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

PRINTED: 04/05/2013
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 |
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| | 535051 | A. BUILDING _____ B. WING _____ | C 03/28/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THERMOPOLIS REHABILITATION AND CARE CENTER | PO BOX 1325 THERMOPOLIS, WY 82443 |

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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations are used throughout this document:<br>ADL - Activities of Daily Living<br>CAA - Care Area Assessment<br>DON - Director of Nursing<br>IP - Infection Preventionist<br>LPN - Licensed Practical Nurse<br>MAR - Medication Administration Record<br>MDS - Minimum Data Set<br>mg - milligram<br>prn - As needed<br>RN - Registered Nurse | F 000 | Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal state and law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date. The facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary. | |
| F 164 SS=D | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information | F 164 | **F164 Personal Privacy**<br><br>Resident #8 is to have physical examinations performed by the physician in the privacy of own room.<br><br>The facility ensures that resident privacy is maintained during physician visits.<br><br>The physician will be in-serviced on the importance of conducting physical examinations in a manner that will maintain resident privacy. To be completed by the DNS/designee.<br><br>Three random audits of physicians conducting physical examinations will be completed each week to ensure | 5-12-13 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Walter Tendall — TITLE: Administrator — (X6) DATE: 4/26/13

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.



4-26-13 11:20A - Adm. notified - POC accepted. Rae Anne White

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| F 164 | Continued From page 1<br>contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure privacy was maintained during a physician visit for one non-sample resident (#8). The findings were:<br><br>Observation on 3/27/13 at 11:50 AM showed physician #1 examined and interviewed resident #8 in the Aspen dining room. At this same time there were seven other residents in the dining room waiting for lunch to be served. The physician assessed the resident's heart and lung sounds and also examined the skin on the resident's forehead. The physician was also heard asking the resident about his/her elimination habits/function.<br><br>Interview on 3/27/13 at 3:10 PM with CNA #1 verified this was customary practice for the physician to interview and examine residents in public areas with other residents present. | F 164 | resident privacy is maintained x 90 days. To be completed by the DNS/designee.<br><br>Audit findings will be reviewed at CQI. | |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>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. | F 248 | **F248 Activities**<br><br>Resident # 9 is attending activities of choice including bingo.<br><br>The facility ensures that resident's attend activities of their choice. | 5-12-13 |

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| F 248 | Continued From page 2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and resident interview, and medical record review, the facility failed to ensure the activity interests for 1 of 11 sample residents (#9) were met. The findings were:<br><br>Review of the 5/11/12 initial activity assessment showed resident #9 enjoyed playing Bingo. Review of the 1/28/13 activity assessment further showed the resident required assistance to attend activities, had appropriate behaviors in activities, preferred to be out of his/her room, enjoyed large and small groups, communicated verbally and was able to make needs known. The following concerns were identified:<br>a. Interview with the resident on 3/27/13 at 9:15 AM revealed s/he was not able to attend the evening Bingo games held every week on Tuesdays and Thursdays at 7:15 PM. The resident stated s/he required staff assistance to transfer and most evenings the staff were unable to assist him/her. The resident further stated s/he was told by a CNA there was not enough staff and that was the reason they could not assist him/her to get to the Bingo games.<br>b. Review of the March 5-26, 2013 Bingo activity record showed the resident was in attendance 1 out of 7 times.<br>c. Interview with CNA #2 on 3/27/13 at 6:45 PM verified once the resident was laid down after dinner, s/he was not gotten up again until the morning. The CNA further explained the night shift had not been trained on how to transfer the resident. She stated the resident had a hip surgery and there were special precautions that needed to be followed. | F 248 | The nursing staff will be in serviced on the importance of ensuring that residents are out of bed so that may attend the activity of their choice. To be completed by the DNS/designee.<br><br>The certified nursing staff will be in serviced on the proper transfer technique for those residents with hip precautions to ensure a safe transfer. To be completed by the DNS/designee.<br><br>Three random resident audits will be completed each week to ensure that the residents have been out of bed and available to attend the activity of their choice x 90 days. To be completed by the DNS/designee.<br><br>Three random audits will be completed each week on those residents with hip precautions to ensure that proper transfer techniques have been utilized x 90 day. To be completed by the DNS/designee.<br><br>Audit findings will be reviewed at CQI. | |

