procedure for the council. Review of the last revised 3/15/07 policy for resident council showed the activity director would assist the officers in coordinating the council. Additionally, the policy showed the activity director was to facilitate follow up on all complaints, suggestions and ideas presented at the meeting and report the results at the next meeting for the resident's information. This information would be included in

F 243 B) During the January resident council meeting, election of officers occurred and an election will be held annually every January. The Activities Director will also complete a resident council follow up form which will include all resident concerns, suggestions and ideas presented at each meeting. Following each meeting this form will be assigned to the department head that can most effectively address the issue. This department leader will complete the form after addressing the issue or suggestion. The department head or designee will update the council regarding the concerns and follow up from the last meeting utilizing completed follow up form.

C) For the next three resident council meetings, the activities director will discuss any concern related to the new follow-up process. Adjustments will be made to the process as needed.

D) The results from the resident council follow up form will be reported to the Performance Improvement Committee monthly by the activities director or designee for the next 90 days or until the committee determines substantial compliance has been achieved.

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F 243 SS=E	Continued From page 4 the minutes. In addition, the policy showed the activity director would encourage maximum resident participation, leadership and development.	F 243	F244 The facility will ensure concerns and grievances identified by the resident group will be acted upon. This will be accomplished by: A) The activities director met with the resident council and explained the following:	1/13/13
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of resident group meeting minutes and resident and staff interview, the facility failed to ensure concerns and grievances identified by the resident group were acted upon for 3 of 3 meetings reviewed. The findings were: Review of the September, October, and November 2012 resident council meeting minutes showed the following residents concerns: a. In the September minutes a concern about the dining service was raised and part of this concern was not having enough staff to assist residents who needed help. Review of the October and November minutes showed the concern continued and was not resolved. Continued review showed there was no documentation as to what was being done to act on this concern. b. Another concern raised in September 2012 related to residents not wanting staff to adjust the thermostats in resident rooms without first getting	F 244	1. The dining room process will be revised to serve independent diners first, allowing the CNA's time to assist all residents to the dining room. Licensed and dietary staff will assist in delivering meal tray to independent diners. Assisted diners will be seated after the independent diners have been seated. 2. Staff education regarding not adjusting thermostats without discussing with the resident. 3. Education provided to all staff including CNA's regarding answering call lights timely and leaving the call light on if assistance is still required. 4. Minutes will be taken by the activities director during each meeting and "old business" will be part of the agenda. 5. The Resident Council follow up form will be implemented during the next council meeting. Any concerns or suggestions will be documented on this from and assigned to the appropriate department head for follow up. This will then be reported at the next meeting by the department head or designee. B. The dining room evening meal service has been revised to serve independent diners first, allowing the CNA's time to assist all residents to the dining room. Licensed and dietary staff will assist in delivering meal trays to independent diners. Assisted diners will be seated after the independent diners have been seated. The placement of assisted diners has been reevaluated to assure that there are no more than two assisted diners and two residents requiring cuing to eat at each four top dining room table that is to be assisted by one CNA. As the CNA's enter the dining room with the assisted diners, they will	

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F 244 Continued From page 5

the resident's permission. Interview with resident #45 on 11/28/12 at 10 AM verified this remained a problem.

c. The September minutes further showed concerns about the CNAs not answering call lights and/or saying they would be back to help but did not do so in a timely manner. The residents also felt they were being rushed by the CNAs so the aides could take a break. The October minutes showed the CNAs were going out two at a time to take breaks and not being attentive to resident needs.

d. The November minutes showed no actions being taken on how the issues were being addressed. The area for nursing in the November minutes showed "no old business" even though the current concerns were related to staffing and residents not getting the help needed at meals and the length of time it was taking to get some residents to bed.

e. Interview with the activity director on 11/28/12 at 3:50 PM revealed there was not an effective system in place for addressing the residents' concerns. She stated sometimes a department head would come to a meeting to hear the concerns or discuss ideas. However, there was nothing in writing to show when and how the grievances were acted upon.

F 244

obtain meal trays and immediately sit to assisted residents. Licensed and dietary staff will continue to assist in delivering meal trays to the assisted diners. After all dining room resident meals are served, licensed and dietary will continue with their other dining room tasks.

An interview of alert and oriented resident was completed by Social Services related to their private room temperatures preferences.

A call light response audit was completed by Social Services or designee to determine who answered and when the call light was answered.

During the January resident council meeting, election of officers occurred and an election will be held annually every January. The Activities Director will also complete a resident council follow up form which will include all resident concerns, suggestions and ideas presented at each meeting. Following each meeting this form will be assigned to the department head that can most effectively address the issue. This department leader will complete the form after addressing the issue or suggestion. The department head or designee will update the council regarding the concerns and follow up from the last meeting utilizing completed follow up form.

F 253 483.15(h)(2), HOUSEKEEPING & SS=D MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

F 253

C. Licensed staff was in-serviced January 13, 2013 by the Staff Development Coordinator or designee on the change is the dining process and seating, adjusting of thermostats and answering of call lights. The activities director was educated on adding "old business" to the resident council agenda and the resident council follow up form and process.

