POC accepted 3/15/12 jc

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

PRINTED: 03/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(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: CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse MDS- Minimum Data Set RN-Registered Nurse PRN-As needed Less commonly used abbreviations will be annotated in each deficiency.	F 000	F226 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of abuse of residents and misappropriation of resident property. A. On February 15, 2012 all Care Center Nursing staff attended an education in-service reviewing recognizing and reporting elder abuse and dealing with the combative resident. B. All residents have the potential to be affected by failing to ensure abuse and neglect training is provided to employees. C. Education regarding recognizing and reporting elder abuse will be provided to all staff and completed by March 16, 2012. Education regarding elder abuse will be reviewed each October during the annual mandatory facility-wide review. This education will also be provided to new employees during orientation.	
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of employee education attendance logs, and review of policies and procedures, the facility failed to ensure abuse and neglect training was provided for employees in accordance with policy and procedure requirements for 181 of 181 of care center employees. The findings were: According to Policy 2.7, entitled "In-services and Education", revised February 2011: "Facility-wide mandatory in-services, which required completion by all employees each year" included patient/resident abuse. During an interview on 2/16/12 at 1:45 PM, DON #2 confirmed the	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheri Berander — TITLE: Administrator — (X6) DATE: 3/12/12

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

MAR 20 2012 — MAR 12 2012

FORM CMS-2567(02-99) Previous Versions Obsolete — Event ID: RYRS11 — Facility ID: WY5024 — If continuation sheet Page 1 of 26

POC accepted. Call to Cheri Berander, Admn. on 3/15/12 @ 3:05pm. Janelle Cox, OSPIL

Healthcare Licensing and Surveys

Healthcare Licensing and Surveys

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F 226	Continued From page 1 mandatory yearly education had not been provided according to the policy. He further said the last time the facility provided abuse and neglect training for employees was in October 2010. During an interview with laundry staff member #1 on 2/16/12 at 10:45 AM, she stated she had not received any training for resident abuse. Interview on 2/16/12 at 9:30 AM with housekeeper #2 revealed she had not received training for abuse since she had transferred to the housekeeping department approximately two years ago. During an in interview on 2/16/12 at 9:50 AM with housekeeper #1, she said she had not received training for resident abuse since her orientation 12 years ago. Review of the employee education attendance logs revealed none of the employees, including those employees interviewed as noted above, had received abuse and neglect education and training since October 2010.	F 226	F226 Cont. D. The Education Director or designee will perform random audits monthly to ensure that all staff receives training regarding elder abuse annually. The Education Director will aggregate the random monthly data and report the results to the Administrator, Resident Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, and record review, the facility failed to ensure dignity was maintained for 1 of 11 sample residents (#41) who required assistance with dressing. The findings were: Review of the 1/25/12 admission MDS	F 241	Completion Date F241 The facility will ensure that resident care is provided in a manner that maintains or enhances dignity, respect and recognizes individuality. A. Resident # 41 expired 2/29/12. B. All residents have the potential to be affected by not providing and promoting dignity, respect, and individuality.	03/31/2012

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F 241	Continued From page 2 assessment for resident #41 revealed s/he had cognitive impairment and required total assistance with dressing. Review of the corresponding care plan showed staff were to preserve the resident's dignity when providing activities of daily living assistance. Review of the 2/9/12 interdisciplinary progress note revealed, "nursing areas of concern expressed by family" include...[resident] history of being a very proud, proper and private [person]..." Observation on 2/16/12 at 8:10 AM revealed the resident was wearing a sweater that had a partially zipped back zipper. Further observation revealed the resident's upper back and shoulders were partially exposed. At that time the visiting family member stated it was very upsetting to see the resident dressed in this manner because dressing neatly was always important to the resident when s/he was able to dress him/herself.	F 241	F241 Cont. C. Education will be provided to all nursing staff regarding resident rights and the importance of maintaining individuality, respect, and dignity while assisting with all cares. Education will be provided in the March CNA and nursing meetings. The Nursing Directors, or designee, will conduct a random audit monthly to ensure that all residents receiving ADL cares are treated with dignity and respect.	
F 278 SS=C	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278	D. The Nursing Directors will aggregate the random monthly data and report results to the Administrator, Resident Services Administrator and the Care Center Medical Director monthly and to the quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	03/31/2012