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| F 248 | Continued From page 3<br>d. Review of the physical therapy notes dated 2/26/13 at 9:51 PM showed the therapist "helped trained CNAs and pt [patient] concerning transfer from bed to chair maintaining hip precautions." In addition, review of a physician order dated 3/13/13 showed the hip flexion restrictions had been discontinued.<br>e. Interview with LPN #1 on 3/28/13 at 8:43 AM verified all the CNAs should have been trained and the resident should have been transferred so s/he could attend the Bingo activities. | F 248 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain a clean and orderly environment for residents on 3 of 4 units (C, D, and E Halls). The findings were:<br><br>Observations during the survey showed the following housekeeping and maintenance concerns:<br><br>1. Floors in the entry foyer, D and E Halls, and TV common area had accumulated dirt and debris built-up in corners, behind doors, and around protrusions from floor-mounted heaters.<br><br>2. Corners and edges of walls in both the D and E Halls were gouged, marred, and exposed peeling | F 253 | **F253 – Housekeeping and Maintenance**<br><br>The floors in the entry foyer, D and E Halls, TV common area, including the corners, behind doors and around the floor-mounted heaters have been cleaned.<br><br>The corners and edges of the walls in the D and E Halls have been repaired and painted.<br><br>The wooden trim on the counter top of the primary nurse's station, adjacent to the main dining room was repaired.<br><br>The floor-mounted heater near room 30 was cleaned.<br><br>The windows at the end of the C Hall were cleaned of accumulated insects. | 5-12-13 |

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| F 253 | Continued From page 4<br>or chipped paint.<br><br>3. The wooden trim below the counter top at the primary nursing station, adjacent to the main dining room, was gouged and discolored over approximately 15% of its exposed surface.<br><br>4. A floor-mounted heater in the vicinity of room 30 contained paper trash and a heavy accumulation of dust and debris. The heaviest accumulation within the heater was the area obscured by a fire door.<br><br>5. Two windows at the end of the C Hall adjacent to a staff break area contained significant accumulations of insects.<br><br>6. Plastic covered handrails were used in several areas of the facility. Several sections of these rails in the C Hall were separating at connecting surfaces and had holes penetrating the outer covering, presenting a non-cleanable surface.<br><br>The housekeeping supervisor acknowledged the above deficiencies in interview on 3/28/13 at 10:10 AM. | F 253 | The handrails in the C Hall were repaired and/or replaced with a cleanable surface.<br><br>The facility ensures that the interior is maintained in a sanitary, orderly and comfortable manner.<br><br>The Housekeeping supervisor, Maintenance Supervisor, Housekeeping Staff and Maintenance staff will be in serviced on the importance of maintain a sanitary, orderly and comfortable environment for the residents. To be completed by the Administrator.<br><br>Five random environmental observation audits will be conducted weekly to ensure that the facility is maintained in a sanitary, orderly and comfortable manner x 90 days. To be completed by the Administrator/designee.<br><br>Audit findings to CQI. | |
| F 273 SS=D | 483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT<br><br>A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) | F 273 | **F273 – Comprehensive Assessments**<br><br>Resident #47 MDS's are current.<br><br>The facility ensures that comprehensive MDS's are completed within 14 calendar days after admission. | 5-12-13 |

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| F 273 | Continued From page 5<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to complete a comprehensive MDS assessment of a newly admitted resident in a timely manner for 1 non-sample resident admitted on 3/4/13. The findings were:<br><br>Resident #47 was admitted to the facility on 3/4/13 with diagnoses to include Alzheimer's disease and chronic obstructive pulmonary disease. The following concerns with timely assessment were identified:<br>a. Review of the resident's medical record on 3/27/13 showed the admission MDS assessment had not been completed.<br>b. Review of the admission MDS assessment signed 3/27/13 showed the assessment was completed on that day, 23 days after admission; 9 days after it was due.<br>c. Interview with the MDS coordinator on 3/27/13 at 4 PM revealed she was "just finishing" the admission MDS assessment, and that she was "behind" on the assessment for this resident. | F 273 | The MDS coordinator will be in serviced on the importance on the timely completion of MDS assessments within 14 calendar days after admission. To be completed by the DNS/designee.<br><br>All new Admission MDSs, will be audited each week to ensure their completion within 14 calendar days of the admission x 90 days. To be completed by DNS/designee.<br><br>Audit findings to CQI. | |
| F 281 SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, and staff and resident interviews, the facility failed to ensure assessments were completed in accordance with professional standards for 11 of 11 sample | F 281 | **F281- Professional Standards**<br><br>Resident #28 is receiving all medications as per physician orders.<br><br>Resident # 17's physician was notified of resident's refusal to be cathed for a urinalysis. | 5-12-13 |