D. Resident evening dining room meal service will be monitored daily for 1 week, weekly for 3 weeks, and monthly for an additional 2 months to assure resident receive their meal trays timely and that assisted diners are assisted in a timely manner.

Residents will be randomly interviewed by Social Services regarding the adjustments of their private room thermostats for the next 30 days.

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F 253 Continued From page 6

Based on observation and staff interview, the facility failed to assure adequate housekeeping in the facility laundry room. The findings were: Observation on 11/29/12 at 9 AM revealed an accumulation of lint and dirt on the return air vent in the ceiling in the clean laundry room. The air vent was approximately 2 feet by 2 feet and directly over the resident's clean clothing rack. Interview with the laundry supervisor at the time of the observation confirmed the findings.

F 281 SS=D 483.20(k)(3)(ii) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and medical record review, the facility failed to ensure staff followed physician's orders for 2 of 18 sample residents (#11, #82). The findings were:

1. Review of the November 2012 physician's recapitulation of orders for resident #82 showed she had diagnoses including adhesive capsulitis of the shoulder and chronic pain. Further review of these orders showed an order for Fentanyl patch 50 micrograms (mcg) per hour for pain. Other orders to address the resident's pain included Gabapentin 300 milligrams (mg) three times per day beginning 2/2/12 and hydrocodone-acetaminophen 7.5-325 mg one tablet every four to six hours PRN and prior to therapy beginning 10/10/12. Review of the pain flow sheet, the MAR, and nursing notes for November 2012 showed no evidence the resident

F 253 The department head or designee will update the council regarding the concerns and follow up from the last meeting utilizing completed follow up form.

Results of the audits and interviews will be submitted to the PI committee monthly by the appropriate department head or designee monthly for the next 90 days or until the committee determines substantial compliance has been achieved.

F 281 F253 The facility will ensure adequate housekeeping in the facility laundry room. This will be accomplished by: 1/13/13

A) The return air vent in the ceiling in the clean laundry room was cleaned on 11/30/12.

B) All return air vents were audited within the building to ensure cleanliness on 11/30/12.

C) The housekeeping department was in-serviced by the Executive Director regarding observing and cleaning return air vents monthly.

D) Return air vents will be randomly audited by housekeeping on a monthly basis.

The results of these audits will be reported to the Performance Improvement Committee monthly by the house keeping manager or designee for the next 90 days or until the committee determines substantial compliance has been achieved.

F 281 The facility will provide services that meet professional standards. This will be accomplished by: 1/13/13

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F 281	Continued From page 7 was medicated with the hydrocodone-acetaminophen prior to showers. Interview with the interim DON on 11/29/12 at 9:20 AM verified there was no evidence the resident received pain medication prior to his/her showers. 2. Review of the November 2012 physician's recapitulation of orders for resident #11 showed s/he had an order dated 6/24/12 to have staff check his/her vital signs on a daily basis. Review of the vital sign flow sheet, nursing notes, the October and November 2012 MAR, and the October and November 2012 TAR showed no evidence the resident's vital signs were obtained on a daily basis as ordered. Interview with the nurse manager on unit one on 11/29/12 at 9:25 AM verified vital signs were not obtained daily as ordered. The nurse manager further said the order should have been clarified because it was originally ordered after a return from the hospital and was probably no longer necessary. 3. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills" 7th Edition, 2008: "Skill and functions that professional nurses perform in daily practice include: ... Administer treatments per physician's order."	F 281	A)The physician order for Resident # 82 was clarified to read: Hydrocodone-acetaminophen 7.5/325 mg one tablet every 4 to 6 hours PRN for pain. An additional physician order clarification for Resident # 82 was written to read: Hydrocodone-acetaminophen 7.5/325 mg one tablet before showers PRN for pain. The physician order for Resident #11 was clarified to read: Vital signs weekly and PRN. B)An audit of residents with physician ordered pain medication prior to showering was completed to identify any other residents with the same omissions. An audit of resident daily vital sign orders was completed to identify any other residents with the same omissions. C)Licensed staff was educated January 13, 2013 by the Staff Development Coordinator or designee to follow physician orders as written and to clarify any physician order that has not been clearly or precisely written. D)Physician orders for resident with pain medication before showers and residents with daily vital sign orders will be reviewed weekly for 30 days and monthly for an additional 60 days assure that physician orders are being followed as written. The results of the reviews will be reported to the Performance Improvement Committee monthly by the DON or designee for the next 90 days or until the committee determines substantial compliance has been achieved.
F 309	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	F 309		

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F 309	Continued From page 8	F 309		

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 staff interview and medical record review, the facility failed to ensure all necessary assessments, monitoring, and nursing measures were implemented for pain management for 2 of 11 sample residents (#52, #81) who experienced pain. The findings were:

1. Review of the November 2012 physician's recapitulation of orders for resident #52 showed s/he was admitted with diagnoses including osteoporosis and chronic pain. Review of the 11/1/12 quarterly MDS assessment showed s/he had pain occasionally rated at 5 out of 10 (5/10) on a scale of 0 to 10 with 10 being the worst. Review of the care plan dated 10/27/12 showed the resident's acceptable level of pain was 3/10 and the goal for the resident was to attain relief or a reduction of pain intensity within one hour post intervention. Review of the physician's orders showed a 3/22/10 order for Tylenol 325 milligrams (mg) one to two tablets every four hours PRN (as needed) for pain. Further review showed a 1/29/11 physician's order for Vicodin 5/100 mg twice daily at 8 AM and at 4 PM for pain management. On 10/31/12 the physician ordered morphine sulfate ER 60 mg twice daily for pain. The following concerns with pain management were identified:

a. Review of the November 2012 MAR

F309 The facility will ensure all necessary assessments, monitoring, and nursing measures were implemented for pain management. This will be accomplished by:

1/13/13

A)Resident # 52 is no longer a resident at this facility due to transfer to another facility closer to family.

