Received and approved 7/1/10 & changes made on pages 4, 33, 57 after discussion with Dan Starks, WHA on 7/1/10 at 09:50. Linda Gray

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

PRINTED: 06/08/2010
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
	535013	A. BUILDING _____ B. WING _____	05/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE & REHABILITATION CENTER	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document. RN - Registered Nurse LPN - Licensed Practical Nurse DON - Director of Nursing CNA - Certified Nurse Aide MDS - Minimum Data Set	F 000	**PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE 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 EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF STATE AND FEDERAL LAW** **This plan of correction is the facility's credible allegation of compliance**	
F 221 SS=G	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, medical record review and review of policies and procedures, the facility failed to ensure restraints were not used for staff convenience for 6 of 12 sample residents (#14, #94, #95, #113, #116, #123) who had a restraint implemented. One of these residents (#14) developed an avoidable pressure sore as a result of the use of a cushioned lap restraint (lap buddy). The findings were: 1. Review of the medical record for resident #14 showed the resident was ambulatory and did not have pressure sores when admitted to the special care unit on 2/20/10. The record revealed that less than a month later, staff noted the resident's increased unsteadiness and poor safety awareness. Review of the March 2010 physician's orders showed orders for a pressure relieving	F 221	**F-221 – Right to be Free From Physical Restraints** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #14 no longer resides at the facility. Residents #94, #95, #113, #116, #123 were re-assessed for restraint use and were evaluated by therapy for positioning and/or a restorative program. Adjustments were made to the care plans accordingly.	

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

Executive Director 6-18-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 23 2010

6-18-10

Office of Healthcare Licensing and Surveys

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F 221	Continued From page 1 wheelchair cushion, urinary catheter, and a lap "buddy" (a cushioned restraining device used to prevent the resident from rising from the wheelchair.) Review of the 4/27/10 significant change Minimum Data Set (MDS) assessment showed the resident required extensive assistance of two staff for transfers, bed mobility and personal hygiene. Further review showed the resident had a pressure relieving cushion in the wheelchair, a urinary catheter and a lap buddy. Review of the May 2010 nursing notes showed the resident was moved from the special care unit to the first floor nursing unit on 5/6/10 with no changes in the physician's orders for the restraint, catheter, or pressure relieving cushion. Review of the April and May 2010 weekly skin check records showed staff first noted the pressure sore on the resident's left ischium on 5/15/10. The following concerns were identified: a. Observation on 5/17/10 at 9 AM revealed RN #1 and LPN #2 changed the pressure sore dressing on the resident's left ischium. At that time, the pressure sore was observed to be a 2.6 by 3.0 centimeter necrotic area surrounded by swollen red tissue. Observation on 5/17/10 from 9:30 AM until 2 PM (over four hours) revealed the resident was restrained with the lap buddy in the wheelchair. Continuous observation during that time, revealed the resident was unable to remove the restraint and lacked the ability to independently off load (change in position to reduce continuous pressure to specific areas of the body). Further observation revealed staff did not remove the restraint or reposition the resident at any time during that observation. b. Review of the care plan interventions revealed the restraint was to remain on while the resident was in the wheelchair, including at mealtime, and only released during activities of	F 221	Staff will be educated regarding the systematic approach to restraint implementation and the necessary care and oversight needed once a restraint is in use. Emphasis will be placed on appropriateness of restraint use, restraint reduction and releasing of devices for repositioning. On 6-14-10 the QIO (Mountain-Pacific Quality Health) provided training to the therapy department and nursing management regarding wheel chair positioning in an effort to reduce restraints. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted to identify other facility residents utilizing restraints. They will be evaluated for appropriateness of restraint use, therapy interventions, and care plan adjustments.	

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F 221	Continued From page 2 daily living. Further review revealed there were no care plan interventions for off loading or for a systematic approach to periodically release the restraint. Interview on 5/20/10 at 7:40 AM, with the first floor nursing unit manager, verified the lack of specific, systematic care plan interventions. She further stated that staff had been instructed to maintain the restraint during mealtimes because they did not want the resident to stand and fall. On 5/20/10 at 4:45 PM, CNA #1 verified the unit manager's statements. c. Review of the 4/27/10 interdisciplinary physical restraint evaluation showed no evidence the lab buddy was the least restrictive intervention for this resident. d. During interview on 5/20/10 at 11:10 AM, LPN #1 stated she provided care for the resident when the resident resided in the special care unit. The LPN stated the staff in the special care unit engaged the resident in ongoing activities that required standing and upper and lower extremity movement. The LPN further stated that while in the special care unit, the resident was not restrained in the wheelchair for prolonged periods of time due to ongoing activities and physical therapy. The LPN also confirmed the resident did not have pressure sores prior to transfer to the first floor nursing unit. e. Review of the therapy notes for this resident showed physical therapy was discontinued on 3/24/10. Further review revealed no documentation of an assessment by the therapist or nursing staff for potential benefits the resident could receive from a nursing restorative program. Review of the restorative records and interview on 5/20/10 at 11:10 AM with the nursing unit manager confirmed the resident had not been assessed for, nor was s/he receiving, nursing restorative care.	F 221	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Prior to implementation of restraints the IDT will perform a thorough assessment for appropriateness and other possible interventions. The IDT will review restrained residents quarterly to confirm that restraints are appropriate and not used for staff convenience, less restrictive measures have failed prior to application of restraints, that restraints are reduced as needed and that care plans identify interventions for off-loading and functional maintenance. Reviews will also determine if elimination of restraints is indicated. Collaboration will continue with the QIO for consultation and education.	

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F 221	Continued From page 3 2. Review of the 1/4/10 and 4/2/10 MDS assessments for resident #116 showed s/he had fallen in the past 30 to 180 days. Review of the nursing notes revealed falls occurred on 1/13/10, 2/7/10, 2/8/10, 2/15/10, 2/25/10, 3/7/10, 3/26/10, 5/3/10, and 5/11/10. The following concerns were identified: a. Review of the post fall evaluation performed after the 5/3/10 fall showed the interdisciplinary team believed a restraint would "negatively impact [the] quality of life" and the resident "would be very upset with [a] restraint." Further review showed the resident did not call for assistance with transfers because s/he preferred to maintain his/her independence. However, observation of the lunch meal on 5/19/10 at 12 noon showed the resident had a lap buddy on the wheelchair during the entire meal. b. Review of the 5/14/10 interdisciplinary team notes written at 11:50 AM revealed the lap buddy was added to the resident's wheelchair to decrease the risk of falls. The note documented the resident was able to release a seat belt but could not remove the lap buddy. Periodic observations on 5/19 and 5/20/10 showed the lap buddy remained on the resident throughout the entire time the s/he was in the wheelchair. Interview with the resident on 5/21/10 at 10:50 AM revealed s/he wanted to retain as much independence as possible and did not like being restrained by the lap buddy on his/her wheelchair. 3. Observation on 5/17/10 at 9:15 AM revealed resident #113 had a seatbelt on his/her wheelchair. Review of the medical record revealed the resident had a history of falls. Review of the interdisciplinary physical restraint evaluation performed on 4/20/10 showed the	F 221	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** Nurse Managers will routinely audit to ensure that residents with restraints are repositioned and that restraints are released in accordance with individual care plans. Staff will be counseled immediately in the event that restraints are not released per the care plan. The Director of Nursing or designee will report any updates or concerns related to restraint use to the Performance Improvement Committee monthly times 3. The Performance Improvement Committee will review, evaluate and provide recommendations or direction as needed. Date of compliance is July 5, 2010.	

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F 221	Continued From page 4 resident had a seat belt with an alarm on his/her wheelchair for the "medical symptom" of "dementia." However, there was no evidence less restrictive alternatives were attempted prior to the implementation of this seat belt. Review of the 4/19/10 nursing notes written at 7 PM showed the resident was aggravated with the new seat belt attached to the wheelchair and "tugs and pulls [at it] constantly." Review of the 4/30/10 nursing notes, undmed, revealed the resident was "upset about having [the] seat belt." Periodic observations on 5/17 and 5/18/10 showed the resident frequently tried to remove the seat belt but was unable to do so. On 5/17/10 at 12:15 PM CNA #2 was overheard saying the resident really "hates that seat belt." Observation and interview with the resident on 5/17/10 at 9:15 AM revealed the resident was unable to release the seat belt. At that time, the resident also stated s/he did not like the seat belt but guessed it was just something in life s/he "had to deal with." 4. Review of the restraint care plan dated 12/2/09 for resident #95 showed the resident used a lap buddy restraint due to poor safety awareness. The care plan further showed the device was not considered a restraint because the resident did not have the function or intent to stand or transfer from the wheelchair. However, the care plan showed the device was to be used while the resident was up in the wheelchair and during meals. Review of the 3/1/10 quarterly MDS assessment showed the resident could usually make him/herself understood. At 5/18/10 at 6:45 PM the resident called the surveyor over to talk. At that time, the resident revealed s/he didn't understand how s/he got there, and while grabbing onto the lap buddy and pulling at it, the resident stated, "I hate this thing! I can't do	F 221		

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F 221	Continued From page 5	F 221		

anything." At 6:50 PM while seated in the main area near the nurses' station of the 3rd floor, the resident again expressed his/her frustration with the restraint by stating in a loud voice, "Can I take this off now?" The resident was ignored by the two staff members in the area, and was unable to remove the lap buddy.

5. Observation on 5/17/10 at 9 AM revealed resident #123 had a lap buddy placed on his/her wheelchair. Periodic observations from 5/17/10 through 5/20/10 showed the lap buddy was on during meals and while the resident was in the wheelchair. Review of the 12/30/09 interdisciplinary physical restraint evaluation showed a lap buddy was placed on the wheelchair due to the resident's poor safety awareness and because the resident had a history of falls. Review of the 3/29/10 restraint evaluation showed the medical symptom for using the lap buddy restraint was a diagnosis of dementia with poor safety awareness. However, review of both evaluations revealed no evidence a less restrictive measure had been tried. Review of the 1/5/10 care plan showed the lap buddy was to remain on during meals because of the resident's poor safety awareness and impulsiveness.

6. Review of a restraint evaluation dated 5/14/10 showed resident #94 used a lap buddy restraint as an intervention for high fall risk. The evaluation showed the restraint was used when the resident was up in wheelchair and during meals. Observation on 5/17/10 from 8:50 AM to 11:15 AM revealed the restraint was not released. Periodic observation on 5/17, 5/18, 5/19 and 5/20/10 showed the resident was unable to self release the restraint.

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F 221	Continued From page 6 7. Interview with the third floor unit manager on 5/19/10 at 5:20 PM revealed staff restrained residents with a lap buddy or seat belt to prevent them from standing and falling. She further stated there were not enough staff to watch everybody at the same time, especially during meals. She further stated restraints were needed to keep residents safe. The facility's Policy and Procedures regarding Restraints, revised 4/28/09, did not address periodic assessment and monitoring during restraint usage.	~~F 221~~	**F-240 – Care and Environment Promotes Quality of Life** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Education of the third floor staff will be conducted to include treating residents with dignity and respect, and their responsibility to confirm that residents are engaged in meaningful activities, that they remain socially engaged, and that the environment is maintained in a manner to enhance their quality of life. Please refer to F-241, F-248, F-250, and F-253 for further actions. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** Residents residing in other areas were observed to determine if they were treated with respect and dignity. Training for facility staff will be conducted to include treating residents with dignity and respect, that residents are engaged in meaningful activities, that they are socially engaged, and that the environment is maintained in a manner to enhance their quality of life.	
F 240 SS=E	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and family interview, and review of medical records, the facility failed to ensure quality of life was promoted and sustained for 16 of 19 sample residents (#89, #91, #94, #95, #101, #107, #110, #111, #112, #113, #114, #116, #119, #120, #123, #124) and 7 non-sample residents (#96, #103, #105, #108, #115, #117, #128) who lived on the third floor, excluding the Reflections Unit. There were also quality of life deficiencies found in 1 (#144) sample closed record. The findings were: Refer to F241 for issues related to promoting and maintaining dignity for residents on the third floor.	F 240		

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F 221	Continued From page 6 7. Interview with the third floor unit manager on 5/19/10 at 5:20 PM revealed staff restrained residents with a lap buddy or seat belt to prevent them from standing and falling. She further stated there were not enough staff to watch everybody at the same time, especially during meals. She further stated restraints were needed to keep residents safe. The facility's Policy and Procedures regarding Restraints, revised 4/28/09, did not address periodic assessment and monitoring during restraint usage.	F 221	Please refer to F-241, F-248, F-250, and F-253 for further interventions.	
F 240 SS=E	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and family interview, and review of medical records, the facility failed to ensure quality of life was promoted and sustained for 16 of 19 sample residents (#89, #91, #94, #95, #101, #107, #110, #111, #112, #113, #114, #116, #119, #120, #123, #124) and 7 non-sample residents (#96, #103, #105, #108, #115, #117, #128) who lived on the third floor, excluding the Reflections Unit. There were also quality of life deficiencies found in 1 (#144) sample closed record. The findings were: Refer to F241 for issues related to promoting and maintaining dignity for residents on the third floor.	F 240	**Measures Put Into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** See training as above and please refer to F-241, F-248, F-250, and F-253 for systemic changes to prevent recurrence. **Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** Please refer to F-241, F-248, F-250, and F-253. Date of compliance is July 5, 2010.	

19

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F 240	Continued From page 7 Refer to F248 for details regarding the lack of assessment, care planning, and engaging residents in individualized activity programs. Resident psychosocial needs were unmet as evidenced by a decline in social interactions (Refer to F250). Finally, refer to F253 regarding the environment not being maintained in a manner to enhance quality of life for residents on the third floor.	F 240		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, and staff, resident, and family interview, the facility failed to ensure dignity was maintained for 13 of 19 sample residents (#89, #91, #94, #95,#101, #107, #110, #111, #113, #114, #119, #123, #124) and 7 non-sample residents (#96, #103, #105, #108, #115, #117, #128), who lived on the third floor, excluding the Reflections Unit. The findings were: 1. Review of the 4/6/10 annual Minimum Data Set (MDS) assessment for resident #119 showed the resident was usually able to make him/herself understood, and was able to understand others. The MDS assessment also showed the resident needed set up help for eating. Review of the medical record showed the resident had a contracted right hand and arm and performed all tasks with one (left) hand and arm. Observation on the third floor during the noon meal service on	F 241	**F-241 – Dignity and Respect of Individuality** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Staff on 3rd floor, who are caring for the cited residents will receive sensitivity training by the District Director of Quality of Life/designee regarding engagement with residents, recognizing and attending to personal needs, honoring their private information, and providing care in a dignified and respectful manner.	