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F 278	Continued From page 3 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the MDS assessments were completed accurately at Section V for 15 of 15 sample residents (#2, #13, #18, #27, #32, #33, #34, #40, #41, #49, #60, #64, #71, #80, #85). The findings were: According to the Centers for Medicare and Medicaid Services Facility Long Term Care Resident Assessment Instrument User's Manual, Version 3.0, September 2010, page 4-7, "Written documentation of the CAA findings and decision-making process may appear anywhere in a resident's record; for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary, narrative, etc..." Review of Section V for residents #2, #13, #18, #27, #32, #33, #34, #40, #41, #49, #60, #64, #71, #80, and #85 showed, with the exception of nutrition, the date of the CAA (care area assessments) document was noted as the written documentation of CAA findings and the decision-making process in Section V. However,	F 278	F 278 The facility will ensure that the assessment accurately reflects the resident's status. A registered nurse must conduct or coordinate each assessment with appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. A. On 3/6/2012 the MDS assessment team was educated to immediately begin documenting the specific area that evidence was found to support the CAA process, and care plan decision for resident # 2, #13, #18, #27, #32, #33, #34, #40, #41, #49, #60, #64, #71, #80, and #85. This information will be listed in Section V., in the CAA Report, Narrative Summary Documentation. B. All residents have the potential to be affected by the failure to complete the MDS assessment accurately. C. Education was provided to the MDS Assessment team documenting the specific area that evidence was found to support the CAA process, and care plan decision for all residents. The MDS Director or designee will perform random audits to ensure that MDS assessments are completed accurately at section V.	

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F 278	Continued From page 4 review of the CAA summaries revealed there was no resident specific information or evidence of the decision making process. During an interview with the MDS coordinator on 2/16/12 at 1:40 PM, she verified the sources of information for the CAA document were not included in Section V or in the CAA summaries.	F 278	F278 Cont. D. The MDS Director or designee will aggregate the data and report the results monthly to the Administrator, Resident Services Administrator and the Care Center Medical Director and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to ensure staff reviewed and revised the care plan to accurately reflect the resident's status for 2 of 11	F 280	Completion Date 03/31/2012 F 280 The facility will ensure that the resident has the right to participate in planning care and that the care plan is periodically reviewed and revised by a team of qualified persons after each assessment. A. The plan of care has been updated for resident #2 by the Wound Care Nurse to ensure current interventions and resident status is reflected in the care plan. A. The plan of care has been updated for resident #32 by the Wound Care Nurse to ensure current interventions and resident status is reflected in the care plan.	

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F 280	Continued From page 5 sample residents (#2, #32). The findings were: 1. Review of the 12/27/11 care plan for resident #2 showed the resident had a "Current Stage III PU [pressure ulcer] on right gluteal fold." Further, the care plan showed the treatment of the wound included cleansing the wound with each dressing change every two hours as needed. An observation on 2/14/12 at 11:15 AM showed two staff members transferred the resident to the restroom. There was no dressing observed on the buttocks at that time. Review of the Photographic Wound Documentation form dated 1/23/12 showed the wound on the right gluteal fold was healed. Interview with the wound care nurse on 2/16/12 at 11 AM revealed the wound had healed but she had not yet updated the care plan. 2. Review of the nurses' notes dated 2/15/12 for resident #32 showed the resident had a wound/pressure ulcer on his/her left outer ankle and right second toe. In addition, the resident wore padded boots on both feet. Review of the Photographic Wound Documentation form dated 2/9/12 showed the resident had a wound on the distal side of his/her left foot. Further, the wound type was documented as a stage II pressure ulcer. Review of the resident's care plan showed no plan of care for the wound located on the distal side of his/her left foot. During an interview with the wound care nurse on 1/16/12 at 1 PM, she said she was responsible for updating the care plans for residents with pressure ulcers. She further verified she had not updated the plan of care to address the pressure ulcer on the distal side of the left foot.	F 280	F280 Cont. B. All residents have the potential to be affected by failure to review or revise the plan of care. C. The Wound Care Nurse will develop a tracking tool to ensure care plans for all residents are reviewed/revised and that the care plans accurately reflects resident status. The MDS Director or designee will perform a random monthly audit to ensure that the appropriate plan is in place and accurately reflects the current interventions and resident status. D. The MDS Director will aggregate the random monthly audit data and report the results monthly to the Administrator, Resident Services Administrator and the Care Center Medical Director and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	03/31/2012
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=D	Continued From page 6 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed the physician's order in regard to the amount of Jevity administered via the percutaneous endoscopic gastrostomy (PEG) tube for 1 of 2 sample residents (#40) who had PEG tubes. In addition, the facility failed to ensure staff followed the physician's order in regard to medications for 2 of 15 sample residents (#33, #40). The findings were: 1. Review of the December 2011 physician's orders for resident #40 showed an order for Jevity (nutritional supplement) via the PEG tube four times per day for a total of 6 cans (1.5 cans per feeding). On 12/6/11, the physician changed the order to read "Dietary - please increase [the] feeds to [a] total [of] 7 cans [of] Jevity daily due to weight loss." This order increased the amount per feeding from 1.5 cans to 1.75 cans per feeding. Review of the January 2012 MAR showed for the first 5 days of the month, only 1.5 cans of Jevity were given four times per day, instead of the 1.75 cans per feeding as ordered. Interview with RN #1 on 2/14/12 at 11:48 AM verified the order for the amount of Jevity administration was not followed as written by the physician. 2. Review of the medical record for resident #33 showed the resident had diagnoses including	F 281	P281 The facility will ensure that services provided meet professional standards in accordance with each resident's written physician's orders. A. All nursing staff will be instructed to follow physician's orders for administration of the supplement feeding via the percutaneous endoscopic gastrostomy (PEG) tube for resident #40, ensuring professional standards. A. All nursing staff will be instructed to follow physician's orders for medication administration, monitoring, and reporting for resident #33, ensuring professional standards. A. All nursing staff will be instructed to follow physician's orders for medication administration, monitoring, and reporting for resident #40, ensuring professional standards. B. All residents have the potential to be affected by not following the physician's orders.	