Resident # 81 will have documentation of pain medication effectiveness on the Pain Flow Sheet after 1 hour of receiving a PRN pain medication. If pain is not reported at or below threshold 4/10, Resident # 81's medical record documentation will show pain intensity level, attempts to decrease pain with the use of non-pharmacological interventions and/or utilization

of PRN pain medication and that the Primary Care Provider was notified of pain medication ineffectiveness with request for further intervention from Primary Care Provider.

B)An initial audit of PRN pain medication effectiveness was completed by Nursing Administration to identify other resident records with the same omissions.

C)Nursing staff will be educated by the SDC or designee by 01/13/2013 on proper documentation of PRN pain medication effectiveness along with appropriate follow-up to Primary Care Provider.

D)PRN pain medication effectiveness documentation and physician notification of pain medication ineffectiveness will be monitored by nursing administration daily for 1 week, weekly for 3 weeks, then monthly for an additional 2 months. The results will be reported to the Performance Improvement Committee monthly by the DON or designee for the next 90 days or until the committee determines substantial compliance has been achieved.

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F 309 Continued From page 9

showed the resident had pain rated 7/10 on the 6 AM to 2 PM shift (no specific time was documented). The resident received a routine Vicodin 5/500 mg at 8 AM. Continued review of the MAR showed the resident's pain was higher at a level of 8/10 on the 2 PM to 10 PM shift (no specific time was documented). Review of the nursing notes and pain flow sheet showed no evidence additional interventions such as non-pharmecological or the PRN Tylenol was offered to resolve the resident's pain. Review of the 10/27/12 care plan showed interventions for pain management included pain medication as ordered, ice, massage, exercise, touch, repositioning, immobilization or music as potential interventions. In addition, the care plan showed the intensity, character, frequency, pattern, location, duration and precipitating factors related to the resident's pain should be noted. However, there was no evidence anything other than the pain intensity was assessed.

b. Review of the November 2012 MAR showed the resident had pain rated 6/10 on 11/8/12 on the 6 AM to 2 PM shift (no specific time was documented). The resident received a routine Vicodin 5/500 mg at 8 AM, however, according to the 2 PM to 10 PM the resident's pain remained at 8/10 throughout that shift as well. Review of the nursing notes and pain flow sheet showed no evidence the resident's pain was relieved by the 8 AM Vicodin or the 4 PM Vicodin. Additionally, there was no evidence other interventions were attempted in order to relieve the resident's pain. Finally, the care plan showed the intensity, character, frequency, pattern, location, duration and precipitating factors related to the resident's pain should be noted. However, there was no evidence anything other than the

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pain intensity was assessed

c. Review of the November 2012 MAR showed the resident had pain rated 5/10 on 11/26/12 on the 6 AM to 2 PM shift (no specific time was documented). The resident received a routine Vicodin 5/500 mg at 8 AM, however, according to the 2 PM to 10 PM the resident's pain remained at 5/10 throughout that shift as well. Review of the nursing notes and pain flow sheet showed no evidence the resident's pain was relieved by the 8 AM Vicodin or the 4 PM Vicodin. Additionally, there was no evidence other interventions were attempted in order to relieve or reduce the resident's pain to an acceptable level of 3/10. Finally, the care plan showed the intensity, character, frequency, pattern, location, duration and precipitating factors related to the resident's pain should be noted. However, there was no evidence anything other than the pain intensity was assessed.

d. Interview with the interim DON on 11/29/12 at 8:30 AM verified pain should be assessed for not only intensity but character, frequency, pattern, location, duration and precipitating factors. She further acknowledged the goal of pain management was to relieve or reduce a resident's pain to an acceptable level.

2. Review of the medical record for resident #81 showed s/he had diagnoses including history of traumatic fracture and other musculoskeletal disorders. Review of the 11/20/12 initial MDS assessment showed s/he frequently had pain that interfered with sleep and day to day activities. Review of the corresponding CAA showed the resident fell on 11/3/12 and fractured the fifth digit on the left hand, precipitated by the onset of pneumonia. In addition, the resident had residual

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F 309 Continued From page 11 F 309

back pain from a compression fracture in September 2012. Finally the resident had a fall with a right hip fracture in February 2012. Review of the November 2012 physician's orders showed an order dated 11/7/12 for 325 mg Tylenol one to two tablets every four hours as needed for pain. On 11/21/12 the physician wrote an additional PRN pain medication order for Tramadol 50 mg one tablet every six hours. Review of these same orders showed the resident's acceptable level of pain was 4/10. Review of the care plan dated November 2012 showed the resident's goal was to attain relief or a reduction of pain intensity within one hour post intervention. The following concerns with pain management were identified:

a. Review of the pain flow sheet showed the resident had back pain rated 8/10 on 11/10/12 at 9:10 PM. The resident was administered Tramadol two tablets at that time and was re-positioned. Review of the medical record showed no evidence the resident's pain was re-assessed to determine the effectiveness of the medication in relieving or reducing the resident's pain.