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| F 281 | Continued From page 6<br>residents (#2, #5, #9, #11, #17, #20, #27, #28, #34, #41, #48). In addition, the facility failed to ensure physician orders were followed for 2 of 11 sample residents (#17, #28). The findings were:<br><br>1. Review of the following MDS assessments revealed the CAAs were completed by an LPN, and not an RN:<br>a. The 7/30/12 annual MDS assessment for resident #28.<br>b. The 9/17/12 significant change MDS assessment for resident #34.<br>c. The 10/15/12 annual MDS assessment for resident #5.<br>d. The 5/28/12 admission MDS assessment for resident #9.<br>e. The 1/21/13 significant change MDS assessment for resident #27.<br>f. The 2/25/13 admission MDS assessment for resident #20.<br>g. The 7/30/12 annual MDS assessment for resident #11.<br>h. The 1/14/13 annual MDS assessment for resident #48.<br>i. The 2/16/13 annual MDS assessment for resident #2.<br>j. The 6/18/12 annual MDS assessment for resident #17.<br>k. The 4/18/12 annual MDS assessment for resident #41.<br><br>During an interview on 3/28/13 at 8:40 AM, LPN #1 confirmed she completed and signed the CAAs. She further stated "nobody ever told me LPNs can't do."<br><br>According to the Wyoming Nurse Practice Act of July 2005 and the Administrative Rules and | F 281 | The facility ensures that all CAA assessments are completed by an RN.<br><br>The facility ensures that all physician orders are followed as written.<br><br>Licensed staff will be in serviced on the importance of informing the physician if medications are not available for administration and if a resident refuses a specific physicians order.<br><br>The MDS coordinator and DNS will be inserviced on the importance of having an RN complete the CAA to comply with the Wyoming Nurse Practice Act. To be completed by the Administrator.<br><br>RN will complete the nursing assessment portion of the CAA's.<br><br>RN will sign for completion of CAA's process.<br><br>Three random MDS audits will be completed weekly to ensure that an RN is signing off on the CAA x 90 days. To be completed by the DNS/designee.<br><br>Three random Medication Administration Record (MAR) audits will be conducted each week to | |

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| F 281 | Continued From page 7<br>Regulations of November 2003, page 3-5, (I) The registered professional nurse:<br>(A) Conducts a comprehensive health assessment that is an extensive data collection (initial and ongoing) regarding individuals, families, groups, and communities.<br>(III) "Validating, refining, and modifying the data..."<br>(B) Establishes and documents the nursing diagnosis which serves as the basis for the plan of care.<br>According to the Wyoming Nurse Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, (a) Standards related to the licensed practice nurse's contribution to the nursing practice:<br>(i) The licensed practical nurse shall:<br>(A) Contribute to the nursing assessment by:<br>(I) Collecting, reporting, and recording objective and subjective data in an accurate and timely manner. Data collection includes observation about the condition or change in condition of the client.<br><br>2. During an interview on 3/26/13 at 4:45 PM, resident #28 stated s/he was not receiving medication that his/her physician said he was going to prescribe. Review of a 3/13/13 physician's progress note showed three new medications were ordered: Naltrexone Hydrochloride 3 mg once per day, Niacin 100 mg one half hour before breakfast and bedtime, and Benfotiamine 600 mg daily. However, review of the March 2013 MAR showed the resident had not received any doses of the Benfotiamine or the Naltrexone Hydrochloride. During interviews on 3/27/13 at 3:34 PM and 3:44 PM, LPN #1 stated the facility had not been able to obtain either medication from the pharmacy. She stated the | F 281 | determine, if any residents have not received an ordered medication, and if not, whether the physician was notified x 90 days.<br><br>Three random chart audits will be completed each week to determine if the resident refused any specific physician orders and whether the physician was notified x 90 days.<br><br>Audit findings to CQI. | |