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F 281	Continued From page 7 hypertension and atrial fibrillation. Review of the physicians communication sheet dated 12/3/11 showed the resident had a low heart rate and the nursing staff was holding his/her digoxin (used in the treatment of atrial fibrillation) on some mornings. Therefore, on 12/6/11, the physician ordered the digoxin to be decreased to 0.125 mg every other day. The following concerns with not following the physician's orders for medication monitoring were identified: a. Review of the physician's order on 12/13/11 showed staff should take a blood pressure (B/P) reading and pulse daily for seven days to monitor and evaluate the effectiveness of the decrease in the digoxin. The results were to be sent to his office along with the MAR after the seven day trial of a lower dosage. However, review of the December 2011 MAR, the nursing notes, and the vital sign flow sheet showed the resident's B/P and pulse were performed and recorded only on three of the seven days. b. Review of the medical record showed no evidence the B/P and pulse readings were sent to the physician as ordered after the seven day trial of a change in dosage. Interview with DON #2 on 2/16/12 at 2:46 PM revealed he had not found any additional documentation related to the physician's order. 3. Review of the medical record for resident #40 showed s/he was admitted 5/26/11 with multiple diagnoses including Parkinson's disease. Review of the January 2012 physician orders showed an order for Sinemet 25/100 mg six times per day. Review of the February 2012 long term care physician orders showed the Sinemet order changed to read one tablet of Sinemet 25/100 mg five times daily, one in the morning, one at noon,	F 281	F281 Cont. C. Education will be provided to all nursing staff regarding the importance of following physician orders. Education will be provided in the March nursing meeting. A random audit of Medication Administration Records (MAR) and physician orders will be performed nightly by nursing staff and by the Directors of Nursing monthly. D. The Nursing Directors will aggregate the random monthly data and report results to the Administrator, Resident Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 03/31/2012	

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F 281	Continued From page 8 one in the afternoon, one at bedtime, and one at night. However, review of the February 2012 MAR showed the medication was given six times per day, one additional dose, for the first five days of February 2012. Interview with LPN #1 on 2/16/12 at 5:48 PM revealed she was unaware the order for Sinemet had been reduced from six times per day to five times per day. She acknowledged the physician's order was not followed as written. According to the Wyoming Nursing Practice Act of July 2011 and the Administrative Rules and Regulations of November 2011, page 3-6, nursing must function under the direction of a licensed physician.	F 281		
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 staff interview and medical record review, the facility failed to ensure staff followed the plan of care in a variety of areas for 2 of 11 sample residents (#27, #33). The findings were: 1. Review of the physician order recapitulation for resident #27 showed s/he had diagnoses including hypertension. Review of the 1/10/12 care plan showed the resident should have his/her blood pressure (B/P) checked daily. Review of the vital sign flow sheet for the month	F 282	F 282 The facility will ensure that services are provided by qualified persons in accordance with each resident's written plan of care. A. All nursing staff will be instructed to follow the plan of care for resident #27 which states, "...monitor blood pressure and pulse daily". Staff will obtain daily blood pressure and pulse and it will be reflected on the resident's record. A. All nursing staff will be instructed to follow the plan of care for resident #33 which states, "....Determine intensity, character, frequency, pattern, location, duration and precipitating and relieving factors of pain...Monitor medication effects within 2 hours of administration and document results....". Nursing staff will perform a standardized pain assessment prior to resident receiving pain medications and pain will be reassessed within two hour following administration. B. All residents have the potential to be affected by not following the resident's individualized care plan.	