b. Review of the pain flow sheet showed the resident had back pain rated 10/10 on 11/29/12 at 10 AM. The resident was administered Tramadol two tablets at that time and was re-positioned. Review of the medical record showed no evidence the resident's pain was re-assessed to determine the effectiveness of the medication in relieving or reducing the resident's pain.

c. Interview with the interim DON on 11/29/12 at 9:30 AM revealed a resident's pain should be re-assessed within one hour after being medicated to determine the effectiveness of the medication in relieving or reducing the pain.

F 323 483.25(h) FREE OF ACCIDENT F 323

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F 323 SS=D	Continued From page 12 HAZARDS-SUPERVISION-DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment in the rehabilitation kitchen. The findings were: Random observations during the survey revealed an unsecured electric range in the rehabilitation kitchen. The range top had four electric burners with individual control knobs. Observations throughout the survey revealed the doors to the rehabilitation kitchen were always open during business hours. In addition, observation on 11/28/12 at 1:45 PM revealed several flammable items were placed on the burners including a puzzle, a cotton sack with an apple in it and a plastic tray. Interview with the speech pathologist on 11/28/12 at 2 PM revealed the range was used by residents for rehabilitation purposes. She also stated there was no safety switch so the range could be turned on at any time.	F 323	F323 The facility will ensure a safe environment in the rehabilitation kitchen. This will be accomplished by: A) All items were removed from the rehabilitation kitchen range top on 11/29/12 and the range was unplugged. A safety switch has been installed on the range. B) The rehabilitation kitchen range top is randomly monitored by the RSM to assure no flammable items are being stored on the range. C) Therapy staff was in-serviced regarding kitchen safety and instructed not use the range top as a storage area. Therapy staff was also educated on the safety switch placed on the range. D) The maintenance staff will audit the range to assure flammable items are not being stored on the range top during their monthly safety audits. Any issues will be addressed immediately. The results of these audits will be reported to the Performance Improvement Committee by the maintenance director or designee for the next 90 days or until the committee determines substantial compliance has been achieved.	1/13/13
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		

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F 333	Continued From page 13	F 333		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and medical record review, the facility failed to ensure the correct dose of insulin was prepared for injection for 1 of 1 sampled residents (#1) who required sliding scale insulin (SSI) for management of diabetes. The findings were:

A review of the November 2012 physician's recapitulation of orders for resident #1 showed s/he was admitted with diagnoses including insulin dependent diabetes. Further review of these orders revealed the resident had finger sticks to check blood glucose levels two times daily before meals and the resident received insulin based on a sliding scale. An observation on 11/27/12 at 4:40 PM revealed LPN #2 performed a finger stick blood sugar for resident #1. The results were 156mg/dcl (milligrams per deciliter). According to the SSI orders, this result required the administration of 3 units of insulin. LPN #2 stated resident #2 was to receive "3 units of insulin...however LPN #2 prepared 5 units of insulin. LPN #2 was in the process of entering resident #2's room to administer the insulin when the surveyor asked LPN #2 to re-check the dose against the MAR prior to administration. LPN #2 stated "I'm pretty sure [s/he] gets 5 units but I will check the MAR." Upon checking the MAR, LPN #2 discovered the correct amount of insulin was 3 units instead of the 5 units she had prepared to administer the resident. LPN #2 then prepared and administered the correct dose of insulin to the resident. An interview with the DON on 11/29/12 at 8:25 AM revealed she expected nurses to reconcile sliding scale insulin orders

F333 The facility will ensure that residents are free of significant medication errors. This will be accomplished by:

A)Resident # 1 is receiving insulin as ordered by Primary Care Provider with implementation and utilization of dial-up insulin pen.

B)Residents currently receiving subcutaneous inject able insulin will now have insulin provided by utilizing dial-up insulin pens for better accuracy of insulin being administered.

1/13/13

C)Nursing staff will be educated by SDC or designee by 01/13/2013 on the use of dial-up insulin pens including accuracy of amount being administered and proper administration technique.

D)Random visualized audits by Unit Managers or Designee of accuracy of amount of insulin being administered to insulin dependent residents will be done 3 times weekly x 4 weeks then 6 times monthly for an additional 2 months.

Results of the insulin administration audits will be reported to the Performance Improvement Committee monthly by the Director of Nursing for the next 90 days or until the committee determines substantial compliance has been achieved.