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F 241	Continued From page 8 5/19/10 at 12:30 PM revealed resident #119 was struggling to keep the clothing protector around his/her neck, and the resident's shirt was hanging off of his/her right shoulder. At that time CNA #3 was seated at the table assisting another resident. CNA #3 made no attempt to assist the resident with adjusting the clothing protector or the shirt. CNA #4 served the resident's meal, placing it in front of the resident without saying a word, or helping to adjust the clothing. A minute later after the resident started to eat, CNA #3 informed CNA #4 the wrong diet had been served to the resident. Without a word to the resident, CNA #4 went over to the table and took away the food as the resident was eating. The resident reached out for the food being taken away and began to cry. A few moments later, the correct meal was served to the resident; however, the staff failed to console the crying resident or provide any explanation. 2. Review of the medical record for resident #119 revealed the resident had a contracted right hand and arm and performed all tasks with the left hand and arm. Review of the 4/6/10 care plan for the resident showed the resident required assistance with all activities of daily living, including grooming. Periodic observations on all days of the survey revealed, at times, the resident preferred to eat with his/her fingers instead of using utensils. Observation on 5/20/10 from 10:15 AM to 12:20 PM revealed the resident had long, rough and dirty fingernails. Continuous observation revealed at 12:10 PM, the resident ate lunch with dirty fingers. 3. Observation on 5/17/10 at 12:20 PM showed resident #119 was finished eating and had wheeled him/herself over to the elevator. At that	F 241	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** Observations of staff providing care to residents (all disciplines) will be done to by the Social Services Director/designee to determine if the residents are treated with dignity and respect. Training will be provided the Staff Development Coordinator/designee to include treating residents with dignity and respect, engagement with residents, recognizing and attending to their personal needs, and honoring their private information.	

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F 241	Continued From page 9 time RN #2 approached the resident to re-direct him/her away from the elevator. As the nurse turned the resident's wheelchair around she told the resident in a stern voice, "Go to your room and clean up!" Then without following, the nurse gave the resident's wheelchair a push propelling the resident and chair toward the resident's room. 4. On 5/21/10 at 6:30 AM, resident #89 was observed at the nursing station without shoes and socks. LPN #4, LPN #9, and RN #2 were at the nursing station at the time when the resident asked someone to find his/her shoes. Observation showed the three staff members did not respond to or attempt to help the resident until s/he propelled the wheelchair up to one of the nurses, blocking her path. RN #2 then took the resident to get his/her shoes and socks. Interview with RN #2 on 5/21/10 at 10:40 AM revealed the resident was unable to dress him/herself and required assistance from staff. 5. Observation of resident #95 on 5/18/10 at 6:50 PM revealed that while seated in the main area near the nurses' station with staff present, the resident expressed frustration with the lap buddy attached to his/her wheelchair. The resident asked in a loud voice "Can I take this off now?" The resident was ignored by the two staff members standing in the area. 6. Observation of the lunch meal on 5/17/10 and the evening meal on 5/18/10 showed non-sample resident #98 was pushed up to the dining table in his/her wheelchair. While sitting in the wheelchair the resident's chin was level with the table edge. Interview with CNA #3 on 5/18/10 at 6:15 PM revealed she noticed this looked uncomfortable and had mentioned the need to adjust the	F 241	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Unit Managers/designee will be required to monitor the daily interactions between residents and staff and corrective action will be taken as needed. The Resident Council will be queried monthly to determine if they are being treated with dignity and respect and outcomes will be addressed as needed. Through the Angel Care program residents and/or family members will be interviewed monthly regarding a variety of topics related to their care and/or quality of life in the facility.	

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	535013	A. BUILDING _____ B. WING _____	05/21/2010

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F 241	Continued From page 10 resident's height more than once to the nursing staff; however, nothing was done. She further stated at one point she set the resident up to eat at a shorter side/lamp table in the dining room thinking it would work better for the resident, but was told by the nursing staff to move the resident back because it was a "dignity" issue. 7. During an observation on 5/18/10 at 10:25 AM, activity aide #1 was overheard to say I think "these people" need to wake up referencing the lack of participation by residents in an activity. The statement was made in a short, curt manner and the staff member had a look of frustration on her face. During this same observation, the same staff member was heard to say to non-sample resident #103, "Just kick it," referring to the ball on the floor. Again, the tone of voice was curt, sharp and the staff member had a frustrated look on her face. 8. Resident #123 was observed on 5/17/10 at 9:27 AM to be running into the table with the wheelchair and hitting his/her arms repeatedly. Observation revealed staff were present but did not attempt to re-direct the resident. Observation of the resident's arms showed old blood blisters and evidence of previous skin tears. Observation on 5/19/10 at 9:45 AM showed the resident left the activity occurring in the dining room and repeatedly propelled his/her wheelchair into the nursing station, hitting his/her knees on the nursing station wall. Observation revealed LPN #3 was standing at the nurses' station next to the resident, but did not assist the resident in any manner. 9. During lunch on 5/19/10, RN #2 was overheard to say resident #113 was on comfort care in a	F 241	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** NHA/DON/designee will conduct facility rounds five (5) times per week to observe interactions between the staff and residents to confirm that staff is engaged with residents, recognizing and attending to personal needs, honoring their private information, and treating residents with dignity and respect. Findings by the NHA/DON, Unit Managers, Resident Council and Angel Care will be reported to the Performance Improvement Committee for review and recommendations monthly times 3 months. Date of compliance is July 5, 2010.	

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F 241	Continued From page 11 voice loud enough for residents, staff, two surveyors, and two visitors to hear. 10. On 5/18/10 at 5:35 PM while CNA #5 was pouring drinks for the evening meal, CNA #3 told the other CNA that every resident had to be given a glass of milk whether they wanted it or not. CNA #5 asked "Even if they don't want it?" and CNA #3 said, "yes." During this verbal exchange the unit manager intervened by telling the two CNAs that the company policy was for every resident to get a glass of milk whether they drank it or not. The discussion betwsen the two CNAs as well as the intervention by the unit manager was loud enough for residents, staff and visitors to overhear. 11. Observation on 5/18/10 at 6:13 PM showed resident #111 said s/he had to use the bathroom. At the time, the resident was seated in a wheelchair just outside the Independent dining room. One nurse looked at the resident but did not respond, and one CNA walked by the resident, also without responding. The resident called out requesting to use the bathroom three times before RN #2 responded and assisted the resident to the bathroom. Interview with RN #2 on 5/20/10 at 10:45 AM revealed this resident 'always" wanted to go to the bathroom. 12. Observation on 5/19/10 at 9 AM showed thirteen residents, #91, #94, #101, #103, #105, #107, #108, #110, #112, #114, #115, #123, #124, were all seated in wheelchairs lined up in a row in front of the nursing station. Interview with CNA #4 at that time revealed the residents were placed there so the dining room floor could be mopped after breakfast. Observation also revealed several residents still had food from breakfast on their faces, hands, or clothing.	F 241		

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F 241	Continued From page 12 13. Observation on 5/19/10 from 3:35 PM until 3:49 PM showed resident #119 and non-sample resident #128 were seated at a table in front of the television. Resident #119 was observed to try to take the other resident's cookie. Resident #128 said, "No you can't take my cookie," and raised his/her hand slightly to push resident #119's hand away. At 3:40 PM resident #119 again tried to take the cookie from resident #128 and resident #128 raised his/her hand higher in an attempt to slap the hand of resident #119. Finally, at 3:45 PM resident #119 tried a third time to take the cookie from resident #128. Resident #128 raised his/her hand again and started to come down on the hand of resident #119. At 3:48 PM a corporate staff member intervened and separated the residents. During the entire observation from 3:35 PM until 3:49 PM staff were present in the vicinity but did not intervene to stop the altercation between the two residents until it had escalated to the point of potential physical harm. 14. Observation on 5/19/10 at 3:10 PM showed three residents sitting at a table in the main activity/dining area on the third floor. At that time activity aide #1 asked these residents if they were interested in watching a movie. One resident (non-sample resident #117) expressed interest. The activity aide positioned the residents in view of the television and put a movie into the player. The introduction started and the selection menu of the movie was on the screen; however, the activity aide left the area without initiating the "play" option. The residents sat watching the menu screen for ten minutes before a surveyor intervened.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

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F 248	Continued From page 13 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure assessments were performed and individualized care plans were developed that included meaningful activities for 12 of 19 sample residents (#14, #91, #107, #111, #112, #113, #114, #116, #119, #120, #123, #124) and 1 non-sample resident (#117). This total absence of a system to address the activity needs for residents resulted in a lack of meaningful and purposeful activities for 12 of 19 sample residents on the third floor, excluding the Reflections Unit. The findings were: Interview with the corporate activities professional and the facility's activity director on 5/20/10 at 2:05 PM revealed they were aware the activities program was not individualized for many residents. According to the activity director they were working on updating the activity assessments, individualizing activity goals, and developing resident care plans to better meet the needs of residents. 1. The following concerns were identified with the lack of meaningful activities: a. Observation on 5/17/10 revealed the activity that took place for the residents on the third floor, excluding the Reflections Unit, were	F 248	**F-248- Activities** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #14 no longer resides at the facility. A new activities assessment was completed for identified residents #91, #107, #111, #112, #113, #114, #116, #119, #120, #123, #124, and #117. A new care plan was created, as needed, focusing on the resident's interests, needs, and strengths that were identified during the assessment process. The CD player was replaced and the unit was provided with supplies, books, etc. to use in the living area on 3rd floor. Activity Aide #1 will be educated on how to follow the plan of care for the individual residents and how to conduct an appropriate activity group that engages participants. Education will be provided to activity staff to enable them to complete accurate assessments, care plans, and conduct appropriate activities that engage residents and address the individual interests of the residents.	

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F 248	Continued From page 14 not carried out in a way to engage residents effectively. The activity aide #1 directed an exercise group activity at 9 AM with eighteen residents. The activity consisted of residents gathered into a large circle seated in the dining room in their wheelchairs. The residents that were awake during the activity were encouraged to kick or pass a ball as it was tossed to them. After the ball was passed around, the residents that were not restrained and were ambulatory were encouraged to get up and dance. The remainder of the residents listened to the music, and if the activity aide was able to make it around the circle to them, and they were awake, she would take their hands and do "the spider dance" holding their hands and swaying them back and forth. After the activity ended at 11 AM the residents were seated at tables for the midday meal, which was scheduled for 12 noon. b. On each day of the survey while an activity called for music, a CD player was used that periodically skipped. Each time the music would begin to skip, the activity aide would have to stop and fix the CD player. On 5/17/10 at 10:05 AM activity aide #1 stopped to fix the CD player and stated it was only a month old and didn't work well. Over the course of the survey, the CD player skipped multiple times each day interrupting the activity taking place. c. Observation on 5/19/10 at 3:10 PM showed three residents sitting at a table in the main activity/dining area on the third floor. At that time activity aide #1 asked these residents if they were interested in watching a movie. One resident (non-sample resident #117) showed particular interest. The activity aide positioned the residents in view of the television and she put a movie into the player. The introduction started and the selection menu of the movie was on the screen;	F 248	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the Activities Director/designee to confirm that the Activities Assessments are current and that the care plan is individualized. Corrective action will be taken as needed. Equipment and supplies on other units will be evaluated and provided as necessary. Observations of activities will be completed by the Activities Director to confirm that residents are engaged in meaningful activities.	

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F 248	Continued From page 15 however, the activity aide left the area without selecting "play." The residents sat in front of the menu screen for ten minutes before a surveyor intervened. d. Observation revealed there was a lack of supplies, books, magazines, etc., available for residents use in the living areas of the third floor. 2. Observation on 5/19/10 at 9:00 AM showed resident #120 was sitting at the breakfast table dozing while staff removed his/her partially eaten breakfast foods. At 9:20 AM, staff directed the resident with his/her walker to a chair within the circled group of residents who were positioned to participate in the morning activity. Resident #120 dozed during the activity, awakened to drink a small glass of juice, dozed and awakened to shake a hand held musical instrument that had been placed in his/her hand. After three minutes the resident laid it on the adjacent table, closed his/her eyes and bowed his/her head. At 11:25 AM, a CNA woke the resident and directed him/her to the dining room table in preparation for lunch. At 12:05 PM, lunch foods were placed in front of the resident and remained untouched until thirty minutes later when a CNA began to help the resident eat. Interview 5/19/10 at 8:36 PM with a family member revealed the resident had some cognitive and physical decline that made it difficult for the resident to participate in some of the same activities that s/he had enjoyed the previous year. Medical record review showed this change was not noted in the most current quality of life assessments for the resident: one activity assessment completed in 2005, two pleasant and meaningful activities forms completed in 2007 and an abilities-focused activities assessment completed in 2007. Review of the care plan for the resident revealed interventions updated on	F 248	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Activities staff will meet with residents upon admission and complete the "Pleasant and Meaningful Activities" and the "Abilities Focused Activity Assessment". An Activities admission note will be written. The Activities staff will complete a progress note (MARBLES) quarterly to reassess their interests and participation level. This addresses the following: **M**ental Status, **A**ny changes, **R**ecent events, **B**ehaviors, **L**evel of participation, **E**valuation of current plan, and **S**uggested changes. This note serves as their quarterly reassessment and addresses updates. Care plans will be created or adjusted to meet the current needs of the resident. Participation by the residents will be monitored through the Participation Records. Observations of activities will be done by the Activities Director to confirm that residents are engaged in meaningful activities per their care plans and that there are sufficient supplies to meet their needs.	

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F 248	Continued From page 16 4/17/10 included the same activity needs, interests, and approaches on 2/10/09. 3. Review of the 4/2/10 activities care plan for resident #116 showed the goal was for the resident to play bingo one to three times per week. Review of the 10/5/07 "Pleasant and Meaningful Activities" form showed the resident also enjoyed listening to music, massage, and reminiscing. The following concerns were identified: a. Review of the 1/4/10 quarterly Minimum Data Set (MDS) assessment showed the resident had decreased social interaction. Review of the 4/2/10 quarterly MDS assessment showed the resident had a sad, pained, and worried expression which was new since the 1/4/10 quarterly MDS assessment. However, review of the medical record showed no evidence the resident was re-assessed for meaningful activities and interests since the original assessment was done on 10/5/07. Interview with the activity director and the corporate activity director on 5/20/10 at 2:06 PM confirmed this resident was not re-assessed, nor had the care plan been revised to meet the current needs of the resident. b. Review of the May 2010 activity participation calendar for this resident showed s/he had not actively participated in any activity from 5/6/10 through 5/18/10 and had been present for only three activities during the twelve day period. Periodic observations from 5/17/10 through 5/20/10 revealed the resident did not participate in or attend any activity, but remained in his/her room in bed. Review of the 3/5/09 lifestyle history showed staff knew when the resident was unhappy because s/he would self-isolate in his/her room.	F 248	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Health Information Manager (HIM)/ Designee will audit records per the MDS schedule to confirm that assessments have been completed and care plans are in place. Activities Director/designee will observe activities five (5) times per week for appropriateness, and monitor equipment for adequate functioning. The Activities Director will review findings with the NHA weekly to review and identify trends and determine necessary action. Findings by the HIM and Activities Director will be reported to the Performance Improvement Committee monthly times 3 months or as directed by the committee. Date of compliance is July 5, 2010.	