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F 282	Continued From page 9 of January showed the B/P was taken only twice in January, 1/1/12 and 1/17/12. Review of the vital signs flow sheet for February 2012, from the first through the sixteenth, showed the B/P was taken on 2/5/12, twice on 2/9/12, once on 2/13/12, and once on 2/16/12. Interview with both DONs on 2/16/12 at 10:20 AM verified the B/P was not taken daily as indicated on the care plan but that it should have been. 2. Review of the 12/27/11 care plan for pain for resident #33 showed s/he was to be assessed for pain. In addition, after s/he received pain medication, it's effectiveness was to be assessed within two hours and the results were to be documented. Review of the November 2011 MAR showed the resident had an order to receive acetaminophen 650 mg every four hours as needed for headache/musculoskeletal pain. Further review of the November 2011 MAR showed the resident received 13 doses of pain medication. Review of the nursing notes for those 13 times, showed no evidence a pain assessment or re-assessment was performed 11 times. Review of the December MAR showed pain medication was given five times. Review of the nurses' notes showed no evidence a pain assessment or re-assessment was performed two of the five times. The January 2012 MAR showed the resident received pain medication one time, however, there was no evidence a pain assessment or re-assessment was completed. Interview with the DON #2 on 2/16/12 at 2:45 PM verified the above noted assessments and re-assessments were not performed. Further, he stated the documentation was "Not good."	F 282	F282 Cont. C. All nursing staff will be educated on the importance of following the resident's plan of care in the March nursing and CNA meetings. The Nursing Directors, or designee, will conduct a random audit monthly to ensure that all services provided by staff are in accordance with the resident's written plan of care. D. The Nursing Directors will aggregate the random monthly data and report results to the Administrator, Resident Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	03/31/2012
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 10 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of policies and procedures, the facility lacked evidence nursing staff provided the necessary assessments, monitoring, and nursing measures to ensure adequate pain management for 1 (#18) of 9 sample residents who had pain. The findings were: Review of the 1/31/12 significant change MDS assessment for resident #18 showed s/he experienced moderate pain frequently and that it limited his/her day-to-day activities. Review of the 1/31/12 care area assessment (CAA) for pain showed the resident had a change in sleep pattern and had exhibited more aggressive behaviors which staff believed might be related to the presence of pain. Additionally, review of the CAA showed the resident had an increase in functional loss, and was more dependent upon staff for activities of daily living. Continued review of the CAA showed the resident's mobility was very limited and his/her activities were curtailed due to the pain. Review of the January 2012 long term care physician orders showed an order for Norco 5/325 milligrams (mg) 1 to 2 tablets every 6 hours as needed for pain. In addition, there	F 309	F 309 The facility will ensure that all necessary assessments and monitoring are implemented for preventive pain management A. All nursing staff will be instructed to follow resident #18 physician's orders for pain medication administration. Nursing staff will perform a standardized assessment prior to resident #18 receiving pain medications and pain level will be reassessed within two hours. Staff will provide the appropriate medication and dose for ongoing pain needs in addition to non-pharmacological interventions. Nursing staff will report to physician when pain medication is ineffective. B. All resident have the potential to be affected by failure to assess pain before and after pain medication administration and providing the appropriate medication and dose for ongoing pain needs. C. All nursing staff will be educated to assess and document pain using the standardized scale and reassessment of pain within 2 hours of medication administration. Staff will also be educated on providing the appropriate pain medication for residents ongoing pain needs, in addition to non-pharmacological	

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	535046	A. BUILDING _____ B. WING _____	02/16/2012

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F 309	Continued From page 11 were orders for Tylenol 650 mg every four hours as needed. Review of the 1/31/12 care plan showed an intervention was to monitor the effects of a pain medication within one to two hours after administration and to document the effectiveness of the medication in alleviating the pain. The following concerns with pain management were identified: a. Review of the 12/9/11 nursing notes written at 1:43 PM showed the resident complained of pain in his/her lower back. Further review revealed the resident was unable to rate the pain on a scale of 0-10 but was administered one tablet of Norco (pain medication) 5/325 mg at 1:30 PM. According to these nursing notes, the patient said s/he had pain "all the time." Review of the 12/9/11 nursing notes written at 9:05 PM showed upon re-assessment of the resident's pain at 4:55 PM, the resident continued to have pain despite receiving the Norco tablet at 1:30 PM (3 hours and 20 minutes earlier). Continued review of these notes revealed it was an additional hour before the resident received anything further for pain. The resident received Tylenol 650 mg at 6 PM with resolution of the pain by 6:50 PM (4 and one half hours after the pain began). Review of physician orders showed the resident could have 1 or 2 tablets for the pain, however, s/he received only one tablet. Additionally, there was no evidence non-pharmacological interventions to alleviate the pain were attempted. b. Review of the 1/23/12 nursing notes written at 8:44 PM showed the resident had pain in the surgical incision and received one Norco 5/325 mg tablet for pain management. Review of the 1/24/12 nursing notes written at 8 AM showed the resident was administered one tablet of Norco	F 309	F309 Cont. interventions. The Nursing Director will conduct random monthly audits to ensure nursing staff assess, reassess, document, and use pain medications appropriately. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator, Resident Services Administrator and the Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	03/31/2012