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F 333	Continued From page 14 with the physician ordered parameters listed on the MAR prior to administering insulin to residents.	F 333		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and staff, resident, and visitor interview, the facility failed to ensure it had adequate staff to serve and or assist with meals in a timely manner for 4 of 18 sample residents (#35, #87, #38, #52) and 2 non-sample residents (#34, #61). In addition, 5 confidential resident interviews verified a less than effective number of	F 353	F 353 The facility does have sufficient nursing staff to provide nursing and related services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 1/13/13 A)Resident # 36 and Resident # 51 are now seated at a four person table, each on either side of a CNA seated between the two residents to assist in a more attentive and timely meal service. Resident # 87 is at an assisted dining table and is being assisted to eat at the time the meal is placed before him/her. Resident # 52 is allowed to enter the dining room before the posted meal service. The expectation is that he/she will be served their meal in a timely manner. The expectation is that Resident #38 will be served his/her meal in a timely manner. Education provided to all staff including CNA's regarding answering call lights timely and leaving the call light on if assistance is still required. Activities director discussed staffing concerns with residents during resident council and explained the facility is properly staffed and ways to properly utilized staff duties and time is being addressed.	

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F 353	Continued From page 15	F 353	B)The dining room evening meal service has been revised to serve independent diners first, allowing the CNA's time to assist all residents to the dining room. Licensed and dietary staff will assist in delivering meal trays to independent diners. Assisted diners will be seated after the independent diners have been seated. The placement of assisted diners has been reevaluated to assure that there are no more than two assisted diners and two residents requiring cuing to eat at each four top dining room table that is to be assisted by one CNA. As the CNA's enter the dining room with the assisted diners, they will obtain meal trays and immediately sit to assisted residents. Licensed and dietary staff will continue to assist in delivering meal trays to the assisted diners. After all dining room resident meals are served, licensed and dietary will continue with their other dining room tasks. A call light response audit was completed by Social Services or designee to determine who answered and when the call light was answered. The Activities Director will complete a resident council follow up form which will include all resident concerns, suggestions and ideas presented at each meeting. Following each meeting this form will be assigned to the department head that can most effectively address the issue. This department leader will complete the form after addressing the issue or suggestion. The department head or designee will update the council regarding the concerns and follow up from the last meeting utilizing completed follow up form.

staff were available to complete cares in a dignified manner. Finally, review of the resident group meeting minutes for the past 3 months revealed ongoing concerns with staff numbers and effectiveness. The findings were:

The following concerns with dining related to reduced staff numbers were identified:

a. Observation of the evening meal dining service on 11/26/12 from 4:55 PM to 5:45 PM showed CNA #1 was attempting to assist residents #36, and #51 with eating and drinking. The residents required extensive assistance, and did not attempt to take any bites without assistance. CNA #1 who was seated on a movable chair, would give one resident a bite, and then move herself to the other residents by wheeling around and giving one bite at a time. On several occasions the CNA was pulled away from this table to help other residents. At one point resident #51 and #36 waited for 7 minutes from 5:28 PM to 5:35 PM for another bite of food. At that time, resident #36 became increasing agitated and was heard to say "hurry up" and "help me" repeatedly.

b. Observation on 11/26/12 at 5:18 PM showed resident #37 was sleeping as his/her uncovered meal was placed on the table. There was no attempt to wake the resident or provide any assistance until 5:28 PM when CNA #1 assisted the resident to drink the health shake. The resident was not offered any bites of food from the plate until 5:40 PM (22 minutes after it was served) and then the food provided from the plate was not re-heated. Interview with CNA #1 on 11/26/12 at 5:30 PM revealed s/he was a restorative aide and helped where needed. She stated when the CNAs on the units were done

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the resident to the dining room to help assist.

c. Interview with resident #52 on 11/26/12 at 5:15 PM revealed s/he was "very hungry" and had been waiting for his/her meal for a long time. Earlier observation revealed the resident had gone to the dining room for dinner at 4:30 PM. This resident said "quite often" it takes a long time to get his/her meal. Observation revealed the resident received his/her meal at 5:30 PM (one hour after entering the dining room for dinner, one-half hour after the meal was scheduled to be served).

d. Observation on 11/26/12 at 5 PM showed resident #38 entered the dining room for the evening meal. At 5:37 PM the resident was heard to say, "I've [I have] been waiting for more than one-half an hour for my meal." The resident said out loud s/he wanted to know where his/her meal tray was because s/he was "hungry." Observation revealed the resident was served soup at 5:40 PM, after expressing his/her frustration out loud.

2. The following concerns related to inadequate staffing numbers were identified by the resident group:

a. During a confidential resident group interview on 11/27/12 at 2 PM, 5 residents shared concerns of having to wait for extended periods of time to have call lights answered. One resident reported having to wait for 3 hours, another resident reported a two hour wait, and another resident stated s/he had waited one hour. These residents reported the wait times were recent and it was not uncommon to wait 30 minutes or more on a daily basis. In addition, the residents revealed they were told staff numbers were down because the census was down. The residents

F 353

C)Licensed staff will be in-serviced by January 13, 2013 by the Staff Development Coordinator or designee to pass medications before and after meals have been served to assure residents are assisted with dining in a timely manner. Nursing and dietary staff was in-serviced regarding the timeliness of delivering meal trays in the dining room as well as the timeliness of assisting residents with eating. CNA's will be in-serviced by January 13, 2013 by the Staff Development Coordinator or designee to place meal trays before assisted diners with the intention of immediately sitting down to begin assisting the resident to eat.