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F 248	Continued From page 17 4. Review of the 11/9/09 "Pleasant and Meaningful Activities" assessment for resident #112 showed s/he enjoyed listening to music and watching television. Review of the 5/5/10 significant change MDS assessment revealed the resident also enjoyed the following activities: cards and games, exercise, spiritual or religious activities, talking, and helping others. Review of the May activity calendar for this resident showed s/he only participated or attended activities on one day during the week of 5/9 through 5/15/10. Review of the medical record showed no evidence the resident was encouraged or asked to participate in activities on any other days of that week. Interview with the resident on 5/20/10 at 3:20 PM revealed s/he liked to attend activities but often fell asleep during them. Observation on 5/19/10 at 9:58 AM showed the resident left the group activity and went to his/her room. At 12 noon the resident was brought out of the room for lunch. During the two hour and two minute observation, no staff member attempted to re-engage the resident back into the group activity, nor did anyone acknowledge that s/he had left the activity. No staff interacted with the resident during the entire observation. 5. Review of the medical record for resident #123 showed no evidence an activities assessment was performed, and, therefore, no care plan was developed. Review of the May 2010 activity calendar in the activity book showed the resident actively listened to music twice during the week of 5/2 through 5/8/10. Otherwise the resident slept through or wandered in and out of the activity. Review of the calendar showed the resident did not attend or participate in any activities during the week of 5/9 through 5/15/10. Periodic observations from 5/17 through 5/20/10 showed	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 18 the resident did not actively participate in any activity. Interview with the activity director on 5/20/10 at 2:05 PM confirmed there was no activity assessment or individualized activity care plan for this resident. 6. Review of the 11/4/09 "Pleasant and Meaningful Activities" assessment for resident #113 showed s/he enjoyed the following activities: arts and crafts, decorating, exercising, fishing, household chores, listening to music, movies, parties, bible study, church services, watching television, reading, drawing, pets, and reminiscing. Interview with the resident on 5/17/10 at 1:45 PM revealed the resident missed his/her cat. The resident had a framed picture of the cat and said the cat's name was "Buffy." Review of activity records showed no evidence a care plan was developed and individualized to incorporate the preferences or address the meaningful things in this resident's life. Review of the May 2010 activity calendar showed the resident actively participated in three music activities from 5/1 to 5/19/10. Observations from 5/17 through 5/19/10 showed the resident did not actively participate in any activity. During interviews with the resident on 5/17/10 at 9:15 AM and 1:45 PM, the resident stated s/he enjoyed the surveyor's visits and liked to talk with people. However, there was no evidence one-to-one visits had been considered for this resident. Review of the one to one activity schedule showed the resident was not included. 7. Review of the 3/13/09 initial MDS assessment for resident #114 showed s/he enjoyed the following activities: cards/other games, crafts/arts, exercise/sports, music, reading/writing, watching television, and talking. Review of the 3/12/10	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 19 significant change MDS assessment showed the resident no longer enjoyed cards/games and crafts/arts, but continued with his/her other interests. The following concerns were identified: a. Observation on 5/17/10 at 9:40 AM revealed the resident attended an activity which was kickball. However, observation from 9:40 Am to 11:10 AM showed no evidence the resident participated or was engaged in the activity. The resident sat in the wheelchair with no observable facial expression or body language to indicate s/he was aware of what was happening. b. Observation on 5/19/10 at 10:55 AM showed the resident remained seated in his/her wheelchair next to a table after an activity ended. Observation showed the resident picked up a few papers from the table and seemed interested in straightening them and keeping them in order. However, within three seconds, activity aide #1 took the papers from the resident. When the staff member noticed the surveyor was observing the interaction, she returned one page to the resident. Review of the medical record showed the resident was a former teacher. c. Review of the medical record and the activity records showed this resident's care plan was not meaningful or individualized to meet his/her needs, nor was there a modification to the care plan regarding activities despite a 3/12/10 change in the resident's condition. 8. Review of the activity assessment for resident #107 revealed it was done on 7/27/07 (three years ago). The assessment showed that at that time the resident enjoyed eating out, exercising, listening to music, movies, parties, bible study, church services, watching television, massage, being alone, visiting with pets, and reminiscing. The following concerns were identified:	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 20 a. Review of the 1/26/10 quarterly MDS assessment showed the resident did not exhibit any behavioral symptoms. However, review of the 4/22/10 annual MDS assessment showed the resident had behavioral symptoms identified as socially inappropriate behaviors. Review of the entire medical record showed no evidence a more current assessment had been done to address the resident's changing needs over the past three years. Review of the 4/22/10 activity care plan showed the goals identified for the resident included attending one to three socials per week and self-propelling around the third floor in a wheelchair daily. b. Observation on 6/19/10 at 9:58 AM revealed the resident self-propelled him/herself out of the group activity taking place and sat by the nursing station. Observation from 9:58 AM until 12 noon (two hours two minutes), showed none of the staff members interacted with the resident or tried to re-engage the resident in the activity. 9. Review of the most current activity assessment for resident #111, which was done two years ago on 5/1/08, showed s/he enjoyed cards, arts and crafts, dancing, eating out, listening to music, movies, parties, watching television, painting/drawing, singing, visiting with pets, and reminiscing. Review of the 3/17/10 activity care plan showed the goal was for the resident to participate in 1:1 visits two to three times per week. Review of the one-to-one list of residents provided by activity staff showed the resident was not listed, and there was no evidence to indicate the resident had ever received one to one visits. Review of the activity calendar of participation showed the resident actively participated in only six activities of seventy-eight opportunities from	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	05/21/2010

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F 248	Continued From page 21 5/1/10 through 5/17/10 (17 days). 10. Review of the section of the care plan, updated 4/3/10, that addressed individualized activities for resident #124 showed staff identified the following as a problem: "likes attention and enjoys hugs and kisses." Further review of the care plan showed the approaches to the problem included encourage to participate in activity of choice, sit next to leader of activity to assist, one-to-one visits as needed and encourage to hold stuffed animal/doll if needed. Medical record review showed a pleasant and meaningful activities assessment was completed on 7/21/09 for the resident. However, observation on 5/19/10 from 9 AM to 12:15 PM and 2 PM to 5 PM showed staff did not engage this resident in the activities that were assessed as pleasant and meaningful for the him/her; it was also noted staff did not position the resident next to the activity leader during the activity or provide a stuffed animal/doll for him/her. Observation on 5/19/10 from 9 AM to 11:56 AM showed resident #124 sat at the breakfast table at 9 AM with his/her head resting on the table with partially dissolved pills settled at the bottle of a glass of water positioned in front of him/her. At 9:20 AM the admissions coordinator discarded the glass with the partially dissolved pills and CNA #2 directed the resident to a chair within the group circle. The resident did not participate in the activity, but was more attentive to the residents positioned beside him/her. At 9:31 AM, LPN #6 said she did not realize the resident had spit the pills into the water instead of swallowing the eight o'clock morning pills. At 9:45 AM, the resident was directed to his/her room for phlebotomist to draw blood. After the phlebotomists departed the resident remained in	F 248		

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F 248	Continued From page 22 the room and slept in a chair until 11:56 AM when the resident ambulated to the dining room for lunch. At 12:15 the resident ate lunch. From 2 PM to 5 PM, the resident sat at the table with other residents during and after the afternoon activity. However, s/he gazed out the windows and intermittently rested his/her head on the table instead of participating in the activity. 11. According to the 4/28/10 care plan for resident #14, staff were to engage the resident in one-to-one activities. Review of the resident's individual activity calendar and independent activity documentation revealed the resident was involved in activities on 5/6/10, but at no time thereafter. Interview on 5/19/10 at 4 PM with the activity director revealed the resident was transferred from the secure unit on 5/6/10 to another nursing unit, and staff had forgotten to continue the service after the transfer. Perfodic observations on 5/19 through 5/20/10 showed the resident sat in the wheelchair or rested in bed without any participation or involvement in activities. 12. Interview with activity aide #1 on 5/21/10 at 11:08 AM revealed she usually had a group of about 16 residents she tried to get involved in group activities. She stated more support and staff help would improve the quality of activities she could provide for the residents. 13. Observation on 5/17/10 at 9 AM of resident #119 showed s/he had partial paralysis on the right side and was unable to communicate very effectively through speech. The resident seemed to understand what was said to him/her. Review of the annual MDS assessment dated 4/6/10, showed the resident was able to understand	F 248		

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F 248	Continued From page 23 others and usually could make self understood by means of speech, signs, gestures and sounds. Review of the medical record showed the resident had a diagnosis of depression and received an anti-depressant medication. According to the 4/6/10 quarterly care plan note, the resident had family that did not visit much, and the resident liked to spend time on the first floor. During the days of survey, the resident was not isolated to his/her room, however, the facility was not allowing resident's to move from floor to floor due to a gastro intestinal outbreak. Observation on 5/19/10 from 9:10 AM to 12:10 PM revealed the resident repeatedly self-propelled to and from the activity area and his/her room. During that time staff did not attempt to engage the resident in meaningful conversation or activities. From 9:10 AM to 9:35 AM, the resident sat in the wheelchair in the dining/activity area. At 9:35 AM the resident self- propelled to his/her room and moved about in the room until 9:50 AM. At 9:50 AM, staff wheeled the resident from the hallway toward the activity group where the resident remained until 10 AM. At that time the resident self-propelled to his/her room where s/he moved back and forth between the television and bed. The resident returned to the activity area at 10:20 AM and sang for five minutes with the other residents. At 10:25 AM, the resident again went to his/her room, then returned to the activity area at 10:40 AM. At 10:50 AM, the resident's departure was halted when his/her wheelchair interlocked with another resident's wheelchair. The resident struggled to free him/herself until staff provided the assistance that was needed. At 10:55 AM the resident went to his/her room, then returned to the activity area at 11:05 AM. From 11:05 AM until 11:20 AM the resident self-propelled near the nurses' desk area and hallway. At 11:20 AM the	F 248		

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F 248	Continued From page 24 CNA wheeled the resident to the bathroom, provided incontinence care and assisted with toileting. At 11:30 AM, the CNA positioned the resident at the dining room table and departed. From 11:30 AM until 12:10 AM the resident sat at the dining room table periodically resting his/her head on the table. 14. Observation on the morning of 5/19/10 at 9:35 AM showed resident #91 was brought into the activity circle, thirty minutes after the activity was started. The resident had been sitting in the area, but not engaged until that time.	F 248	**F-250- Provision of Medically Related Social Services**	
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and family interview, and medical record review, the facility failed to ensure the psychosocial needs were met for 7 of 32 sample residents (#15, #70, #91, #111, #113, #119, #144). The lack of these services resulted in an avoidable decline in social interactions for residents #111 and #113. The findings were: 1. Review of the diagnosis history for resident #113 showed s/he was admitted with diagnoses including depressive disorder, anxiety disorder, malaise, and failure to thrive. Review of the 11/16/09 physician progress notes showed s/he	F 250	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Residents #15 and #144 no longer reside at this facility. Psychosocial needs have been assessed for residents #70, #91, #111, #113, and #119 using the Lifestyle History, Abilities Focused Psychosocial Summary, SLUMS, and Cornell Depression Scale assessments. Changes will be made to residents' care plans as appropriate and services will be adjusted to meet the identified psychosocial needs. Social Services staff will be re-educated on how to accurately assess the needs of the resident, create a comprehensive plan of care, and provide necessary	

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OMB NO. 0938-0391

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

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F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and family interview, and medical record review, the facility failed to ensure the psychosocial needs were met for 7 of 32 sample residents (#15, #70, #91, #111, #113, #119, #144). The lack of these services resulted in an avoidable decline in social interactions for residents #111 and #113. The findings were: 1. Review of the diagnosis history for resident #113 showed s/he was admitted with diagnoses including depressive disorder, anxiety disorder, malaise, and failure to thrive. Review of the 11/16/09 physician progress notes showed s/he	F 250	services to meet the resident's psychosocial needs.	

PAGE: 25A

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F 250	Continued From page 25 admitted to feeling depressed at times because s/he "really misses [his/her spouse] who died after 59 years of marriage." Review of the 11/9/09 initial and the 2/1/10 quarterly MDS assessments showed the resident exhibited a sad, apathetic and anxious appearance. The following concerns were identified: a. Review of the social services notes written on 1/13/10 (the resident was admitted on 10/27/09, 3 months earlier) revealed she identified the resident had a history of depression and that the goal for social services was to be available for the residents needs. Review of the care plan included the approach of allowing the resident time to verbalize his/her feelings. However, there was no evidence the resident was considered for counseling or one-to-one visits to address his/her depression and sadness, particularly in relation to the loss of his/her spouse. During interviews with the resident on 5/17/10 at 9:15 AM and 1:45 PM, the resident stated s/he enjoyed the surveyor's visits and liked to talk with people. b. Review of the 2/22/10 social service notes showed the resident exhibited a sad facial expression on occasion. However, there was no evidence the resident's depressive disorder and sadness was addressed other than with an antidepressant medication. There was no evidence the resident was encouraged to verbalize his/her feelings regarding his/her loss. c. Review of the 3/9/10 social services notes revealed the social worker spoke with the resident's daughter regarding his/her dental needs. Again, there was no evidence the resident's depression and sadness was addressed. d. Review of the 3/12/10 social services notes revealed the social worker had discussed comfort	F 250	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** Facility records will be audited by the Social Services Director/designee for accuracy of social service assessments and the provision of social services. Records containing inaccuracies or requiring updating will be completed. Changes will be made to their care plans as appropriate and services adjusted to meet the identified psychosocial needs.	