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F 309	Continued From page 12 5/325 mg at 1:20 AM for the pain, 4 and one half hours after the pain began. Review of the January 2012 MAR verified no pain medication was administered from 8:44 PM until 1:20 AM. Additionally, there was no evidence non-pharmacological interventions to alleviate the pain were attempted. c. Review of the 1/25/12 nursing notes written at 4 AM showed the resident had requested pain medication and was administered one tablet of Norco 5/325 mg at 2 AM. Continued review of these notes showed the patient's hip was "hurting." Review of the 1/25/12 nursing notes written at 7:21 AM revealed the resident was administered one tablet of Norco 5/325 mg at 6 AM to address the resident's continued pain, which started at 2 AM was rated at 8 out of 10, and lasted four hours without relief. Review of physician orders showed the resident could have 1 or 2 tablets for the pain, however, s/he received only one tablet. In addition, there was no evidence non-pharmacological interventions to alleviate the pain were attempted d. Interview with both DONs, the administrator, the administrator in training, and the MDS coordinator on 2/16/12 at 10:20 AM revealed all pain assessments were written in the progress notes. If the pain re-assessment was not in the progress notes, it was probably not performed. DON #1 further said all pain medications should be re-assessed within 1 to 2 hours after administration. In addition, DON #1 said because the resident's pain was not managed adequately and had not been for at least two months, the physician changed the PRN Norco 5/325 mg from 1 to 2 tablets every 6 hours to 1 to 2 tablets every 4 hours. e. Review of the facility's policy on pain	F 309		

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F 309	Continued From page 13 assessment and management, reviewed 4/11, showed "The ...resident's pain will be re-assessed after every pain control mechanism employed by the ...resident care providers as per the appropriate care setting procedure. The timing of the reassessment ....will be dependent upon the route of administration. The reassessment will be,...2 hours for oral and will be documented in the appropriate portion of the medical record."	F 309	F325 The facility will ensure that a resident maintains acceptable parameters of nutritional status such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. A. All nursing staff will be instructed to follow physician's orders for administration of the supplement feeding via the percutaneous endoscopic gastrostomy (PEG) tube for resident #40, ensuring adequate calories and protein are provided. B. All residents receiving nourishment via a PEG tube have the potential to be affected by not following the physician's orders. C. Education will be provided to all nursing staff regarding the importance of following physician orders. Education will be provided in the March nursing meeting. A random audit of Medication Administration Records (MAR) and physician orders will be performed nightly by	
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure staff provided an adequate amount of nutrition via the percutaneous endoscopic gastrostomy (PEG) tube for 1 of 2 sample residents (#40) who had PEG tubes. The findings were: Review of the 11/22/11 quarterly MDS assessment for resident #40 showed s/he required total assistance with nutrition by means	F 325		

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F 325	Continued From page 14 of a PEG tube. Review of the December 2011 physician's orders showed an order for Jevity (nutritional supplement) via the PEG tube four times per day for a total of 6 cans (1.5 cans per feeding). On 12/6/11, the physician changed the order to read "Dietary - please increase [the] feeds to [a] total [of] 7 cans [of] Jevity daily due to weight loss." This order increased the amount per feeding from 1.5 cans to 1.75 cans per feeding. Review of the January 2012 MAR showed for the first 5 days of the month, only 1.5 cans of Jevity were given four times per day, instead of the 1.75 cans per feeding as ordered. During an interview with RN #1 on 2/14/12 at 11:48 AM, she acknowledged the error in the amount of Jevity provided resulted in not meeting the nutritional needs of the resident.	F 325	F325 Cont. nursing staff and by the Directors of Nursing monthly. D. The Nutrition Services Director will aggregate random monthly data and report results to the Administrator, Resident Services Administrator, and the Care Center Medical Director and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free of any significant medication errors for 2 of 11 sample residents (#33, #40). The findings were: 1. Review of the medical record for resident #33 showed the resident had diagnoses including hypertension and atrial fibrillation. Review of the physician's communication sheet dated 12/3/11 showed the resident had a low heart rate and the nursing staff was holding his/her digoxin (used in	F 333	Completion Date F333 The facility will ensure that residents are free of any significant medication errors. A. Unable to address past medication omissions on Medication Administration Record (MAR) for resident #33 Nursing staff will be instructed to follow physician's orders and 5 Rights of Medication	03/31/2012