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| F 281 | Continued From page 8<br>pharmacy could not find a supplier for the Benfotiamine and the resident's insurance would not pay for the Naltrexone Hydrochloride. Furthermore, she stated the physician had not been contacted regarding the facility's failure to follow orders.<br><br>Review of medical records for resident #17 showed an order for a urinalysis dated 1/25/13. No urinalysis results were found in the record. Nursing notes dated 1/28/13 and 1/29/13 showed the resident refused to allow a urine sample to be obtained via straight catheter. Interview with DON #1 on 3/27/13 at 2:20 PM confirmed the urinalysis was not completed as ordered and the physician was not notified of the resident's refusal.<br><br>According to the Wyoming Nurse Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. | F 281 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interview, and medical record review, the facility failed to ensure the care plan was followed for 1 of 11 sample residents (#9). The findings were: | F 282 | **F282 – Care Planning**<br><br>Resident # 9 is attending activities of choice including bingo.<br><br>The facility ensures that resident's attend activities of their choice.<br><br>The nursing staff will be in serviced on the importance of ensuring that residents are out of bed so that may | 5-12-13 |

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| F 282 | Continued From page 9<br>Review of the 2/24/13 care plan for functional/ADL decline for resident #9 showed s/he required extensive to total assistance for transfers. The level of assistance was dependent on the resident's stamina and weight bearing ability. The care plan further showed if needed, staff may use either a sit-to-stand or hoyer lift. The following concerns were identified with staff following the care plan:<br>a. Interview with the resident on 3/27/13 at 9:15 AM revealed s/he was not able to attend the evening Bingo games held every week on Tuesdays and Thursdays at 7:15 PM. The resident stated s/he required staff assistance to transfer and most evenings the staff were unable to assist him/her.<br>b. Review of the March 5-26, 2013 Bingo activity record showed the resident was in attendance 1 out of 7 times for the evening Bingo games.<br>c. Interview with CNA #2 on 3/27/13 at 8:45 PM verified once the resident was laid down after dinner, s/he was not gotten up again until the morning. The CNA further explained the night shift had not been trained on how to transfer the resident. She stated the resident had a hip surgery and there were special precautions that needed to be followed.<br>d. Review of the physical therapy notes dated 2/26/13 at 9:51 PM showed the therapist "helped trained CNAs and pt [patient] concerning transfer from bed to chair maintaining hip precautions." In addition, review of a physician order dated 3/13/13 showed the hip flexion restrictions had been discontinued.<br>e. Interview with LPN #1 on 3/28/13 at 8:43 AM verified the staff should have transferred the resident so s/he could attend the Bingo activities. | F 282 | attend the activity of their choice. To be completed by the DNS/designee.<br><br>The certified nursing staff will be in serviced on the proper transfer technique for those residents with hip precautions to ensure a safe transfer. To be completed by the DNS/designee.<br><br>Three random resident audits will be completed each week to ensure that the residents have been out of bed and available to attend the activity of their choice x 90 days. To be completed by the DNS/designee.<br><br>Three random audits will be completed each week on those residents with hip precautions to ensure that proper transfer techniques have been utilized x 90 day. To be completed by the DNS/designee.<br><br>Audit findings will be reviewed at CQI. | |