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F 250	Continued From page 26 care and possibly hospice with the resident's daughter. However, there was no evidence the social worker discussed comfort care or hospice with the resident who was still able to verbalize his/her needs and desires according to nursing notes dated as recent as 5/7/10. Review of the physician orders written on 4/2/10 revealed an order for comfort care only. Review of the 4/13/10 physician's progress notes showed the resident "states [s/he] wants to live." e. Review of the 3/31/10 significant change MDS assessment showed the resident had experienced new psychosocial and emotional behaviors including repetitive verbalizations, repetitive health complaints, and had declined in social interactions in addition to exhibiting sad and apathetic behaviors. Periodic observations on 5/17/10 through 5/20/10 showed the resident had a sad look on his/her face. Interview with LPN #6 on 5/20/10 at 10:30 AM revealed the resident appeared sad. 2. Review of the diagnosis history for resident #111 showed s/he had diagnoses including depressive disorder and anxiety. The following concerns were identified: a. Review of the 7/6/09 quarterly MDS assessment showed the resident exhibited mood and behavior patterns that included repetitive questions such as "Where do I go? and What do I do?," repetitive verbalizations (calling out for help) and repetitive anxious complaints (non-health related). Review of the 12/21/09 quarterly MDS assessment, 3 months later, showed the resident exhibited the same symptoms and also exhibited persistent anger with him/herself and others, had repetitive health complaints, and exhibited repetitive physical movements including hand wringing, restlessness, fidgeting, and picking.	F 250	**Measures Put Into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Residents will be evaluated upon admission with the required social services assessments to include depression scales, mental status evaluations (SLUMS), social history and abilities-focused summary. Based on the assessments an individualized care plan will be created to meet their personal needs. Quarterly notes will be written to address the status and/or changes for each resident. Care plans will reflect the resident status. Social services will provide care per the person centered care plans.	

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F 250	Continued From page 27 Review of the 3/17/10 annual MDS assessment showed the resident exhibited all the same behaviors, and, in addition, the the resident exhibited reduced social interactions. b. Review of the 6/25/07 lifestyle history and the undated initial social service history showed the resident found happiness in his/her family and enjoyed having family present. Interview with a family member on 5/19/10 at 11:40 AM revealed s/he did not visit as often as s/he used to because coming to the facility was so depressing for him/her. As noted above, review of the 3/17/10 annual MDS assessment showed the resident had a reduction in social interactions. Observation on 5/17/10 through 5/20/10 showed the resident remained in bed except to get up for meals. c. Review of the medical record showed the social worker wrote a note on 5/6/10 which indicated the resident exhibited signs and symptoms of depression "i.e., repetitiveness with reduced social interaction." However, the care plan was not modified or individualized to meet the resident's specific needs. Review of a psychological evaluation report included in the medical record and written on 8/8/09 showed recommendations for individualized therapeutic interventions to address the resident's depression; however, these recommended interventions were not integrated into the resident's care plan. Interview with RN #2 on 5/20/10 at 10:45 AM revealed she was unaware of the 8/8/09 psychological evaluation in the record. RN #2 also said the recommendation from the evaluation should have been incorporated into the care plan. 3. Review of the 3/16/10 quarterly MDS assessment for resident #91 showed s/he was able to make his/herself understood, and was	F 250	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** Audits will be conducted by the Social Services Director/designee to validate that assessments have been completed, with care plan updates as needed, and that services are implemented according to the care plan. The Social Services Director/designee will present results of the completed audits to the Performance Improvement Committee for recommendations and review monthly times 3 months. Date of compliance is July 5, 2010.	

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F 250	Continued From page 28 able to understand others. In addition, the MDS assessment showed the resident exhibited crying and tearfulness, repetitive questions and health complaints, and persistent anger with self or others up to five days a week. Observation on 5/17/10 at 8:50 AM showed the resident was seated in a wheelchair next to the nurses station. Interview with the resident at that time revealed s/he didn't want to be there. The resident began to cry and further stated, "I don't know how to get out of here." Observation on 5/18, 5/19, and 5/20/10 showed the resident crying and grabbing the arms of his/her wheelchair in a frustrated manner. The following concerns were identified: a. Although review of the May 2010 behavior sheet showed the resident had only one day when crying was noted (5/2/10), CNA #3 stated in an interview on 5/20/10 at 11:55 AM the resident "cries all the time." She also stated the resident was unhappy about moving to the third floor. b. Review of the 9/29/09 care plan related to behavior in mood showed the resident was to be given reassurance as needed, be redirected as needed, and referred to social services as needed. In addition, there was an added note on 4/30/10 that showed the resident was having difficulties adjusting to a roommate. The approaches documented were for social services to monitor and help the resident adjust. c. Review of the record showed no evaluation of the resident's depression or tearfulness. Furthermore, there was not evidence the resident was being monitored by social services related to the room change. The record showed a room change notification where the resident was moved from the 1st floor to the 3rd floor on 5/5/10. The reason listed for the change was "LTC [long term care] room available." In addition, the record showed a depression scale	F 250		

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F 250	Continued From page 29 that was completed on 5/20/10 showing the resident had no signs or symptoms of depression. d. Interview on 5/20/10 at 10:35 AM with the social service assistant (SSA) who completed this assessment revealed she had been instructed that morning to complete this type of assessment on each resident on the third floor. She then stated the information on this resident may not be accurate as she could not recall who was interviewed, or what records were reviewed, and she made only a ten minute observation of the resident. 4. Review of the 5/7/10 significant change MDS assessment for resident #70 showed s/he had become resistant to care, which was a change from the 2/9/10 quarterly and 8/22/09 annual MDS assessment. Review of the April and May 2010 individualized activity calendars showed the resident was non-participatory in activities or refused activities for those months, which was also a change from the March 2010 individualized activity calendar. Review of the medical record showed the facility failed to address the resident's resistance to care and change in resident participation in activities, and failed to address any potential psychosocial needs related to the resident's behavior changes. During interviews on 5/17/10 at 8:40 AM and 5/18/10 at 11:40 AM, the resident stated that s/he was too tired to participate in activities or allow staff to assist with care most of the time. During an interview with a social worker consultant and a corporate activity specialist on 5/18/10 at 3:35 PM, they stated the resident should have been assessed for psychosocial needs after the resistance to care and decreased involvement in activities were identified on the MDS assessment. During an interview with CNA #6 on 5/20/10 at 9:30 AM, she	F 250		

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F 250	Continued From page 30 stated the resident became more resistant to care and less involved in activities when no longer being given care by LPN #5 after the resident was moved to a different room on 4/6/10. 5: Review of the medical record for resident #144 revealed s/he was admitted on 2/25/10 with diagnoses which included cancer of the breast with metastasis to the bone. Review of the 3/8/10 admission MDS assessment showed the resident desired to return home, but had experienced an increase in overall care needs since admission. Review of the entire medical record showed the facility failed to assess the resident for potential psychosocial issues, which included end of life issues, increased dependence for care, and potential hospice care needs. Further record review showed the resident was sent to an emergency room on 4/17/10, and the hospital transferred the resident to a hospice. During an interview on 5/20/10 the DON stated she could find no other documentation to show there had been an assessment of psychosocial needs for this resident. 6. Observation on 5/17/10 at 9 AM of resident #119 showed s/he had partial paralysis on the right side and was unable to communicate very effectively through speech. The resident did, however, seem to understand what was said to him/her. Review of the annual MDS assessment dated 4/6/10, showed the resident was able to understand others and usually could make him/herself understood by means of speech, signs, gestures and sounds. Review of the medical record showed the resident had a diagnosis of depression and received an anti-depressant medication. According to the 4/6/10 quarterly care plan note, the resident had	F 250		

20

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE & REHABILITATION CENTER	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 250	Continued From page 31	F 250		

family that didn't visit much, and the resident liked to spend time on the first floor. During the days of survey, the resident was not isolated to his/her room, however, due to a GI outbreak the facility was not allowing resident's to move from floor to floor. The following concerns were identified related to the resident's psychosocial needs not being met:

a. Review of nursing notes dated 4/19/10, at 7 PM, 4/21/10, 2-10 shift, and 5/15/10, 6-2 shift revealed the resident was upset and crying because s/he was unable to use the elevator and was isolated to his/her room due to an illness outbreak. The 4/19/10 note showed the resident had to be escorted back to his/her room seven times, and each time the resident cried. The 4/21/10 note showed the resident cried and was asking "Why?" The note failed to show how the resident's question was answered or how his/her psychosocial needs were addressed related to the isolation.

b. During the survey, observation showed the resident had exhibited episodes of crying on 5/18/10 and 5/20/10.

c. Interview with the DON on 5/20/10 at 4:50 PM revealed the resident had not been recently evaluated related to psychosocial needs demonstrated by crying episodes and communication limitations. The DON stated the last time the resident was assessed related to communication had been in 2008.

7. Review of the medical record for resident #15 showed a 4/27/10 psychologist's assessment included "depression" as one of the resident's conditions. During an interview on 5/17/10 at 3:45 AM, the resident stated the facility had not addressed his/her concerns about an impending discharge. The resident further stated s/he was

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F 250	Continued From page 32 upset when staff instructed him/her to move to another room with no prior discussion. Review of the medical record showed no evidence of a psychosocial or social services assessment. Interview with the SSA on 5/18/10 at 9:45 AM revealed a social services assessment conducted within seven days of admission (per facility policy) had not been done for this resident. The SSA further stated she talked with the resident at various times, but was unsure whether the resident's psychosocial needs had been identified or addressed.	F 250		
F 251 SS=E	483.15(g)(2)&(3) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS A facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is an individual with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility provided social services documentation, and staff interview, the facility failed to employ a qualified social worker. The findings were: Review of a social services schedule showed the facility was without a qualified social worker on the following dates: 6/12/09 through 6/25/09, 4/24/10 through 5/4/10, 5/7/10 through 5/9/10,	F 251	**F-251-Qualification of Social Worker>120 beds** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** A qualified Social Services Director was hired on 05/25/10 and she has a BSW **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Social Services Director will meet the mandatory requirements as per regulation.	

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F 250	Continued From page 32 upset when staff instructed him/her to move to another room with no prior discussion. Review of the medical record showed no evidence of a psychosocial or social services assessment. Interview with the SSA on 5/19/10 at 9:45 AM revealed a social services assessment conducted within seven days of admission (per facility policy) had not been done for this resident. The SSA further stated she talked with the resident at various times, but was unsure whether the resident's psychosocial needs had been identified or addressed.	F 250		
F 251 SS=E	483.15(g)(2)&(3) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS A facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is an individual with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility provided social services documentation, and staff interview, the facility failed to employ a qualified social worker. The findings were: Review of a social services schedule showed the facility was without a qualified social worker on the following dates: 6/12/09 through 6/25/09, 4/24/10 through 5/4/10, 5/7/10 through 5/9/10,	F 251	**Measures Put Into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Future Social Services Directors will be required to meet the regulatory requirements. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** NHA/designee will bring identified concerns to the monthly QA to the Performance Improvement Committee for review and recommendations. LB Date of compliance is July 5, 2010.	

Changes made 7/1/10 after telephone discussion w/ Ruth A re this submission

LB

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F 251	Continued From page 33 5/12/10, and 5/14/10 through 5/16/10. Further review of social services' documentation revealed the following: "Mountain Towers is currently without a Director of Social Services. There are multiple resident charts missing the required Social Services Documentation. This includes; Lifestyle History Forms, Abilities Focused Psychosocial Summaries, SLUMS exams, Mood Scales, Admit notes, and Assessment notes." Interview with the administrator on 5/21/10 at 11 AM confirmed the aforementioned information was accurate. Refer to F250 for details related to facility failure to provide needed social services for 14 sample residents.	F 251		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide maintenance and housekeeping to ensure 3 of 3 floors, were comfortable, clean and in good repair. The findings were: Observation of the third floor, excluding the Reflections Unit, during tours on 5/20/10 and 5/21/10 showed the following issues related to the upkeep of building maintenance and cleanliness. 1. Third floor: a. The main dining room/day room area had	F 253	**F-253-Housekeeping and Maintenance Services** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #110 had the torn area on the Broda chair repaired. Resident #111 has a new lap buddy. Maintenance items cited will be either repaired or replaced. The housekeeping department cleaned the cited areas.	

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F 253	Continued From page 34 the following maintenance issues: Below the windows the bottom molding between the floor and wall panels was loose. There were also two areas of the molding, measuring 47 inches each, that were missing. The vertical blinds had missing individual blinds at random places throughout. At the fireplace on the side nearest to the windows, an area was damaged approximately two feet wide, several inches from the floor. b. The following third floor resident bathroom doors were discolored on the outside anywhere from 4 inches to 3 and 1/2 feet around the doorknob: 302, 305, 305, 306, 308, 310, 312, 315, 316. In addition, the third floor dirty utility closet door was discolored from the floor to 4 feet up. c. The following doors on third floor had additional damage: i. In room 328 the front door on the inner side had 2 holes that measured 2 and 1/2 inches around and located three feet above the floor around the middle of the door. ii. In room 330 the bathroom door had a 2 and 1/2 inch hole located 4 feet high in the middle of the outer surface. iii. In room 306 the front door was roughly chipped in the inner area from the floor to 3 feet high. iv. In room 304 the front door kick plate had a 6 inch triangular area cut off on the upper inner area. v. In room 321 the front door inner area had a 4 inch chipped out area on the kick plate. vi. In room 320 the bathroom door had numerous indentations from the bottom to 2 feet high and all across on the outside. vii. In room 319 the front door had scraped off paint and scratches from the floor to 3 feet high and all across on the outside.	F 253	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The Restorative Nurse/Designee will conduct an audit for residents using lap buddies and positioning devices to ensure that they are free of rips and tears. The Maintenance Director/designee will audit each unit of the facility to identify broken items or items in need of repair. He will meet with the NHA to identify a plan to correct findings. The Housekeeping Supervisor will make facility rounds to identify areas in need of cleaning and a thorough cleaning will occur.	