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F 333	Continued From page 15 the treatment of atrial fibrillation) on some mornings. Therefore, on 12/3/11, the physician ordered the digoxin to be decreased to 0.125 mg every other day. The following concerns were identified: a. Review of the physician's order on 12/13/11 showed staff should take a blood pressure (B/P) reading and pulse daily for seven days to monitor and evaluate the effectiveness of the decrease in the digoxin. The results were to be sent to his office along with the MAR after the seven day trial of a lower dosage. However, review of the December 2011 MAR, the nursing notes, and the vital sign flow sheet showed the resident's B/P and pulse were performed and recorded only on three of the seven days. b. Review of the medical record showed no evidence the results of the blood pressure and pulse rate readings were sent to the physician as ordered after the seven day trial of a change in dosage. Interview with DON #2 on 2/16/12 at 2:45 PM revealed he had not found any additional documentation related to the physician's order. 2. Review of the medical record for resident #40 showed s/he was admitted 5/26/11 with multiple diagnoses including Parkinson's disease. Review of the January 2012 physician's orders showed an order for Sinemet 25/100 mg six times daily. Review of the February 2012 long term care physician orders showed a change in the order from six times daily to five times daily, one in the morning, one at noon, one in the afternoon, one at bedtime, and one at night. However, review of the February 2012 MAR showed the medication was given six times per day, one additional dose, for the first five days of February 2012. Interview with LPN #1 on 2/15/12 at 5:48 PM revealed she	F 333	F333 Cont. Administration, along with physician required monitoring, and reporting for resident #33. Nursing staff will monitor Medication Administration Records to ensure resident # 33's medications accurately reflect the physician's orders. A. All nursing staff will be instructed to follow physician's orders and 5 Rights of Medication Administration for resident #40, ensuring medication accuracy. Nursing staff will monitor Medication Administration Records to ensure resident # 40's medications accurately reflect the physician's orders. B. All residents have the potential to be affected by not administrating medications accurately or by not following the physician's orders. C. Education will be provided to all nursing staff regarding the importance of accurate administration of all	

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F 333	Continued From page 16 was unaware the order for Sinemet had been reduced from six times per day to five times per day.	F 333	F333 Cont. medications and following physician's orders. Education will be provided in the March nursing meeting. A random audit of Medication Administration Records (MAR) and physician order documentation will be performed nightly by nursing staff and by the Directors of Nursing monthly. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator, Resident Services Administrator and the Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to take precautionary measures to prevent possible sewage back up into the facility's coffee machine located in the kitchen/dining area during 1 of 1 random observations. The findings were: Observation on 2/15/12 at 2:48 PM showed there was a one inch discharge drain hose leading from the coffee machine into a floor drain. The end of the tube was below the flood level rim of the discharge well. At the time of the observation, the facility kitchen manager confirmed the tube was below the flood level rim and presented a potential sanitary issue. According to Food Code 2009, U.S. Public Health Service: 5-202.13 Backflow Prevention, Air Gap. An air gap between the water supply inlet and the	F 371	Completion Date 03/31/2012 F371 The facility will ensure that food is stored, prepared, distributed and served under sanitary conditions.	

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F 371	Continued From page 17 flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less that 26 millimeters (1 inch).	F 371	F371 Cont. A. The T-valve hose was replaced on 2/28/2012 to prevent backflow in order to ensure sanitary conditions. B. All residents have the potential to be affected by food that is not stored, prepared, distributed and served under sanitary conditions and drain hoses not being maintained properly. C. The Dietary Manager will perform random audits monthly to check that all drains have an air gap between the water supply inlet and the flood level rim of the plumbing fixture. D. The Nutrition Services Director will aggregate random monthly data and report results to the Administrator, Resident Care Services Administrator, and the Care Center Medical Director and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 441 S&S=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an infection control program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	Completion Date	03/31/2012

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F 441	Continued From page 18 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy and procedure and the Centers for Disease Control recommendations, the facility failed to ensure staff followed appropriate infection control practices during 2 random observations of staff performing glucose testing for 4 residents (#60, #54, #73, #92). The facility further failed to ensure staff complied with recognized guidelines for hand-hygiene while providing resident care during 5 random observations. The findings were: In regard to glucometers: According to the Centers for Disease Control recommendations, "Glucometers should be assigned to individual patients. If a glucometer that has been used for one patient must be reused for another patient, the device must be cleaned and disinfected." Recommended infection-control and safe injection practices to prevent patient-to-patient transmission of bloodborne pathogens, Centers for Disease Control website, 2005. Available at: www.cdc.gov/hepatitis/Resources/OrderPubs/HealthProf/PrevP-to-PTransHandout_Eng.pdf. Accessed May 10, 2010. The following concerns were identified: a. On 2/14/12 at 11:20 AM LPN #2 was observed using a glucometer for glucose testing	F 441	F441 The facility will ensure that staff wash their hands after each direct resident contact and follow infection control practices during cleaning of glucometers. A. LPN # 2 will be educated regarding the need to disinfect the glucometer after each use with resident # 54. The Infection Prevention practitioner will research alternative disinfecting agents and recommend solution that meets disinfecting guidelines. A. RN #1 will be educated regarding the need to disinfect the glucometer after each use with resident # 73, 50, & 92. The Infection Prevention practitioner will research alternative disinfecting agents and recommend solution that meets disinfecting guidelines. A. Policy A. 101 "Waived Laboratory Testing" will be revised to include directions to clean and disinfect the glucometer after each use. A. CNA # 2 will be educated regarding infection control practices and washing hands between contact with resident # 38, #41, and #46.	