All nursing staff will be in-services by January 13, 2013 by the Staff Development Coordinator or designee on answering call lights timely and leaving the call light on if follow up assistance is needed. An in-service was also conducted to "all staff" educating them that everyone can answer a call light and how to get appropriate help as needed.

The activities director was educated on adding "old business" to the resident council agenda and the resident council follow up form and process.

D)Resident evening dining room meal service will be monitored daily for 1 week, weekly for 3 weeks, and monthly for an additional 2 months to assure resident receive their meal trays timely and that assisted diners are assisted in a timely manner.

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F 353	Continued From page 17 were concerned because of the long waits to get assistance and they see residents who require assistance not receiving it, especially in the dining room. b. Review of the September, October, and November 2012 resident group meeting minutes showed continuing concerns related to staffing patterns. Theses documented resident concerns included: "Being served in a more timely manner...residents that need help eating and getting the help that is needed...call lights not being answered in a timely manner...turning off the light and saying they will be back to help and they don't come back or it takes an hour plus...rushing a resident so they can go smoke...CNA's going out two at a time to smoke...CNA's saying this isn't my side...residents who need more help are not getting it, especially at meal times." 3. Interview with the interim DON on 11/29/12 at 8:30 AM revealed staffing was strictly based upon budget, not resident needs based on acuity. The DON also said the facility was currently on low census staffing, so there were less staff than usual.	F 353	The Social Service Director or assigned designee will do audits 1x per week with residents for the next sixty days to ensure that call lights are being answered timely. The department head or designee will update the council regarding the concerns and follow up from the last meeting utilizing completed follow up form. The results of the dining room monitoring, the call light audits and the resident council concerns follow up will be reported to the Performance Improvement Committee monthly by the appropriate department head or designee for the next 90 days or until the committee determines substantial compliance has been achieved.	
F 371 SS=F	483.35(i) FOOD PROCURE. STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.	F 371	F371 The facility will ensure sanitary conditions in the kitchen are maintained. This will be accomplished by: A)The hoods were deep cleaned on11/30/12 and were added to the monthly cleaning schedule. The oven range/burners were deep cleaned on 11/30/12 and added to the daily cook cleaning schedule. The walk in refrigerator condenser and surrounding areas, including the ceiling were deep cleaned on 11/30/12. The walk in freezer condenser was scheduled for repair. The ice buildup in the freezer was removed and the surrounding areas were cleaned. The walk in refrigerator and freezer were added to monthly Maintenance Check list. The kitchen floors were deep cleaned by dietary and housekeeping on 11/30/12. The Registered Dietitian educated staff on regarding proper sanitation, cleaning schedules and deep cleaning schedule. B)All residents have the potential to be affected.	1/13/13

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This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain sanitary conditions in the kitchen. The findings were:

According to Food Code 2009, U.S. Public Health Service, 4-501.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."

Observation on 11/26/12 at 2:10 PM revealed several items and areas in the kitchen which were in need of cleaning and or repair. The following concerns were identified:

a. The vents of the hood system located above the range and fryer unit had visible accumulation of dust and grease. The vents were observed on 11/27/12 at 3:30 PM to be in the same unclean condition.

b. The gas range top burners and surrounding areas of the range top had accumulated burned on food. Observation of the range on 11/27/12 at 3:30 PM revealed the equipment remained in an unclean condition.

c. The walk-in refrigerator condenser unit was soiled with black dust. The dust covered the fans and grates of the unit, and the ceiling area around this unit inside the walk-in's interior.

d. The condenser unit in the walk-in freezer was not working properly. There were large

C)The Registered Dietitian provided an in-service to staff that included daily, weekly & monthly cleaning schedules and the importance of good sanitation and infection control. The Maintenance staff will check condensers in the refrigerators/freezer during their monthly safety audits. Housekeeping will assist dietary in deep cleaning of the kitchen floors monthly.

D)Dietary Manager or designee to complete rounds in the kitchen 5 x per week x 30 days. If sustained compliance, the Dietary Manager or Designee will complete kitchen rounds in the kitchen 3 x per week for another 60 days, monitoring to ensure all cleaning is being completed as indicated on cleaning schedules, including hoods, oven range, walk-in refrigerator & freezers & floors.

Results will be reported to the Performance Improvement Committee monthly by the Dietary Manager or designee for the next 90 days or until the committee determines substantial compliance has been achieved.

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F 371	Continued From page 19 amounts of ice formed on the condenser and the water pipes. Some ice had built-up on a box of frozen dough. Interview with the dietary manager on 11/28/12 at 11:20 AM verified the ice had been a problem for more than 6 months. She further revealed the maintenance department had not been recently notified. e. The kitchen floor was noted to have considerable build-up of grease and dirt in multiple areas. The areas with the most soil accumulation were around the legs of equipment such as the range, steamer, ovens, and preparation tables. The unclean condition remained on 11/27/12 at 3:30 PM. Interview with the dietary manager on 11/28/12 at 11 AM verified the cleaning needed to be accomplished more regularly. She also stated the department was down a couple of employees and they were in the process of hiring more help.	F 371		
F 441 SS=D	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.	F 441	F441 The facility will ensure that glucometers are disinfected prior to use. This will be accomplished by: A)The Glucometer is being cleaned before and after use for Resident # 1 using Super Sani-Cloth wipes per facility policy. B)An observation audit of nurses using the Glucometer was completed to identify any other nurses not cleaning the Glucometer prior to and after use with Super Sani-Cloth wipes per facility policy. C)Nursing Staff will be educated by January 13, 2013 by the Staff Development Coordinator or designee on the proper technique for cleaning the Glucometer using Super Sani-Cloth wipes per facility policy. D)Random Visual Audits by Unit Managers or Designee of proper cleaning of Blood Glucose monitor will be done 3 times weekly X 4 weeks then 6 times monthly for 2 additional months. Results of the random audits will be presented to the Performance Improvement Committee monthly by the DON or designee monthly for the next 90 days or until substantial compliance has been achieved.	1/13/13