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F 253	Continued From page 35 vii. In room 319 the bathroom door on the inner side near the doorknob had a 4 inch round hole and a chipped area. ix. In room 314 the bathroom door had 2 holes on the outer side measuring 1 and 1/2 inches around, and 4 inches by 2 and 1/2 inches. e. The following cleanliness issues were noted: The fan in front of the third floor nurses station (above the common walkway area) was dirty, with a coating of dust visible on each of the fan blades. In addition, the ceiling above the fan was dirty to several inches past the fan in a circular pattern. The third floor main dining/dayroom area had eleven windows, which were all dirty with various smudges. The third floor main dining/day room area had a collection of dirt and dust along the floor where the broken molding was below the windows. f. Observation of the Broda chair for resident #110 on 5/17/10 at 9:31 AM showed there was a torn area on the right side of the Broda chair. g. Observation of the lap buddy for resident #111 on 5/17/10 at 11:30 AM showed it was torn. 2. Second Floor: a. Room 201 had the heat radiator cover missing, approximately 6 feet across. b. Room 229 bathroom had a toilet seat with chipped paint over the entire seat. c. The entrance to the C Hall on the second floor had chipped paint on each side from the floor to 3 feet high. d. The main dining area on the first floor had a 3 inch circular hole in the wall on the wall to the left of the entrance, at 3 feet from the floor and at the middle of the wall. e. The following resident bathroom doors were discolored on the outside anywhere from 4 inches to 3 and 1/2 feet around the doorknob:	F 253	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Restorative Nurse/Designee will conduct routine audits to confirm that Broda chairs, lap buddies, and positioning devices are in proper condition. Corrective action will take place as needed. The Maintenance Director/designee will conduct preventative maintenance rounds to evaluate the condition of doors, walls, and paint to determine any additional and ongoing needs. He will meet with the NHA to establish a plan to correct. The Housekeeping Supervisor will make routine rounds to maintain a clean facility environment.	

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F 253	Continued From page 36 202, 203, 204, 205, 206, 207, 208, 210, 212, 213, 219, 220, 228, 229, and 231. f. The closet door was discolored in room 220 from 6 inches high to 18 inches across. g. In room 207 the inner bathroom door had a 3 inch round hole. h. In room 203 the outside bathroom door had a 3 inch hole at 2 and 1/2 feet up from the floor. i. In room 221 the front door had a 7 inch triangular tear at the top inner area of the kickplate, and 3 inch by 6 inch area gash on the inner door area from the floor up. j. In room 219 the outer front door had a 3 and 1/2 long by 7 inch gash across at about 2 feet from the floor. k. In room 212 the closet doors had wood support around the doors unpainted with slight gaps completely around the outside of the doors. 3. First Floor: a. In room 102 the front door on the outside had multiple scuffs from the floor to 3 feet up and entirely across. b. In room 104 the front door on the outside had multiple scuffs from the floor to 2 feet up and entirely across. c. The inner bathroom door in room 106 had 2 gashes that measured 32 inches across each, starting at 2 feet from the ground. d. In room 103 the inner bathroom door had a gash that measured 32 inches across, at 1 foot from the floor. e. In room 109 the outer front door had multiple scuffs entirely across at 2 feet from the floor. f. In room 113 the outer front door had multiple scuffs entirely across at 3 feet from the floor.	F 253	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Maintenance Director/Restorative Nurse/Housekeeping Supervisor/designee will report outcomes of audits to the Performance Improvement Committee monthly x3 months. The Performance Improvement Committee will review and provide recommendations and direction based on the outcome of the audits and ongoing sustained compliance. Date of compliance is July 5, 2010.	

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F 253	Continued From page 37 g. The outer front door of room 114 had multiple scuffs entirely across at 3 feet from the floor. h. In room 117 the outer front door had multiple scuffs entirely across at 2 feet from the floor. I. In room 115 the outer bathroom door had 3 feet long and 6 inch wide gash across. j. In room 116 the inner bathroom door had an 18 inch gash across. k. The following resident bathrooms had missing paint from 4 to 6 inches completely around each towel dispenser: 228, 226, 225,224, 222, 219, 218, 209, 207, 206, 204, and 203. 4. During an interview with the maintenance supervisor on 5/21/10 at 11 AM, he stated the building was old and needed a lot of work, and said he was aware of the issues pertaining to doors, paint chipping and missing in various areas, heat radiator damage, damage in the third floor dining/day room area. He further stated the issues would be taken care of, but did not have a specific written plan to address the issues. During an interview with the housekeeping supervisor on 5/21/10 at 10 AM, he stated the facility would clean the third floor fan, dining area and windows, and remove the collected dust outside of room 310.	F 253		
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	F 280	**F-280 Right to Participate in Planning Care** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Care Plans for those residents identified (#70, #110, #113, #116) have been reviewed to identify inaccuracies related to meaningful activities and interests, safety devices, resident lack of participation in activities, splint or sling use. Corrections were made accordingly.	

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F 280	Continued From: page 38 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure needed care plan revisions were made for 4 of 32 sample residents (#70, #110, #113, #116). The findings were: 1. Review of the 1/1/10 quarterly Minimum Data Set (MDS) assessment for resident #116 showed the resident had decreased social interaction. Review of the 4/2/10 quarterly MDS assessment showed the resident had a sad, pained, and worried expression which was new since the 1/4/10 quarterly MDS assessment. However, review of the medical record showed no evidence the resident was re-assessed for meaningful activities and interests since the original assessment was performed on 10/5/07 (2 and 1/2 years earlier). Interview with the activity director and the corporate activity director on 5/20/10 at 2:05 PM revealed this resident was not re-assessed nor had the care plan been updated to meet the current needs of the resident.	F 280	Staff who participate in care planning will be educated by the Case Management Coordinator/designee on the need to accurately care plan interventions that are individualized for each resident. Education will include care planning for appropriateness related to meaningful activities and interests, safety devices, resident lack of participation in activities, splint or sling use. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit of care plans will be conducted by the Case Management Coordinator/MDS Coordinator/designee to identify that the care plans accurately reflect individualized interventions for the residents with emphasis on meaningful activities and interests, safety devices, resident lack of participation in activities, splint or sling use. Corrections will be made accordingly.	

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F 280	Continued From page 39 2. Periodic observations on 5/17 through 5/20/10 revealed resident #113 had a seatbelt on his/her wheelchair. Review of the interdisciplinary physical restraint evaluation performed on 4/20/10 showed the resident had an alarming seat belt on his/her wheelchair. Review of the current care plan showed it was not modified to include the use of a seat belt. 3. Review of the 5/7/10 significant change MDS assessment for resident #70 showed s/he was involved in activities from 1/3 to 2/3 of the time. Review of the resident's activity care plan showed the goal was to attend bingo 2-3 times per week. The plan also stated that family visits often and takes him/her to their house. However, review of the resident's activity documentation for April and May 2010 showed s/he did not actively participate in activities. The plan, re-dated from 5/7/10 to 8/5/10, showed the facility failed to make revisions to take into account the lack of participation by the resident concerning activities. During an interview with the resident's family member on 5/18/10 at 2:30 PM, the family member stated that family could only visit on occasion, and had not visited in three weeks (date uncertain). During an interview with the activities director on 5/18/10 at 3:05 PM, she stated the resident should have been reassessed due to the lack of activity participation, the care plan should have been revised, and the resident could have benefited from 1:1 activities. 4. Review of the 10/1/09 annual MDS assessment for resident #110 showed s/he had no limitations in range of motion. Review of the medical record revealed the resident fractured his/her right wrist in in November 2009. Review of	F 280	**Measures Put Into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Care plans will be reviewed and updated at a minimum upon admission, quarterly, and with change of condition. Ongoing audits of care plans will be conducted by the Case Management Coordinator/MDS Coordinator/designee per the MDS schedule to identify that changes in residents' status have resulted in changes to the care plan. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly x3. The Performance Improvement Committee will review and provide recommendations and direction based on the outcome of the audits and ongoing sustained compliance. Date of compliance is July 5, 2010.	

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F 280	Continued From page 40 the care plan reviewed 3/26/10 showed the resident had a splint for the hand which was discontinued on 1/25/10. The care plan also showed the resident's arm was in a sling which was also discontinued. 5. Interview with the unit manager on 5/20/10 at 10:45 AM revealed care plans should be updated to indicate the current status of the resident.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and medical record interview, the facility failed to ensure staff followed the care plan for 2 of 32 sample residents (#110, #111). The findings were: 1. Observation on 5/17/10 at 8:45 AM showed resident #111 had a contracture in the right hand. Review of the care plan revealed staff was to encourage the resident to exercise the right hand utilizing range of motion (ROM) and was to encourage him/her to use the hand more frequently extending the fingers and opening up the hand. Observation on 5/17/10 at 8:45 AM to 12 noon showed staff did not follow the care plan in regard to assisting or encouraging ROM and increased use of the right hand. Refer to F315 for further details regarding the contracted right hand of this resident. 2. Review of the 10/1/09 annual MDS	F 282	**F-282 – Services by Qualified Persons/Per Care Plan** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #111 was reassessed by therapy services for recommendations related to his/her contracture of the right hand. Care plan updates were completed as indicated. Resident #110 was reassessed by therapy services for recommendations related to the limited use of his/her right hand. Care plan updates were completed as indicated. Staff will be educated regarding recommendations from therapy for resident #111 and #110. An in-service will be conducted by the Staff Development Coordinator/designee with staff regarding the need to follow the care plan for individual residents with emphasis on the use of splints	

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	535013	A. BUILDING _____ B. WING _____	05/21/2010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 40 the care plan reviewed 3/26/10 showed the resident had a splint for the hand which was discontinued on 1/25/10. The care plan also showed the resident's arm was in a sling which was also discontinued. 5. Interview with the unit manager on 5/20/10 at 10:45 AM revealed care plans should be updated to indicate the current status of the resident.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and medical record interview, the facility failed to ensure staff followed the care plan for 2 of 32 sample residents (#110, #111). The findings were: 1. Observation on 5/17/10 at 8:45 AM showed resident #111 had a contracture in the right hand. Review of the care plan revealed staff was to encourage the resident to exercise the right hand utilizing range of motion (ROM) and was to encourage him/her to use the hand more frequently extending the fingers and opening up the hand. Observation on 5/17/10 at 8:45 AM to 12 noon showed staff did not follow the care plan in regard to assisting or encouraging ROM and increased use of the right hand. Refer to F316 for further details regarding the contracted right hand of this resident. 2. Review of the 10/1/09 annual MDS	F 282	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by Unit Managers/designee to identify if other residents have care plan interventions not being followed. Individual staff will be educated related to identified areas of improvement. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Unit Managers/designee will conduct routine audits/observations for 3 months to confirm that staff provides care for residents in accordance with their individual care plans.	

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	535013	A. BUILDING _____ B. WING _____	05/21/2010

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F 282	Continued From page 41 assessment for resident #110 showed s/he had no limitations in range of motion. Review of the 12/28/09 quarterly MDS assessment showed the resident had limitation with partial loss of function in the right hand. Review of the medical record revealed the resident fractured his/her right wrist in November 2009. Review of the 1/25/10 physician's orders showed an order to place a rolled wash cloth in the resident's right palm to prevent a contracture. The order included having staff remove the wash cloth and washing the resident's palm every shift then replacing the wash cloth. Review of the care plan reviewed 3/26/10 showed the resident had a splint for the hand which was discontinued on 1/25/10. The care plan also showed the resident's arm was in a sling which was also discontinued. Observation of morning care on 5/17/10 at 9:31 AM showed CNA #7 did not place a rolled wash cloth in the resident ' s right hand. Interview with the unit manager on 5/20/10 at 10:45 AM revealed staff should have followed the care plan for this resident regarding placement of the wash cloth in the contracted hand. She also said this resident frequently removes the rolled wash cloth. Review of the care plan revealed interventions to address the resident ' s removal of the wash cloth, and possible alternatives, were not included in the care plan. She furtner said staff should follow the care plan for all residents.	F 282	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DNS/ Designee will report outcomes of the audits to the Performance Improvement Committee on a monthly basis for 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to ensure personal hygiene was provided for 4 (#94, #110, #111, #119) of 19 sample residents on the third floor, all of whom were dependent upon staff. The findings were: 1. Review of the medical record revealed for resident #119 showed s/he had a contracted right hand and arm and performed all tasks with the left hand and arm. Review of the 4/6/10 annual Minimum Data Set (MDS) assessment and the 4/6/10 care plan for the resident showed the resident required assistance with all activities of daily living, including grooming. Observations on 5/17/10 at 9 AM showed the resident's fingernails were un-trimmed and visibly soiled. In addition, the resident's hair appeared greasy and was uncombed. Periodic observations on all days of the survey revealed, at times, the resident preferred to eat with his/her fingers instead of using eating utensils. Observation on 5/20/10 from 10:15 AM to 12:20 PM revealed the resident had long, poorly manicured, and dirty fingernails. Continuous observation revealed at 12:10 PM, the resident ate lunch with dirty fingers. On 5/17/10 at 9 AM the resident was noted to have untrimmed fingernails that appeared to press into the contracted right hand. 2. Review of the 4/16/10 quarterly MDS assessment for resident #94 showed s/he required extensive assist with personal hygiene. Observation on 5/17/10 at 8:50 AM showed the resident was up in his/her wheelchair at the dining table with hair unkempt. On 5/19/10 at 2:15 PM	F 312	**F-312 –ADL Care Provided for Dependent Residents** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Residents #94, #110, #111, #119 were provided appropriate individual grooming. These residents require frequent grooming throughout the day. An in-service will be conducted by the Staff Development Coordinator/designee with facility staff to educate on the need to identify and address resident grooming needs. Emphasis will be placed on nail care, hair care, clean clothing, and clean hands and faces.	

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F 312	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to ensure personal hygiene was provided for 4 (#94, #110, #111, #119) of 19 sample residents on the third floor, all of whom were dependent upon staff. The findings were: 1. Review of the medical record revealed for resident #119 showed s/he had a contracted right hand and arm and performed all tasks with the left hand and arm. Review of the 4/6/10 annual Minimum Data Set (MDS) assessment and the 4/6/10 care plan for the resident showed the resident required assistance with all activities of daily living, including grooming. Observations on 5/17/10 at 9 AM showed the resident's fingernails were un-trimmed and visibly soiled. In addition, the resident's hair appeared greasy and was uncombed. Periodic observations on all days of the survey revealed, at times, the resident preferred to eat with his/her fingers instead of using eating utensils. Observation on 5/20/10 from 10:15 AM to 12:20 PM revealed the resident had long, poorly manicured, and dirty fingernails. Continuous observation revealed at 12:10 PM, the resident ate lunch with dirty fingers. On 5/17/10 at 9 AM the resident was noted to have untrimmed fingernails that appeared to press into the contracted right hand. 2. Review of the 4/16/10 quarterly MDS assessment for resident #94 showed s/he required extensive assist with personal hygiene. Observation on 5/17/10 at 8:50 AM showed the resident was up in his/her wheelchair at the dining table with hair unkempt. On 5/19/10 at 2:15 PM	F 312	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** Observations/audits will be conducted by the Unit Managers/designee to confirm that residents are properly groomed and personal hygiene is provided. This will include trimmed and cleaned fingernails, clean and combed hair, clean clothing, proper oral care, and clean hands and faces. Corrective action will be taken as needed. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Unit Managers/designee will routinely observe residents related to personal hygiene will be routinely conducted to confirm that appropriate care is provided. Education regarding the provision of care will be included in the orientation process for new hires.	