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F 441	Continued From page 19 for resident #54. Continuous observation revealed the LPN completed the task without cleaning or disinfecting the glucometer after use. Interview with the LPN on 2/14/12 at 12:10 PM revealed she routinely cleaned/disinfected the glucometer after she completed the testing for all the residents instead of between residents because the disinfectant solution affected the glucometer screen. b. On 2/14/12 from 11:40 AM to 11:55 AM RN#1 was observed using a glucometer for glucose testing for residents #73, #50 and #92 without cleaning or disinfecting the glucometer between resident use. Interview with the RN on 2/14/12 at 11:55 AM revealed she knew she should disinfect/clean the glucometer after use, but she did not do this because the disinfecting solution "fogs up" the machine. c. Review of the facility Policy A.101, entitled, "Waived Laboratory Testing", revised May 2011, revealed the policy included instructions for cleaning and disinfecting the glucometer, but directions for performing the procedure after each use were lacking. During an interview with the Administrator on 2/16/12 at 9:30 AM, she stated she did not know the policies and procedures did not include directions to clean and disinfect the glucometer after use. She further stated staff were expected to clean/disinfect the glucometers after each use and the policies and procedures needed to be revised to include this. In regard to hand hygiene: 1. The Centers for Disease Control & Prevention (CDC) Guideline for Hand Hygiene in Health-Care Settings, published in Mortality & Morbidity Weekly Report, RR-16, October 26, 2002, pp	F 441	F441 Cont. A. CNA #3 will be educated regarding infection control practices and washing hands between contact with resident # 21, # 107, and #42. A. The transportation aide will be educated regarding infection control practices and washing hands between contact with resident # 22, and #50. B. All residents have the potential to be affected by failure to follow infection control practices during cleaning of glucometers and the failure to wash hands after each direct resident contact. C. An education in-service will be conducted during March Nursing staff meetings regarding the need to follow infection control practices during cleaning of glucometers after each use and to follow infection control practices by washing hands between each resident contact. The Nursing Director or designee will conduct random monthly audits to ensure staff is cleaning glucometers between each use. The Education Director or designee will	

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F 441	Continued From page 20 32-33, strongly recommends healthcare workers perform hand hygiene after contact with patients [residents], after contacting environmental surfaces in the vicinity of the patient, before and after potential contact with non-intact skin [such as a wound], and after removing gloves. The following concerns were identified: a. On 2/14/12 CNA #2 was observed removing her gloves after completing resident care task without performing hand hygiene then proceeding to another task or resident room. This practice was noted during the following observations: At 4:30 PM, the CNA assisted resident #38 with toileting and personal hygiene care. The CNA completed the task, removed her gloves, put the clean disposal brief on the resident, then assisted the resident into the wheelchair. The CNA left the room, deposited the bagged trash in the appropriate receptacle, and entered another resident (#41) room without first performing hand hygiene. b. At 4:48 PM, the CNA was observed as she entered the room of resident #46 and provided toileting assistance and personal hygiene care for the resident. The CNA completed the task, removed her gloves, placed the clean disposable brief on the resident and transferred the resident to the wheelchair. The CNA combed the resident's hair and left the room with the bagged trash. After she disposed of the trash, she went into another resident's room without first performing hand hygiene. Interview with the CNA on 2/15/12 at 1:05 PM revealed she did not perform hand hygiene between tasks, after removing gloves and before leaving resident rooms on 2/14/12 because "it was such a busy day."	F 441	F441 Cont. conduct random monthly audits to ensure staff is washing hands after each direct resident contact. D. The Nursing and Education Director will aggregate the random monthly audit data and report the results monthly to the Administrator, Resident Services Administrator, and Care Center Medical Director and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	03/31/2012

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F 441	Continued From page 21 2. Observation on 2/14/12 at 8:46 AM showed CNA #3 assisted resident #21 to the bathroom. The CNA had gloves on and after she had completed his/her care, the CNA removed her gloves, and exited the resident's room. The CNA did not cleanse her hands after she removed her gloves and completed resident care. The CNA then picked up a food tray from room #107 and took it to the kitchen. 3. Observation on 2/14/12 at 12:00 PM showed CNA #3 in the dining room moving chairs. She then sat at a dining room table to assist resident #59 with his/her food. After assisting the resident she turned to assist resident #42. During the entire observation, the CNA did not perform hand hygiene. 4. Observation on 2/14/12 at 12:00 PM showed the transportation aide touched resident #22 on the back then cut his/her food. She then went to get a drink for resident #50. The transportation aide did not perform hand hygiene between residents. An interview on 2/16/12 at 9:30 AM with the transportation aide verified she understood the importance of cleansing her hands between residents. Further, she stated the facility provided hand sanitizer for individual use but she did not have any with her at the time of the observation. An interview with the DON #2 on 2/16/12 at 12:15 PM he stated staff are to cleanse their hands before and after each resident contact.	F 441		
F 496 SS=F	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification	F 496	**F496** The facility will ensure staff receives the required in-service training on abuse prevention.	