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(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, the facility failed to ensure that a glucometer was disinfected during 1 of 1 observation for one of one resident (#1) who received a finger stick blood sugar. The findings were:

A medication administration observation on 11/27/12 at 4:45 PM with LPN #2 revealed she performed a finger stick on resident #1 to check a blood sugar level using a glucometer (a hand held device that calculates blood sugar levels at bedside). The glucometer was cleaned with alcohol wipes. At that time, LPN #2 stated "the

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F 441	Continued From page 21 facility's policy was to clean glucometers with alcohol after each use." An interview with the infection control nurse on 11/27/12 at 4:55 PM revealed glucometers were cleaned with Super Sani-Cloths (disinfectant wipes that kill blood borne pathogens and hepatitis B). A review of the facility's policy entitled "Cleaning and Disinfection of the Glucometer" dated 03/10 stated under Equipment and Supplies: "Super Sani-Cloth or Sani-Cloth Plus (individual wipe) or an equivalent product that kills hepatitis B and blood-borne pathogens. The product must contain specific language addressing these two criteria. Number 7. Pick up the glucometer disinfect it with a Super Sani-Cloth wipe or an equivalent product that kills hepatitis B and blood borne pathogens." An interview with the DON on 11/28/12 at 4:55 PM revealed she expected nurses to clean glucometers with Super Sani-Cloths after each use per the facility's policy.	F 441		
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514		

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F 514	Continued From page 22 services provided, the results of any preadmission screening conducted by the State, and progress notes This REQUIREMENT is not met as evidenced by Based on observation, medical record review and staff interview the facility failed to ensure accurate medical records were maintained for 5 of 18 sample residents (#5, #11, #50, #53, #82). In addition, based on medical record review and staff interview, the facility failed to ensure medical records were properly filed for 1 (#73) of 21 sample residents and 1 non-sample resident (#68). The findings were: 1. Review of the medical record for resident #5 showed a physician's order dated 11/13/12 for Coumadin 4mg by mouth to be administered on Monday, Wednesday, Friday, Saturday and Sunday. The medication administration record (MAR) revealed no documentation whether the resident received this medication on 11/21/12 and 11/25/12. A physician's order dated 10/18/12 revealed the resident was to receive Risperidone 1mg by mouth at bedtime for a diagnosis of bipolar disease. The MAR revealed no documentation for 11/7/12, 11/13/12, and 11/26/12. A physician's order dated 10/18/12 revealed resident #5 was supposed to receive Valproic Acid 750mg at bedtime for bipolar disorder. The MAR revealed no documentation for 11/13/12, 11/18/12 and 11/28/12. A physician's order dated 10/18/12 revealed an order for Digoxin 125 mcg by mouth daily for atrial fibrillation. The MAR revealed no documentation was recorded whether the medication was	F 514	F514 The facility will ensure accurate medical records are being maintained and filed properly. This will be accomplished by: A)Resident # 5 was discharged from facility to home. Resident # 50 and 53 will have no omissions on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). Clarification physician orders were obtained for Resident # 11 and # 82 regarding discontinuing fluid intake orders. Resident # 11 and # 82 will have no output omissions in the electronic documentation record (RITA). Medical Records audited Resident # 73 medical record and removed all incorrectly file documentation and filed the documentation correctly. B)An initial audit of MARs and TARs identifying the omissions in documentation was completed by nursing administration. An initial audit of RITA documentation for physician ordered intake and outputs for catheterized residents was completed by nursing administration. Medical Records will audit resident records using the RAI schedule for correct filing of resident information in appropriate record. C)Nursing staff will be educated by January 13, 2013 by the Staff Development Coordinator or designee on proper documentation on the MAR and TAR and monitoring CNA documentation of intake and output in RITA. CNAs will be educated by January 13, 2013 by the Staff Development Coordinator or designee on documenting intake and output in RITA.	1/13/13