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F 312	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to ensure personal hygiene was provided for 4 (#94, #110, #111, #119) of 19 sample residents on the third floor, all of whom were dependent upon staff. The findings were: 1. Review of the medical record revealed for resident #119 showed s/he had a contracted right hand and arm and performed all tasks with the left hand and arm. Review of the 4/6/10 annual Minimum Data Set (MDS) assessment and the 4/6/10 care plan for the resident showed the resident required assistance with all activities of daily living, including grooming. Observations on 5/17/10 at 9 AM showed the resident's fingernails were un-trimmed and visibly soiled. In addition, the resident's hair appeared greasy and was uncombed. Periodic observations on all days of the survey revealed, at times, the resident preferred to eat with his/her fingers instead of using eating utensils. Observation on 5/20/10 from 10:15 AM to 12:20 PM revealed the resident had long, poorly manicured, and dirty fingernails. Continuous observation revealed at 12:10 PM, the resident ate lunch with dirty fingers. On 5/17/10 at 9 AM the resident was noted to have untrimmed fingernails that appeared to press into the contracted right hand. 2. Review of the 4/16/10 quarterly MDS assessment for resident #94 showed s/he required extensive assist with personal hygiene. Observation on 5/17/10 at 8:50 AM showed the resident was up in his/her wheelchair at the dining table with hair unkempt. On 5/19/10 at 2:15 PM	F 312	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DNS/Designee will report outcomes of the observation/audits to the Performance Improvement Committee on a monthly basis times 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	

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F 312	Continued From page 43 observation showed the resident was seated in the main dining/activity area without his/her glasses on, hair unkempt and food dried on his/her mouth, and shirt. 3. Review of the 1/25/10 physician's orders for resident #110 showed an order to place a rolled wash cloth in the resident's right palm to prevent a contracture. The order included having staff remove the wash cloth and washing the resident's palm every shift then to replace the wash cloth. However, observation of morning personal care on 5/17/10 at 9:31 AM showed CNA #7 did not wash the resident's right hand and palm. 4. Observation on 5/17/10 at 8:45 AM showed CNA #4 provided morning care for resident #111 but did not perform or assist with oral care, did not wash the resident's face or hands, and did not comb his/her hair.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to implement an effective system to prevent the	F 314	**F-314 – Treatment/SVCS to Prevent/Heal Pressure Ulcers** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #14 no longer resides in the facility. Staff will be educated by the Staff Development Coordinator/designee regarding the risk of skin breakdown related to restraint use. Emphasis will be placed on the need to reposition residents in accordance with the plan of care and that mobility/activity status should be maintained.	

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F 312	Continued From page 43 observation showed the resident was seated in the main dining/activity area without his/her glasses on, hair unkempt and food dried on his/her mouth, and shirt. 3. Review of the 1/25/10 physician's orders for resident #110 showed an order to place a rolled wash cloth in the resident's right palm to prevent a contracture. The order included having staff remove the wash cloth and washing the resident's palm every shift then to replace the wash cloth. However, observation of morning personal care on 5/17/10 at 9:31 AM showed CNA #7 did not wash the resident's right hand and palm. 4. Observation on 5/17/10 at 8:45 AM showed CNA #4 provided morning care for resident #111 but did not perform or assist with oral care, did not wash the resident's face or hands, and did not comb his/her hair.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to implement an effective system to prevent the	F 314	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** Residents with restraints will be evaluated for the risk of skin breakdown and appropriate interventions will be implemented. Care plans will be updated with necessary changes.	

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F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to implement an effective system to prevent the	F 314	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Residents will be assessed for skin risk upon admission and quarterly. Care plan interventions will be implemented when a resident is identified as at risk for skin breakdown. Audits will be completed for residents with a safety restraint to confirm that interventions are implemented to prevent skin breakdown. Weekly skin assessments will be conducted by licensed nurses to confirm that skin is intact and care plan interventions are effective.	

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F 314	Continued From page 44 development of pressure sores for 1 (#14) of 6 residents who had facility acquired pressure sores and were restrained. The restraint and lack of preventive measures likely contributed to the development of an avoidable pressure sore for resident #14. The findings were: Refer to example #1 in F221 for information regarding the facility's failure to provide care to prevent the pressure sore that developed on the ischium of resident #14. According to the Clinical Practice Guidelines from the Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov <http://www.ahrq.gov> (Guideline No. 3: Pressure Ulcers in Adults: Prediction and Prevention): Staff should reposition chair-bound persons every hour or teach chair-bound persons, who are able, to shift weight every fifteen minutes. The guidelines also include instituting a rehabilitation program to maintain or improve mobility/activity status. The facility's Preventive Skin Care Policy and Procedure, revised 4/08/07, showed interventions should include a care plan based on individual resident needs for scheduled turning and repositioning (in bed and chair) and weekly assessments of the effectiveness of care plan interventions.	F 314	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DNS/Designee will report outcomes of the audits to the Performance Improvement Committee on a monthly basis times 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	
F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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F 314	Continued From page 44 development of pressure sores for 1 (#14) of 6 residents who had facility acquired pressure sores and were restrained. The restraint and lack of preventive measures likely contributed to the development of an avoidable pressure sore for resident #14. The findings were: Refer to example #1 in F221 for information regarding the facility's failure to provide care to prevent the pressure sore that developed on the ischium of resident #14. According to the Clinical Practice Guidelines from the Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov <http://www.ahrq.gov> (Guideline No. 3: Pressure Ulcers in Adults: Prediction and Prevention): Staff should reposition chair-bound persons every hour or teach chair-bound persons, who are able, to shift weight every fifteen minutes. The guidelines also include instituting a rehabilitation program to maintain or improve mobility/activity status. The facility's Preventive Skin Care Policy and Procedure, revised 4/08/07, showed interventions should include a care plan based on individual resident needs for scheduled turning and repositioning (in bed and chair) and weekly assessments of the effectiveness of care plan interventions.	F 314		
F 318 SS=G	483.25(a)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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

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F 318	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 3 of 6 sample residents (#107, #111, #119) who were on floor maintenance for restorative exercises received the exercises as planned. This failure contributed to avoidable decline in physical function for resident #111. The findings were: 1. Observation on 5/17/10 8:45 AM showed resident #111 had a contracture in the right hand. Review of the care plan revealed staff were to encourage the resident to exercise the right hand utilizing range of motion and were to encourage him/her to use the hand more frequently, extending the fingers and opening up the hand. Review of the 4/25/08 occupational therapy (OT) evaluation showed the resident sustained a right wrist fracture from a fall. The resident received OT services with a goal of increasing functionality of the right hand and wrist. The potential for achieving the goals at that time was determined to be good. Review of the 4/10/09 OT evaluation revealed the resident had experienced a decline in ADL (activities of daily living) function and was readmitted to OT services with potential for achieving the goal of increasing the resident's right hand. Review of the restorative range of motion (ROM) program care plan dated 6/8/09 showed the resident was to receive active ROM and strengthening exercises to the right hand. Continued review of the restorative care progress notes showed the resident was discharged from the restorative program on 9/29/09 because the goals were met. The resident was placed on the maintenance restorative nursing program with a	F 318	**F-318 – Increase/Prevent Decrease in ROM** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The current "Floor maintenance" restorative programs for residents #107, #111, #119 will be reviewed for appropriateness. A therapy screen and/or evaluation will be requested for additional recommendations. Staff will be educated by the Staff Development Coordinator/designee related to the individual needs of these residents with care plan updates as indicated. Staff will be educated by the Staff Development Coordinator/designee on the need to complete "floor maintenance" restorative programs as indicated.	

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F 318	Continued From page 46 plan for upper extremely ROM exercises three to five times per week. The following concerns were identified: a. Review of the April and May 1 through 16, 2010 maintenance restorative nursing documentation showed the resident only received ROM exercises one time during the weeks of 4/4/10 through 4/10/10, 4/18/10 through 4/24/10, 4/25/10 through 5/1/10, and 5/2/10 through 5/8/10. During the week of 4/11/10 through 4/17/10 the resident received no ROM exercises. b. Observation on 5/20/10 at 10:05 AM showed the resident was unable to open his/her right hand, and s/he also stated that hand caused him/her pain. c. Review of the care plan showed staff was to encourage the resident to exercise the right hand utilizing ROM. The care plan also showed staff should encourage the resident to use his/her hand more frequently; extending the fingers and opening up the hand. However, observation on 5/17/10 from 8:45 AM to 12 noon showed staff did not follow the care plan in this regard. d. Interview with the DON and the unit manager on 5/20/10 at 10:45 AM confirmed ROM was not performed as ordered. 2. Review of the restorative ambulation program care plan for resident #107 showed s/he had difficulty with ambulation and required restorative therapy. Review of the restorative care plan revealed the goal was for the resident to walk with supervision in a Merry Walker or with a front wheel walker. The plan was for restorative staff to assist the resident with walking for fifteen to twenty minutes, three times per week for four weeks beginning 11/11/09. This care plan also showed the resident was discharged from the restorative program on 1/27/10 because the goal	F 318	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the Restorative Aides/designee of those residents on a "floor maintenance" restorative program to identify if the programs are occurring as ordered. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Restorative Aides will complete ongoing audits of residents on floor maintenance programs to validate that the programs are conducted as ordered. They will meet with the Restorative nurse or DNS for corrective actions as needed to resolve issues.	

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	535013	A. BUILDING _____ B. WING _____	05/21/2010

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F 318	Continued From page 47 was met. The resident was transitioned to the floor maintenance restorative nursing program with a plan for ambulation three to five times per week. The following concerns were identified: a. Periodic observations on 5/17/10 through 5/20/10 showed the resident was in the wheelchair whenever s/he was not in bed. b. Review of the February 2010 maintenance restorative nursing documentation revealed the resident was not ambulated at any time during the month. c. Review of the March 2010 flowsheet documented the resident was ambulated only four times during the month. d. Review of the April 2010 flowsheet documented the resident was ambulated only six times during the month. e. Review of the May 2010 flowsheet showed the resident received ambulation maintenance exercise three times during the first week, but only twice during the second week and during the week of 5/16/10 through 5/20/10 (end of the survey) the resident had received no ambulation exercises based on review of the flowsheet and periodic observations. 3. Observation of resident #119 during the survey from 5/17/10 through 5/21/10 showed s/he had a contracture of the right hand and arm. Review of the 4/6/10 annual MDS assessment showed ROM limitations for the hand arm and leg. Review of the 4/3/10 care plan related to contractures showed the interventions to minimize the risk for further loss in ROM included: "Splint/brace if MD ordered, refer to therapy as needed, ROM to affected area per MD order, monitor for skin breakdown, keep fingernails trimmed, monitor and treat pain." The following concerns were identified:	F 318	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DNS/Designee will report outcomes of the audits to the Performance Improvement Committee on a monthly basis times 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	

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F 318	Continued From page 48 a. On 5/17/10 at 9 AM the resident was noted to have untrimmed fingernails that appeared to press into the contracted right hand. In addition, there was no brace or device being used for the contracted arm or hand. b. Interview with the DON and corporate RN on 5/20/10 at 4:50 PM verified the resident had last been seen by occupational therapy (OT) for the contractures to the right hand and upper extremities two years earlier, on 6/2/08. Review of the 6/2/08 OT discharge summary revealed the resident had met his/her highest potential at that time secondary to non-compliance. Record review and interview with the DON on 5/20/10 at 4:50 PM confirmed there was no evidence a re-evaluation of this resident's therapy needs had been considered since that date.	F 318		
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 and staff interview, the facility failed to ensure the environment was free of safety hazards on the third floor, excluding the Reflections Unit, in addition, the facility failed to ensure adequate supervision for 2 of 19 sample residents (#101, #120) who wandered. The facility failed to ensure the brakes on a Broda chair worked properly for 1 (#110) of 1 sample resident	F 323	**F-323-Free of Accident Hazards/Supervision/Devices** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #101 has been moved to the secured unit. The brakes on the Broda chair for resident #110 have been repaired. Resident #120 was redirected at the time of the incident and continues to be redirected as indicated. Resident #120 has been evaluated for placement in our secured unit.	

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F 323	Continued From page 49 who used a Broda chair on third floor. Finally, the facility failed to ensure staff implemented appropriate interventions to keep 1 (#114) of 29 sample residents safe which likely contributed to one fall, on 5/16/10, and to the resident's escalated aggressive and assaultive behaviors. The findings were: 1. Observation on 5/17/10 at 8:50 AM revealed resident #101 ambulated independently, and wandered the third floor area. At 9:40 AM, and 10:17 AM the resident was seen by the surveyor in other resident rooms. At 10:17 AM while in room 308 resident #101 looked around while the two who occupied the room laid in beds sleeping. The resident helped herself to a greeting card of one of these residents. S/he then wandered into the room across the hall and looked around. During these observations, there were no staff in the area. Review of resident progress notes dated 5/5, 5/15, and 5/16/10 showed the resident wandered into other resident rooms and would take things. According to the 11/12/09 care plan related to wandering, an intervention included staff to redirect the resident when entering other resident's room by offering an activity of choice or engaging in 1:1 conversation. Review of the wander/elopement risk evaluation dated 5/13/10 determined the resident was at risk due to impaired decision making skills and decreased safety awareness. The evaluation comments showed the resident had increased intrusive wandering and failed the trial on the non-secure third floor. The conclusion was to move the resident back to the secure unit as soon as a room was available. However, safety concerns were not addressed related to how staff should handle the wandering behavior until the resident could be moved. Interview with the unit manager	F 323	An assessment has been completed for resident #114 related to the use of the restraint. Environmental safety checks will be completed for rooms 331, 307, 304, and 201 with repairs completed as indicated. Staff education will be conducted by the Staff Development Coordinator/designee to alert maintenance staff upon identification of wheelchairs that need repair to maintain resident safety. Staff will be educated by the Staff Development Coordinator/designee to redirect residents from wandering into other resident rooms to maintain resident safety and to alert nursing supervisors to evaluate wandering behaviors to keep residents safe. Staff education will be completed related to restraint use (see F221).	