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	535045	A. BUILDING _____ B. WING _____	02/16/2012

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F 496	Continued From page 22 that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on employee record review, staff interview, and review of facility policies and procedures, the facility failed to provide the required in-service training on abuse prevention for 50 of 50 CNAs. The findings were: Review of the employee records and education	F 496	F496 Cont. A. On February 15, 2012 all Care Center Nursing staff attended an education in-service reviewing recognition and reporting elder abuse and dealing with the combative resident. B. All residents have the potential to be affected by failing to ensure abuse and neglect training is provided to employees. C. Education regarding recognizing and reporting elder abuse will be provided to all staff and completed by March 16, 2012. Education regarding elder abuse will be reviewed each October during the annual mandatory facility-wide review. This education will also be provided to new employees during orientation. The Education Director or designee will perform random audits monthly to ensure that all staff receives training regarding elder abuse annually.	

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F 496	Continued From page 23 attendance logs revealed CNA's had not received abuse and neglect education and training since October 2012. According to Policy 2.7, entitled "In-services and Education", revised February 2011: "Facility-wide mandatory in-services, which required completion by all employees each year" included patient/resident abuse. During an interview on 2/16/12 at 1:46 PM, DON #2 confirmed the mandatory yearly education on abuse prevention training for CNAs was not provided. He further said the last time the facility provided abuse and neglect training for CNA's was in October 2010.	F 496	F496 Cont, D. The Education Director will aggregate the random monthly data and report the results to the Administrator, Resident Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medical records were complete and contained accurate documentation for 2 of 11 sample residents (#60, #64). The findings were:	F 514	Completion Date F514 The facility will ensure that resident's records are in accordance with accepted professional standards that are accurate, complete, readily accessible, and systematically organized. A. Unable to address past medication omissions on Medication Administration Record (MAR) for resident #60. Nursing staff will be instructed to follow physician's orders and 5 Rights of Medication Administration, including accurate and complete documentation for resident medications and treatments for resident #60.	03/31/2012

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F 514	Continued From page 24 1. Review of the medical record for resident #60 showed the physician ordered Estrogen Cream 0.625 milligrams (mg) to be applied every Monday and Thursday. According to the documentation on the December 2011 and January 2012 MAR, there was no documentation to show the resident received the medication as ordered on one of the nine days in December and two of eight days in January as scheduled. Interview with DON #1 on 2/16/12 at 2:45 PM revealed she was unable to confirm whether or not the resident received the medication because she was unable to find any documentation that explained the blank areas on the MAR. Interview on 2/16/12 at 3 PM with DON #2 revealed the facility did not have a system for periodically reviewing records for accuracy and completion. 2. Review of the medical record for resident #64 revealed the resident was admitted on 5/24/11 with multiple diagnoses including hypertension. The anti-hypertensive medication Lisinopril 10 mg two times per day was prescribed at the time of admission. On 6/23/11 an additional hypertension drug was prescribed which was hydrodiuril, 25 mg daily every morning. The following concerns with documentation were identified: a. Review of the December 2011 MAR revealed no evidence staff administered the Lisinopril on the afternoon of 12/24/11. In addition, the hydrodiuril was not signed as administered on 12/19/11, 12/20/11, 12/24/11, and 12/30/11. b. Review of the January 2012 MAR revealed no evidence staff administered Lisinopril on the afternoon of 1/4/12 and 1/26/12. c. Interview with RN #1 on 2/14/12 at 11:48	F 514	F514 Cont. A. Unable to address past medication omissions on Medication Administration Record (MAR) for resident #64. Nursing staff will be instructed to follow physician's orders and 5 Rights of Medication Administration, including accurate and complete documentation for resident medications and treatments for resident #64. B. All residents have the potential to be affected by not administrating medications accurately, following the physician's orders and accurate, complete documentation. C. Education will be provided to all nursing staff regarding the importance of accurate administration of all	

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F 514	Continued From page 25 AM revealed "staff probably missed charting on those days."	F 514	F514 Cont. medications, following physician orders and accurate, complete documentation. Education will be provided in the March nursing meeting. A random audit of Medication Administration Records (MAR) and physician order documentation will be performed nightly by nursing staff and by the Directors of Nursing monthly. D. The Nursing Directors will aggregate the random monthly audit and report results to the Administrator, Resident Services Administrator and the Care Center Medical Director monthly and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	03/31/2012