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F 514	Continued From page 23 administered on 11/25/12. 2. Medical record review for resident #50 revealed a physician's order for Atenolol 25mg by mouth twice daily. The MAR revealed no documentation whether the medication was given in the evening on 11/21/12 and 11/27/12. A physician's order dated 11/09/12 revealed an order for the resident to wear a bone stimulator 10 hours daily on his/her lower leg to facilitate healing. The MAR revealed no documentation the bone stimulator was taken off on 11/13/12, 11/14/12 and 11/27/12, and no documentation that the bone stimulator was applied on 11/22/12, 11/23/12, 11/25/12, 11/27/12 and 11/28/12. A physician's order dated 10/02/12 revealed an order for the resident's blood sugar to be checked before meals and at bed time at 6:30 AM, 11:30 AM, 4:30 PM, and 8 PM. The MAR revealed no documentation this was done on 11/02/12, 11/08/12, 11/15/12, 11/24/12 and 11/25/12 at 11:30 AM before lunch meal, no documentation for 11/09/12 and 11/15/12 at 4:30 PM before the dinner meal, and no documentation on 11/07/12, 11/16/12, and 11/17/12 at 8:00 PM. A physician's order dated 10/02/12 revealed an order for Novolin N insulin 7 units subcutaneous twice daily for uncontrolled diabetes. The MAR revealed no documentation this was given on 11/23/12 and 11/26/12 AM dose and 11/15/12, 11/16/12, 11/22/12, 11/23/12 and 11/26/12 PM dose. 3. Medical record review for resident #53 revealed a physician's order for Duoneb nebulizer treatments 4 times daily at 8 AM, 12 PM, 4 PM, and 8 PM for chronic obstructive pulmonary disease (COPD). The MAR revealed no documentation Duoneb was administered	F 514	Nursing staff will be educated on proper filing of the medical record documentation in the appropriate medical record by January 13, 2013 by the Staff Development Coordinator or designee. D)Audits of MARs and TARs identifying the omissions in documentation will be completed by nursing administration daily x 1 week, weekly x 3 weeks, then monthly for two additional months. A RITA documentation audit for physician ordered intake and outputs for catheterized residents will completed by nursing administration daily x 1 week, weekly x 3 weeks, then monthly for two additional months. Medical Records will audit resident records using the RAI schedule for correct filing of resident information in appropriate record. Results of the audits will be submitted to the PI Committee by the DON or designee monthly for the next 90 days or until the committee determines substantial compliance has been achieved.	

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11/21/12 at 8 AM, 11/21/12 at 12 PM, 11/08/12, 11/20/12 and 11/21/12 at 4 PM and 11/27/12 at 8 PM. A physician's order dated 11/06/12 revealed an order for Flonnef 0.1mg by mouth daily times 1 week then increase to Flonnef 0.2mg by mouth daily for blood pressure. The MAR revealed no documentation for 11/21/12. A physician's order dated 11/06/12 revealed an order for Daliresp supplement 500mcg by mouth daily for COPD. The MAR revealed no documentation for 11/21/12. An interview with RN #1 on 11/28/12 at 4:45 PM revealed nurses are expected to document on the MAR that a resident was given a medication by signing their name at the bottom of the MAR and signing their initials in the block provided under the date. RN #1 further revealed if the resident is out of the facility or refused the medication the nurse would circle their initials and document the reason for the omission on the space provided on the back of the MAR. An interview with the DON on 11/28/12 at 4:55 PM revealed she expected nurses to document whether a medication or treatment had been administered to residents by signing their initials on the MAR. She further revealed nurses should document that the medication or treatment was not administered by initialing, circling their initials and documenting the reason for the omission in the space provided on the back of the MAR.

4. Review of the medical record for resident #11 showed s/he had a supra pubic catheter placed for a diagnosis of cauda equina syndrome (spinal cord damage) with neurogenic bladder. Review of physician orders showed an order dated 6/24/12 to "monitor and record intake/output" every shift daily (three times per day). Review of the intake and output flow sheets showed on 18 days during

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the month of September 2012 the catheter output was not recorded on at least one of the three shifts. Review of the October 2012 intake and output flow sheet showed the catheter output was not recorded on 23 days for at least one of the three shifts. Finally, review of the November 2012 intake and output flow sheet showed the catheter output was not monitored or recorded on at least one of the three shifts for 17 of 27 days to date. Interview with the interim DON on 11/29/12 at 8:30 AM verified the document had blanks where the staff had not followed the physician's order to record the catheter output. She further said the staff should have recorded the output every shift as ordered.

5. Review of the medical record for resident #62 showed s/he had a supra-pubic catheter placed because of urinary obstruction. Review of the November 2012 physician's recapitulaton of orders showed an order dated 3/27/09 to record the catheter output every shift (three times per day). Review of the September 2012 intake and output flow sheet showed no evidence the catheter output was recorded on 19 days on at least one of the three shifts. Review of the October 2012 intake and output flow sheet showed the catheter output was not recorded on 22 days on a least one of the three shifts. Additionally, review of the November 2012 intake and output flow sheet showed the catheter output was not recorded on 18 of 27 days to date on at least one of the three shifts. Interview with the interim DON on 11/29/12 at 8:30 AM verified the document had blanks where the staff had not followed the physician's order to record the catheter output. She further said the staff should have recorded the output every shift as ordered.

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6. Review of the medical record for resident #73 showed it contained medical records belonging to another resident (non sample resident #68). The inappropriately filed records included: 7 pages of the November MAR, 2 pages of the MAR PRN drug administration sheet, 1 page of a pain assessment and 1 page of a lab administration record. Interview with LPN #1 on 11/27/12 at 11:48 AM revealed "the records were misfiled by the medical records department."