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

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F 323	Continued From page 50 on 5/17/10 at 2:45 PM revealed resident #101 would be moved back into the secure unit as soon as a bed was available. She revealed the resident could fall, or could get into a resident to resident altercation because staff couldn't supervise her close enough on the non-secure unit. 2. Review of the 4/8/10 wander/elopement risk evaluation for resident #120 showed s/he was at risk due to impaired decision making and decreased safety awareness. The note documented on the evaluation showed the resident ambulated up and down the hallways, but did not go into other resident rooms. However, observation on 5/19/10 at 5:05 PM showed the resident was in the room of non-sample resident #100. Resident #100 was heard telling resident #120 "Don't fall, sit here on the edge of the bed." Another resident (non-sample resident #88) who did not reside in the room was also present and was seated in his/her wheelchair in the middle of the room watching the other two residents. No staff members were in the area. A few moments later resident #120 came out into the hallway. A CNA was flagged by the surveyor from the other end of the hall to assist resident #120. The aide took the resident by the arm and asked the resident the location of his/her walker. According to the care plan, the resident was at high risk for falls. Observation on 5/19/10 at 2:10 PM revealed the staff on the third floor could not find resident #120 and RN #2 instructed staff to look for the resident. During interview with the RN at that time she stated the resident could have been "anywhere, in anybody's room, in anybody's bed." At 2:20 PM, CNA #8 located the resident in another resident's bathroom and escorted the resident from the	F 323	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** A review of residents who wander will be conducted by nursing management/designee to determine that their wandering behaviors are adequately managed for safety. An audit by nursing management/designee will be completed to identify wheelchairs in need of brake repairs. A facility environmental safety audit will be conducted by nursing management/designee to identify repairs needed to maintain resident safety. An audit will be completed related to restraints (see F 221).	

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F 323	Continued From page 51 room. 3. Observation of morning care for resident #110 on 5/17/10 at 9:27 Am revealed CNA #3 told CNA #7 that the right brake of the Broda chair did not work. Observation revealed the wheelchair rolled on its own during the transfer from the bed to the wheelchair. The CNAs were able to keep the resident safe by holding the chair against their bodies. Interview with the maintenance director on 5/21/10 at 11 AM revealed he was unaware of the broken brakes on the chair. Also, during that interview the maintenance supervisor stated he was unaware of any brake issues with resident wheelchairs, including resident #110. He further stated he periodically picks up work orders at the different nurses' stations, and was not usually aware of wheelchair issues unless there was a work order. 4. Review of the medical record for resident #114 showed s/he initially lived on the Reflections Unit (secure unit). Review of the Reflections Unit annual activity and nursing assessment written on 3/2/10 showed the resident did well with 1:1 interactions and enjoyed music and visits. The note also showed the resident was declining physically and required increased assistance and cueing for meals and activity participation. In addition, the note documented the resident required the use of a wheelchair at times due to weakness. The review also revealed the resident was placed on comfort care, but continued to benefit from the low stimulation and routine of the secure unit. The following concerns were identified: a. Review of the 3/9/10 nursing notes showed the resident was moved from the Reflections Unit to the first floor. Review of the 3/9/10	F 323	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Residents will be evaluated upon admission and quarterly for wandering/elopement risk. Interventions will be implemented to promote safety. A maintenance log will be placed on each unit and staff will be responsible to identify needed repairs. The Maintenance staff will review the log and sign off once the repairs are completed. Staff will be educated by the Staff Development Coordinator/designee to use the maintenance log to alert maintenance of environmental concerns that may pose a safety risk. Ongoing audits will be conducted by nursing management/designee to identify staff response to safety concerns.	

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F 323	Continued From page 52 interdisciplinary team notes written at 2:30 PM revealed the resident was moved to first floor because s/he required the use of a wheelchair. This note documented the resident was too unsteady to walk independently and nursing would need to evaluate the resident for the implementation of a lap buddy or self- releasing seat belt. Review of the medical record showed no evidence an evaluation or assessment was done to determine the need for either of these devices. b. Review of the 3/22/10 nursing notes written at 7:30 PM revealed the resident hit a nurse when she tried to re-buckle the seat belt the resident had un-buckled earlier. Review of the assessment "Determining Cause of Disruptive Behavior" that was done on 3/22/10 showed the behaviors described included the resident was observed rolling and unrolling the ends of the seat belt then finally s/he unfastened it. The resident then struck out at the nurse when she attempted to refasten the seat belt. The intensity was noted as "severe." Continued review of the assessment showed the resident's behaviors stopped when the nurse backed away and just observed the situation. Later a CNA was able to re-buckle the seat belt. c. Review of the nursing notes written on 5/16/10 at 11:45 AM showed the resident fell after unbuckling the seat belt in the dining room. Review revealed the resident had been unbuckling the seat belt and setting off the alarms "all shift." The resident fell to the floor in the back of the dining room. Continued review of these notes showed family had noticed the resident had been repeatedly trying to un-buckle the seat belt during the past few visits. According to these notes, the family member agreed to a trial of a lap buddy instead of the seat belt at that time.	F 323	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DNS/Designee will report outcomes of the audits to the Performance Improvement Committee on a monthly basis times 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	

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

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F 323	Continued From page 53 However, review of the medical record showed no evidence a reassessment was done to determine the effectiveness of the seat belt in keeping the resident safe or an evaluation of a change in interventions, including a trial of using a lap buddy. d. Observations from 5/17/10 through 5/20/10 revealed the resident had a seat belt on his/her wheelchair and frequently made attempts to remove it from the wheelchair. Review of the 5/20/10 nursing notes written at 6:45 PM revealed the resident unbuckled the seat belt several times and became more agitated each time a staff member re-buckled it. It was noted that the resident finally hit a staff member in the jaw when the staff member tried to re-buckle the seat belt. e. Interview with the unit manager on 5/19/10 at 5:20 PM revealed lap buddies or seat belts were placed on resident wheelchairs to prevent residents from standing and falling. She further stated there were not enough employees to watch everybody at the same time. 5. The following safety issues were observed during building tours on 5/19/10 and 5/20/10: In room 331 a television cable was stapled around the entryway to the bedroom and jutted 4 inches into the walking area just above the floor, creating a fall risk. In room 307, the heat radiator located on the floor/wall by the distant bed was pulled loose from the wall 6 feet across and was lying on the floor, creating a fall risk. On the door to room #304, a 8-inch sharp and jagged area on the upper door kick plate was pulled out 1-inch from the door. this damaged area was located close to the doorknob, creating a hazard when opening or closing the door. In room #201 the heat register next to the floor was missing its cover, exposing a 6 ft. sharp, metal edge.	F 323		

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

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F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the drug regimen was free of unnecessary drugs for 1 of 19 sample residents (#111) who received psychoactive medications. This failure contributed to the worsening of extrapyramidal symptoms (EPS) for the resident. The findings were:	F 329	**F-329 – Drug Regimen is Free From Unnecessary Drugs** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #111 will be assessed for appropriate medication with IDT members and the physician. Medication orders are followed as ordered by the MD. The members of the Psychotropic Drug Committee will be educated by the Staff Development Coordinator/designee on the need to follow-up with the primary physician in the event that increases in EPS are noted. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be completed by nursing management/designee to identify if other residents have a documented increase in EPS. Physicians will be notified if increased EPS are noted.	

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

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F 329	Continued From page 55 Review of the 8/16/09 physician's orders for resident #111 showed an order for Abilify 10 mg for delusional disorder. The following concerns were identified: a. Review of the medical record revealed an AIMS (abnormal involuntary movement scale) assessment was performed on 12/15/09 and showed an increase in EPS in the following areas: lip and perioral area (puckering, pouting, smacking) from minimal/normal to moderate, jaw (biting, clenching, chewing, mouth opening, lateral movement) from none to moderate, tongue from none to moderate. The severity of abnormal movements increased from none to moderate from 11/10/09 to 12/15/09. However, review of the quarterly psychoactive committee notes from 1/6/10 revealed the increased EPS were not discussed, and the conclusion of the committee was to continue on the current medications. b. Review of the physician's progress notes and orders written on 1/18/10 showed the resident had demonstrated increased behaviors since the Abilify was decreased from 15 mg to 10 mg on 8/16/09 and therefore the medication was increased back to 15 mg. Review of the medical record showed no evidence the physician was notified of the increased EPS until 2/5/10 (seven weeks after it was determined the resident's EPS had worsened). At that time an order to decrease the Abilify back to 10 mg was written. Periodic observations on 5/17/10 through 5/20/10 showed the resident exhibited chewing motions frequently. Interview with the unit manager and DON on 5/20/10 at 10:45 AM revealed the physician had access to the medical record and the AIMS report so should have picked up on the resident's increased EPS behaviors without being notified by the facility. c. Review of the medication administration	F 329	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Residents who receive antipsychotic medications or medications with the possible side effect of tardive dyskinesia will be evaluated with an AIMS assessment upon admission and quarterly. Changes of status will be addressed with the physician. Ongoing audits of AIMS will be completed quarterly by nursing management/designee to identify if there is a change in status. Physicians will be notified and medications adjusted accordingly.	

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

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	535013	A. BUILDING _____ B. WING _____	05/21/2010

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MOUNTAIN TOWERS HEALTHCARE & REHABILITATION CENTER	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 56 record showed the resident continued to receive the 15 mg dose of Abilify through the first four days in March 2010, even though the order was decreased to 10 mg on 2/5/10.	F 329		
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 family interview, the facility failed to ensure adequate staff were assigned to provide for the physical, psychosocial, and quality of life needs for 19 of 29 sample (#14, #15, #70, #89, #91, #94, #95, #101, #107, #110, #111, #112, #113, #114, #116, #119, #120, #123, #124) and 9 (#88,	F 353	**F-353-Sufficient 24-hr Nursing Staff Per Care Plans** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Staffing patterns have been evaluated to provide for the physical, psychosocial, and quality of life needs for those residents identified: #14, 15, 70, 89, 91, 94, 95, 101, 107, 110, 111, 112, 113, 114, 116, 119, 120, 123, 124, 88, 96, 100, 102, 103, 105, 108, 117, 128, 115. Additional resources have been allocated to assist with residents during meal times on 3rd floor and with ADL needs.	

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

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F 353	Continued From page 57 #96, #100, #102, #103, #105, #108, #117, #128) non-sample residents. The findings were: 1. Refer to F240, F241, F248, F250, F251, and F253 for details regarding quality of life deficient practices. Refer to F221 for details regarding the use of restraints because there were not enough nursing employees to watch all the residents all of the time. 2. Interview with a family member of resident #111 on 5/19/10 at 11:40 AM revealed s/he was concerned the resident had sustained so many falls in the past few months. The family member stated s/he had discussed the concerns with facility staff and was told there just were not enough staff members to watch every resident at all times and, therefore, falls happen. The resident had three falls in April: 4/2/10, 4/5/10, and 4/13/10. 3. During an interview with a family member of non-sample resident #88 on 5/20/10 at 2 PM, it was revealed the facility was short of staff, and this resulted in prolonged time before residents were assisted with toileting. The family member stated s/he sometimes heard residents shout that they could wait no longer, then heard residents sometimes state that it was "too late." In addition, on several occasions s/he witnessed two tables of residents in need of dining assistance (a total of eight residents) being assisted by only one staff member. This family member stated she felt the residents were not getting the assistance they needed. The family member could not give specific dates or resident names. 4. Observation on 5/17/10 at 10:30 AM revealed CNA #8 wheeled resident #14 to the dining room	F 353	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** Staffing levels will be evaluated by the Director of Nursing/designee for the facility and adjustments will be made as needed to confirm adequate staffing ratios are occurring to provide quality of care and quality of life for the residents. **Measures Put Into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Schedules will be created to meet the staffing ratios to include the increase in staffing levels. Review of the daily staffing sheet will be conducted by the Director of Nurses/designee to identify if the staffing levels are adequate and meet the needs of the residents.	

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

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F 363	Continued From page 58 and assisted him/her with breakfast. Interview with the CNA at that time revealed the resident should have been assisted with his/her breakfast at 8 AM, but due to staffing problems the CNA was unable to help the resident in a timely manner. 5. During the group interview on 5/17/10 at 2 PM, all four residents attending the group stated the facility did not have a sufficient number of staff to assist them. They further stated the lack of staff most impacted the residents during mealtimes when there was not enough staff to provide necessary assistance.	F 363	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DNS/Designee will report outcomes of the audits to the Performance Improvement Committee on a monthly basis times 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the menu was followed related to portion sizes for two of two meal service observations. The findings were: 1. Observation of the evening meal service on 5/18/10 on the third floor showed the main entree was triple cheese pizza. At 5:30 PM server #1 began dishing up food for resident meals. Review of the menu showed the serving size for the pureed pizza was 2- #8 scoops (this is equivalent to 1 cup). During the observation it was noted that	F 363	**F-363 Menus Meet Resident Needs/Prep in Advance/Followed** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Server #1 will be re-educated regarding following the serving sizes on the menu. Kitchen staff will be educated to follow the serving size on the menu for all units.	