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| F 371 SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to serve food under sanitary conditions for 2 of 13 (#5, #38) residents in the secure unit. The findings were:<br><br>1. Observation of the evening meal on 3/25/13 at 5:10 PM revealed resident #5 was seated at the front table in the secure unit dining room. During the observation, the resident was served a cheese sandwich, and a peanut butter and jelly sandwich. Both sandwiches were placed directly on the table in front of him/her, rather than on a plate, napkin or placemat. The table was observed to be visibly soiled with smears of unknown substances. Additionally the wooden trim around the side of the table was made of unfinished, unsealed wood.<br><br>2. Observation of the mid-day meal on 3/27/13 at 12:10 PM revealed the food for resident #5, consisting of a ham and cheese sandwich and a peanut butter and jelly sandwich, was again placed directly on the table top in front of him/her. | F 371 | **F371 – Food Procurement**<br><br>Resident #5 and #38 are being served food on either a plate, napkin or placemat.<br><br>The facility ensures that food is served under sanitary conditions.<br><br>The nursing staff and dietary staff will be in serviced on the proper policy and procedure of serving food to ensure that it is not placed directly on the table. rather on a plate, napkin or placemat. To be completed by the Food Service Director.<br><br>Three random meal and snack offering observations will be completed each week to ensure that the resident are served food that is not placed directly on the table x 90 days. To be completed by Food Service Director/designee.<br><br>Audit findings to CQI. | 5-12-13 |

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| F 371 | Continued From page 11<br>The table top was observed to be visibly soiled with crumbs and smears of unknown substances. In addition, this meal observation showed resident #38, who was also seated at the front table, placed his/her food directly on the table top before eating it.<br><br>3. During an interview with the IP on 3/27/13 at 1:35 PM, she confirmed that the front table in the secure unit was visibly soiled, and stated serving residents' food directly on the table was not acceptable. She further confirmed that the unfinished wood edge of the table could not be effectively sanitized.<br><br>According to Food Code 2009, U.S. Public Health Service 4-702.11: "UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning." | F 371 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections. | F 441 | **F441 – Infection Control**<br><br>The facility ensures that a complete and accurate surveillance program for infections and antibiotics is in place, that a safe and sanitary environment is maintained during meals, that appropriate antibiotic usage is determined based upon submitted cultures and sensitivities and that residents are offered hand hygiene prior to meals.<br><br>The administrative nursing team will be in-service on the importance of | 5-12-13 |

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| F 441 | Continued From page 12<br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and review of the infection surveillance program, the facility failed to implement a complete and accurate surveillance program for infections and antibiotic therapy and failed to maintain a safe and sanitary environment for residents during meals. The facility also failed to determine appropriate antibiotic therapy based on submitted culture and sensitivities results for 2 non-sample residents (#12, #50). In addition, the facility failed to practice acceptable hand hygiene for residents in 2 of 2 dining rooms. The findings were:<br><br>1. The infection surveillance program was reviewed with the IP on 3/27/13 at 1:35 PM. | F 441 | establishing and maintaining a complete Infection control Program that includes infection surveillance, antibiotic use as well as the antibiotic determination based upon cultures and sensitivities., providing a sanitary environment during meals, and the need to offer hand hygiene to residents prior to meals. To be completed by DNS/designee.<br><br>The McGeer's criteria will be utilized to track facility infections and antibiotic usage, as well as the cultures and sensitivities when they are obtained.<br><br>Three Random audits will be completed each week on those residents that have had signs and symptoms of infection or had antibiotics ordered, to ensure that the infection and antibiotic use is being tracked and is being appropriately used as per the culture and sensitivity x 90 days.<br><br>Three random meal audits will be performed each week to ensure that food is served in a safe and sanitary environment and that the residents are offered hand hygiene prior to the meal x 90 days. | |

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| F 441 | Continued From page 13<br>During this interview the IP self-identified deficiencies in acquiring complete and timely data, and revealed the program was principally based on passive data collection. The IP expressed frustration that only select staff members responsible for reporting information were diligent in doing so.<br><br>Review of the infection control logs for January 2013 and February 2013 revealed that bacterial cultures were performed for residents #12 and #50; however, no isolate was recorded leading to uncertainty as to whether appropriate antibiotic therapy was ordered and completed based on laboratory confirmation.<br><br>2. Observation during the 3/25/13 evening meal and 3/27/13 mid-day meal revealed that none of the 13 residents in the secure unit were offered an opportunity or assisted to practice hand hygiene. Two of these residents were noted to eat primarily with their hands. The IP stated during an interview on 3/27/13 at 1:35 PM "the expectation is that resident's hands will be washed before meals." Similarly, observations of the 3/25/13 evening meal and 3/26/13 breakfast meal in the main dining room showed facility staff failed to offer or assist residents with hand hygiene prior to eating. Staff were observed during these meals to perform hand hygiene, but failed to recognize the need for this same sanitary practice among residents. | F 441 | Audit findings to CQI. | |
| F 503 SS=D | 483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT<br><br>If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 | F 503 | **F503 – Labs** | 5-12-13 |

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| F 503 | Continued From page 14 of this chapter.<br><br>If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter.<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of product label information, the facility failed to remove expired laboratory test strips from use and, further, failed to accurately monitor laboratory testing referred to another facility for completion. The findings were:<br><br>1. Observation on 3/27/13 at 10:50 AM revealed a bottle of urine dipsticks (Roche Chemstrip 10 SG) in the nurses' station containing 52 of the original 100 test strips. Review of the label showed the test strips expired in February 2013. The unit nurse at that time, LPN #2 confirmed in interview on 3/27/13 at 10:55 AM the observed test strips were expired. She further acknowledged this was | F 503 | All lab strips utilized in the facility are current. All expired strips have been disposed of.<br>The facility ensures that current laboratory test strips are utilized and that a tracking method has been established that identifies when laboratory specimens have been picked up.<br><br>Licensed nursing staff will be in serviced on the importance of utilizing current laboratory test strips and on the laboratory specimen tracking method thus ensuring the accurate and timely completion of laboratory tests and accurate treatment of resident conditions.<br><br>All laboratory test strips will be audited weekly to ensure they are current and not outdated. All laboratory tracking sheets will be audited weekly to ensure that they are complete and that there is an accurate account of laboratory specimen test status x 90 days. To be completed by the DNS/designee.<br><br>Audit findings to CQI. | |

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| F 503 | Continued From page 15<br>the only container of urine test strips available for staff and, after checking with the supply room, discovered there were no other replacements in the facility.<br><br>2. The facility's logsheets used to track laboratory specimens submitted to an offsite laboratory for testing were reviewed with the IP on 3/27/13 at 1:50 PM. These documents were incomplete in that 6 of 26 entries failed to include the status of the laboratory report, to include test requests submitted between 2/18/13 and 3/14/13. The IP confirmed the laboratory tracking system was incomplete and she further stated that she lacked confidence the logsheets reflected the current status of resident specimens submitted for testing. The IP stated she was not aware of the status of laboratory results for those residents with incomplete information on the laboratory tracking logsheets. She acknowledged the only way for staff to accurately determine if a laboratory specimen had been sent for outside testing and results were received was to individually review resident medical records. | F 503 | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>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.<br><br>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 | F 514 | **F514 – Records**<br><br>Resident #9's pain medication effectiveness was recorded 2 out of 4 times on audit and nursing staff was in-serviced.<br><br>Resident# 20 was discharged from the facility. | 5-12-13 |

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| F 514 | Continued From page 16<br>preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure the effectiveness of prn medications were documented for 2 of 4 sample residents (#9, #20) who received prn pain medications. The findings were:<br><br>1. Review of the March 1- 24, 2013 MAR for resident #20 showed s/he received prn hydrocodone-acetaminophen 10-325, 48 times for back pain. Further review of this MAR showed the effectiveness of the pain treatment was documented 9 out of those 48 administrations.<br><br>2. Review of the March 1- 24, 2013 MAR for resident #9 showed s/he received prn ydrocodone-acetaminophen 10-325, 11 times for hip/leg pain. Further review of the MAR showed the effectiveness of the pain medication was not documented for any of these 11 administrations.<br><br>3. Interview with LPN #1 on 3/27/13 at 9:45 AM verified there were problems with the electronic medical record and although nursing was conducting the pain assessments, some of the entries were missing. | F 514 | The facility ensures that resident pain medication effectiveness is documented.<br><br>Licensed nursing staff will be in serviced on the importance of documenting the effectiveness of prn pain medications. To be completed by DNS/designee.<br><br>Five random audits of medication administration records will be completed weekly to ensure that the effectiveness of the prn medications has been recorded x 90 days. To be completed by the DNS/designee.<br><br>Audit Findings to CQI. | |