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

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F 363	Continued From page 59 server #1 failed to provide this planned serving size, and rather served 1 and one-half scoop of the pureed pizza for all residents having this diet. The reduction in portion size was 1/4 less than planned. Review of the diet cards provided by the facility for the third floor residents showed 15 residents received pureed diets. Interview with server #1 that evening at 6:15 PM revealed she was worried she may run out, so she did not serve the full portion of the pureed pizza. She revealed there was a new cook and it appeared that there was not as much as usual. In the end she did run out and had to call to have a couple more servings brought up from the main kitchen. Interview on 5/20/10 at 8:50 AM with the dietary manager and the corporate registered dietitian (RD) revealed the serving size on the menus should be followed, and more training was needed due to several new food service employees. 2. Observation on the third floor of the noon meal service on 5/19/10 at 12 PM showed the scoop size used for serving the mechanical ground country fried steak was a #10 size scoop (2/5 cup). According to the planned menu, the serving size should have been a #8 scoop (1/2 cup). Review of the diet cards for the third floor dining room revealed there were 13 residents who had diet orders for the mechanical ground diet. Interview on 5/20/10 at 8:50 AM with the dietary manager and the corporate RD revealed the serving size on the menus should be followed, and more training was needed due to several new food service employees.	F 363	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** Observations of meal service on other units will be conducted by the Nutrition Services Manager/designee to determine if correct portion sizes are being served to the residents. Corrective action will be taken. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** New staff will be trained by the Nutrition Services Manager/designee on the correct scoop sizes to be used during meal service. Therapeutic spreadsheets will be posted for kitchen staff to refer to during meal service. NSM/RD/designee will routinely monitor meal service on all units to confirm that correct portion sizes are being served and that an adequate amount of food is available for meal service. Corrective action will be taken as concerns are identified.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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

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F 363	Continued From page 59 server #1 failed to provide this planned serving size, and rather served 1 and one-half scoop of the pureed pizza for all residents having this diet. The reduction in portion size was 1/4 less than planned. Review of the diet cards provided by the facility for the third floor residents showed 15 residents received pureed diets. Interview with server #1 that evening at 6:15 PM revealed she was worried she may run out, so she did not serve the full portion of the pureed pizza. She revealed there was a new cook and it appeared that there was not as much as usual. In the end she did run out and had to call to have a couple more servings brought up from the main kitchen. Interview on 5/20/10 at 8:50 AM with the dietary manager and the corporate registered dietitian (RD) revealed the serving size on the menus should be followed, and more training was needed due to several new food service employees. 2. Observation on the third floor of the noon meal service on 5/19/10 at 12 PM showed the scoop size used for serving the mechanical ground country fried steak was a #10 size scoop (2/5 cup). According to the planned menu, the serving size should have been a #8 scoop (1/2 cup). Review of the diet cards for the third floor dining room revealed there were 13 residents who had diet orders for the mechanical ground diet. Interview on 5/20/10 at 8:50 AM with the dietary manager and the corporate RD revealed the serving size on the menus should be followed, and more training was needed due to several new food service employees.	F 363	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** NSM/RD/ Designee will report findings to the PI Committee monthly times 3 or until substantial compliance is achieved or as directed by the Committee. Date of compliance is July 5, 2010.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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

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F 371	Continued From page 60 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure slicing equipment was clean when it was stored. In addition, vents and hoods were not adequately cleaned presenting a potential contamination source in the food preparation area. The findings were: 1. Observation of the electric slicer on 5/18/10 at 3:30 PM revealed it was covered with a plastic bag. Inspection under the bag revealed it was not clean. There were food particles on and around the circular blade, and underneath the equipment there was an accumulation of a reddish brown liquid. Interview with the dietary manager at that time revealed the slicer was last used the day before to slice cooked corned beef. She stated she was in a hurry and failed to clean it thoroughly. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation of the kitchen on 5/17/10 at 6 AM, and on 5/18/10 at 3:30 PM showed the hood	F 371	**F-371-Food Procure, Store/Prepare/Serve-Sanitary** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The electric slicer was thoroughly cleaned and the hood vents and ceiling air vents were cleaned on 05/20/10. Dietary staff will be in-serviced by the NSM/RD/designee on sanitation principles. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** Rounds will be completed in the kitchen and food service areas by the NSM/designee to confirm acceptable sanitary conditions. Corrective measures will be taken as needed.	

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

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F 371	Continued From page 60 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure slicing equipment was clean when it was stored. In addition, vents and hoods were not adequately cleaned presenting a potential contamination source in the food preparation area. The findings were: 1. Observation of the electric slicer on 5/18/10 at 3:30 PM revealed it was covered with a plastic bag. Inspection under the bag revealed it was not clean. There were food particles on and around the circular blade, and underneath the equipment there was an accumulation of a reddish brown liquid. Interview with the dietary manager at that time revealed the slicer was last used the day before to slice cooked corned beef. She stated she was in a hurry and failed to clean it thoroughly. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation of the kitchen on 5/17/10 at 6 AM, and on 5/18/10 at 3:30 PM showed the hood	F 371	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** RD/ED/designee will conduct quick rounds routinely and review with the ED on a weekly basis. Position specific cleaning schedules will be implemented. Hood and vents were added to the weekly cleaning schedule. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The RD/Designee will report findings regarding sanitation in the kitchen to the PIC monthly x 3 for review and recommendations. Date of compliance is July 5, 2010.	

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

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F 371	Continued From page 61 vents above the griddle section of the range had an accumulation of dust and grease. In two areas grease trails were visible from where it was dripping from the edge. In addition, there was a ceiling air vent above a food preparation table that was visibly soiled with dust and grease on the vent and the wall and ceiling around the vent. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically 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,	F 431	**F-431-Drug Records, Label/Store Drugs & Biologicals** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The multi-dose vials and cream that were undated/expired were disposed of. There was no noted negative affect for resident #114. Staff will be educated by the Staff Development Coordinator/designee on the need to date vials as they are opened and to identify expiration. Education will include the need to dispose of these medications and replace with new items.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 62 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, medical record review, and staff interview, the facility failed to ensure open multidose vials stored in 1 of 4 medication carts were dated when opened. In addition, an expired medication available for use and administered to one resident (#114) was observed in 1 of 3 medication refrigerators. The findings were: During an observation of the B hall medication cart for the second floor nursing station on 5/20/10 at 4:20 PM, one multi-dose vial of Novolin R insulin was used, but had not been dated, and was available for use. During an observation of the B hall medication cart for the first floor nursing station on 5/20/10 at 4:45 PM, one multi-dose vial of Lantus Insulin was used, but had not been dated, and was available for use. During an observation of the medication refrigerator for the third floor nursing station on 5/20/10 at 4 PM, 19 1cc syringes of ABHR [Ativan, Benadryl, Haldol, Reglan-used as anti-emetic (nausea)] cream was outdated on 5/8/10, but were available for use. In addition, review of the medication administration record for resident #114 showed s/he received ABHR on 5/15/10, 5/18/10, and 5/19/10.	F 431	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be completed by nursing management/designee to identify any additional opened vials or creams that are without open dates or are expired and items will be discarded. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Vials and creams will be dated once opened. Undated items will be discarded. Weekly audits will be completed by nursing management/designee to look for expired medications and opened undated vials with subsequent follow-up as indicated.	

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F 431	Continued From page 63 During interviews with LPN #7 and RN #3 immediately after each observation of the medication carts, they confirmed the used vials were not dated and were available for use. During an interview with LPN # 8 immediately after the medication refrigerator observation, she stated the ABHR was outdated and available for use. In addition, she stated that resident #114 had received ABHR three times after 5/6/10. According to "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, & Martin, Seventh Edition, page 606, "If multi-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials." According to "Nursing Interventions and Skills" by Elkin, Perry, & Potter, Fourth Edition, page 392, "Medications used past expiration date may be inactive or harmful to client."	F 431	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DNS/Designee will report outcomes of the audits to the Performance Improvement Committee on a monthly basis times 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	
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	**F-441-Infection Control, Prevent Spread, Linens** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #61 has chronic MRSA infections, had no acute/active symptoms, and the MD had chosen not to treat the resident. There was no negative affect noted for this resident. Staff will be educated by the Staff Development Coordinator/designee to notify the ICN regarding abnormal culture results.	

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

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F 441	Continued From page 64 (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, medical record review, staff interview, and review of the facility policy and procedure, the facility failed to identify one of three residents (#61) with methicillin resistant staphylococcus aureus (MRSA). The findings were: Review of the medical record for resident #61 showed s/he had a urine culture collected on 4/23/10 with results received by the facility on 4/27/10. The urine culture results included more than 100,000 colony forming units per milliliter of MRSA and 25,000 to 50,000 colony forming units per milliliter of Pseudomonas aeruginosa. The following concerns were identified: a. During an interview on 5/20/10 at 3 PM	F 441	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the Infection Control Nurse/designee to identify any other culture results that have not been tracked or monitored. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The ICN will review the telephone orders to determine who has orders for cultures. The staff nurses will be asked to forward copies of the culture results to the ICN. The ICN will track culture orders and follow-up to confirm that infections are adequately addressed and monitored. Routine audits will be conducted by the ICN/designee to confirm that culture results are communicated to the ICN and they are addressed, tracked and monitored.	

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	535013	A. BUILDING _____ B. WING _____	05/21/2010

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F 441	Continued From page 65 with the infection control nurse and DON, each stated they were unaware that resident #61 had MRSA or Pseudomonas aeruginosa. Review of the infection control log and infection control data at the time of the interview showed the resident was not included in the infection control information. b. According to the facility policy and procedure titled, "Infection Control and Prevention Program," essential elements of a surveillance system include: b. Use of surveillance tools such as: 1. Infection surveys and data collection templates.....4. Identification of the processes or outcomes selected for surveillance, and 5. Statistical analysis of data that can uncover an outbreak, and feedback of results to the primary caregivers so that they can assess the residents for signs of infection.	F 441	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The ICN/designee will report outcomes of the audits to the Performance Improvement Committee on a monthly basis times 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure adequate space was available for meals on the third floor in the main dining room for 25 of 39 sample and non-sample residents. The findings were: 1. Observation of the noon meal on 5/17/10 at	F 464	**F-464-Requirements for Dining and Activity Rooms** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The 25 residents cited on the 2567 are not identified. Furniture has been removed and rearranged in the 3rd floor dining room to create additional space.	

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F 464	Continued From page 66 12:08 PM revealed CNA #2 had to lift a rolling stool over the head of resident #97 to place it where he needed to sit to assist residents. Interview with CNA #3 at 12:55 PM on 5/17/10 revealed there were normally only four staff members in the main dining room to assist residents with their meals and thirteen of the residents required total assistance. 2. Observation on 5/18/10 at 5:50 PM during the evening meal showed CNA #3 had to lift the rolling stool over residents heads to place it between the tables where she needed to sit. 3. Observation on 5/19/10 at 11:50 AM showed there were 25 residents in the main dining room for lunch. Continued observation showed 12 of the residents were seated in wheelchairs which were so close together CNA #3 had to lift a rolling stool over the residents' heads in order to place it where she needed to sit while assisting residents. 4. Observation on 5/19/10 at 12:26 PM showed resident #113 tried to leave the dining room but was unable to do so because of the crowding. CNA #8 was finally able to assist the resident in leaving the dining room by moving another resident (#116) while s/he was eating the meal. 5. Interview with the administrator on 5/21/10 at 11 AM revealed he and the PI team had identified the third floor dining area was crowded.	F 464	Residents in wheelchairs have been assessed by the therapy department for participation in a walk-to-dine program or to be transferred to dining room chairs as appropriate. This has created additional dining service space and provided a more comfortable dining experience. Staff will be educated by the Staff Development Coordinator/designee regarding the need to configure dining room tables to maximize dining room space. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The dining space in other areas has been observed for adequate space. Those spaces are sufficient to meet resident's needs.	
F 503 SS=D	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.	F 503		

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F 464	Continued From page 66 12:08 PM revealed CNA #2 had to lift a rolling stool over the head of resident #87 to place it where he needed to sit to assist residents. Interview with CNA #3 at 12:55 PM on 5/17/10 revealed there were normally only four staff members in the main dining room to assist residents with their meals and thirteen of the residents required total assistance. 2. Observation on 5/18/10 at 5:50 PM during the evening meal showed CNA #3 had to lift the rolling stool over residents heads to place it between the tables where she needed to sit. 3. Observation on 5/19/10 at 11:50 AM showed there were 25 residents in the main dining room for lunch. Continued observation showed 12 of the residents were seated in wheelchairs which were so close together CNA #3 had to lift a rolling stool over the residents' heads in order to place it where she needed to sit while assisting residents. 4. Observation on 5/19/10 at 12:26 PM showed resident #113 tried to leave the dining room but was unable to do so because of the crowding. CNA #8 was finally able to assist the resident in leaving the dining room by moving another resident (#116) while s/he was eating the meal. 5. Interview with the administrator on 5/21/10 at 11 AM revealed he and the PI team had identified the third floor dining area was crowded.	F 464	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Dining areas will be consistently monitored and observed by Unit Managers/designee for adequate space. Changes will be communicated to the IDT for review in consideration of resident needs. Audits will be conducted the NSM/RD/designee at various meal times to identify if space is adequate in order to meet the needs of the residents. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The ED/designee will report outcomes of the audits to the Performance Improvement Committee on a monthly basis times 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	
F 503 SS=D	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.	F 503		

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F 464	Continued From page 66 12:08 PM revealed CNA #2 had to lift a rolling stool over the head of resident #97 to place it where he needed to sit to assist residents. Interview with CNA #3 at 12:55 PM on 5/17/10 revealed there were normally only four staff members in the main dining room to assist residents with their meals and thirteen of the residents required total assistance. 2. Observation on 5/18/10 at 5:50 PM during the evening meal showed CNA #3 had to lift the rolling stool over residents heads to place it between the tables where she needed to sit. 3. Observation on 5/19/10 at 11:50 AM showed there were 25 residents in the main dining room for lunch. Continued observation showed 12 of the residents were seated in wheelchairs which were so close together CNA #3 had to lift a rolling stool over the residents' heads in order to place it where she needed to sit while assisting residents. 4. Observation on 5/19/10 at 12:26 PM showed resident #113 tried to leave the dining room but was unable to do so because of the crowding. CNA #8 was finally able to assist the resident in leaving the dining room by moving another resident (#116) while s/he was eating the meal. 5. Interview with the administrator on 5/21/10 at 11 AM revealed he and the PI team had identified the third floor dining area was crowded.	F 464		
F 503 SS=D	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.	F 503	**F-503 - Laboratory Services** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** No specific residents were identified as having been affected. The outdated glucometer test solution was disposed of upon identification. Nursing staff will be In-serviced by the Staff Development	

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F 503	Continued From page 67 If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure quality control procedures were properly performed for glucometer on 2 of 4 resident units (second floor, third floor). The findings were: Observations on 5/20/10 at 4 PM at the third floor nurses' station, and 4:20 PM at the second floor nurses' station, showed each testing solution was outdated as of January 2010. Each solution was located with the Life Scan glucometer on each floor, and was the only low test solution available. During interviews with LPN #8 and RN #4 immediately after the observations, both nurses stated the outdated solutions were the only test solutions available for each glucometer, and verified that the solutions were outdated.	F 503	Coordinator/designee to check for expiration dates of glucometer test solution prior to use in order to identify and dispose of outdated product. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit of glucometer test solutions will be done by nursing management/designee to identify other outdated product. Items will be discarded as appropriate.	

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F 503	Continued From page 68 Interview with the third floor unit manager on 5/20/10 at 5 PM, revealed the night shift staff performed quality control procedures for each glucometer in the facility, which included use of the low test solution.	F 503	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Prior to use nurses will check the glucometer test solution for expiration and corrective action will be taken as indicated. An audit tool will be used nursing management/designee to routinely audit glucometer test solutions for expiration dates. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The DNS/designee will report outcomes of the audits to the Performance Improvement Committee on a monthly basis times 3 months for their review, recommendations and direction as needed. Date of compliance is July 5, 2010.	