STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535034	A. BUILDING _____ B. WING _____	PP 05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN - registered nurse LPN - licensed practical nurse DON - director of nursing OT - occupational therapist PT - physical therapist/therapy PTA - physical therapy aide MDS - Minimum Data Set CNA - certified nursing assistant CAA - Care Area Assessment CAT - Care Area Triggers ADL - activities of daily living Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	Submission of the Plan of Correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged or that any regulatory violation has occurred. The following is to be considered our Credible Allegation of Compliance.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assess 2 of 2 residents (#29, #43) observed during medication passes to self-administer medications. The findings were: 1. Observation on 5/10/11 showed RN #1 prepared and administered medications to resident #29 at 8:17 AM. When handed the medications, the resident stated, "I'll take them,"	F 176	**F176** 1. Self-medication assessment was completed on Residents #29 and #43. Nurses #1 and #2 were inserviced on self-medication assessment on 5/10/11. 2. Interdisciplinary Team will review each resident chart for a completed self administration assessment. 3. Nurses will be inserviced that medications can not be left with resident unless the resident has been assessed to safely self administer medications Random medication administration audits	06/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Schultz — TITLE: Administrator — (X6) DATE: 6/20/11

POC accepted. 6/27/11 @ 9AM per telephone with Donna / RPhinney

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F 176	Continued From page 1 so the RN turned her back and walked to the medication cart where she continued preparing medications for other residents. The RN stated she would keep an eye on the resident to assure the medications were taken. However, when asked, she did not know if the resident had been assessed and care planned by the interdisciplinary team for self-administration of medications. Review of the medical record with the director of health information management (HIM) on 5/11/11 at 6:20 PM showed no evidence the assessment was conducted. 2. After handing medications to resident #43 on 5/10/11 at 8:47 AM, RN #2 was observed to turn and walk away before the resident swallowed them. The resident was out of the RN's line of sight as she walked back to the medication cart and prepared other medications. Review of the medical record with the director of HIM on 5/11/11 at 6:25 PM provided no evidence the facility performed an interdisciplinary assessment for self-administration of medications. 3. On 5/12/11 at 9:40 AM the DON verified neither resident had been assessed for self-administration of medications.	F 176	will be completed by the Director of Nursing or designee three times a week for the next 90 days and weekly thereafter for compliance to self administration of medications policy and procedures. Issues identified will be corrected immediately. 4. Weekly audits will be reviewed monthly by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	**F246** 1. Resident #1 was referred to occupational therapy for a wheelchair positioning screen on 5/25/11. Resident #5 has had wheelchair pedals lowered so distance to table is minimized. 2. Hospice residents in wheelchairs will be screened by nursing staff for proper positioning and referred to occupational therapy if needed.	06/24/11

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F 246	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to ensure adaptations were made to promote comfort and function for 2 of 11 sample residents who utilized a wheelchair (#1, #5). The findings were: 1. Review of the 1/3/11 annual and 3/22/11 quarterly MDS assessments revealed resident #1 had range of motion limitations to both lower extremities. A physician's progress note dated 5/10/11 showed the resident's ankles were plantar flexed [toes pointed]. Observation of the resident in the wheelchair on 5/9/11 at 5:10 PM, and on 5/10/11 at 7:58 AM and 9:27 AM, revealed the resident's ankles were plantar flexed, and his/her feet were not supported on the footplates of the leg rests. During the observations, the resident's feet either barely touched the footplate, or did not touch at all. Review of the medical record showed no evidence a wheelchair positioning evaluation had been completed. During an interview on 5/12/11 at 8:10 AM, the DON confirmed an evaluation for wheelchair positioning had not been done. 2. Review of the 2/22/11 quarterly MDS assessment for resident #5 showed the resident was wheelchair dependent and needed extensive or total assistance with locomotion, mobility, and positioning. According to the assessment the resident had moderate cognitive impairment, but was able to feed him-/herself with set up assistance and supervision. Observations of the dining room on 5/9/11 at 5:55 PM and on 5/10/11	F 246	Residents in dining room will be assessed for proximity to table. 3. Staff will be inserviced to be observant of wheelchair positioning, how to make a referral for therapy to screen for appropriate positioning and distance of wheelchairs to dining room tables. Audits for wheelchair positioning and wheelchair proximity to table will be done by interdisciplinary team members three times a week in conjunction with existing dining room audit. 4. The results of random weekly audits will be reviewed monthly by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	

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F 246	Continued From page 3 at 8 AM, revealed the resident was not positioned close enough to the table, and this caused him/her to spill food while eating. Further observation revealed the extended wheelchair foot and leg rests had not been adjusted to allow positioning closer to the table. During an interview on 5/10/11 at 8 AM, the resident talked about not being positioned close enough to the table and stated, "It is hard to eat." Observation on 5/10/11 at 1 PM revealed the wheelchair leg and foot rests were moved to the sides of the wheelchair instead of in front, and the resident was able to eat without spilling food.	F 246	**F248** **1.** The Activity care plan for resident #24 has been reviewed and revised by the Activity Director and Social Services Designee to accommodate this resident's medical isolation, her agoraphobia, and her refusals to participate in one-to-one activity programming.	06/24/11
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to implement an individualized program that provided life affirming activities for 1 of 11 sample residents (#24). The findings were: Observation throughout the survey showed resident #24's room was dark with the dividing and entrance curtains partially pulled. The resident shared the room and was not positioned next to the window. In addition, since returning on 5/3/11, the resident had a wound vacuum and was on isolation precautions. According to	F 248	**2.** There are no other residents in isolation. Newly readmitted residents have been reviewed for appropriateness of assessment and care plan. **3.** Activity staff will be inserviced on implementing activity plans for isolation and revisions to plan for those who refuse. Implement Activity Action plan to visit at admission, readmission and change of condition with residents to identify reasons for non-participation or identify why resident is not willing or capable of pursuing activities in or outside of room. The Interdisciplinary Team will discuss weekly at the team risk meeting any compounding factors contributing to resident's inability to participate or unwillingness to participate. Individualized one-to-one programming specific to the	

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F 248	Continued From page 4 Information documented in the discharge plan by social services on 3/8/11, the resident "wants to become more socially active." Review of the 3/15/11 admission MDS assessment showed the resident had little interest or pleasure in doing things. Review of the 3/21/11 activity assessment confirmed the resident enjoyed reading and independent activities such as word search. The record also showed another assessment had not been conducted since the resident's return on 5/3/11 with curtailed independence. Review of the life enhancement care plan showed staff were to do one-to-one visits, the resident would work on word search and read books/newspaper, and pet therapy would be encouraged during pet visits. During an interview on 5/10/11 at 9:30 AM, the resident stated s/he was unable to read in bed, did not watch television unless his/her roommate was present, and did not listen to the radio. The resident spent time "...thinking about things" as that was the "only thing to do." The resident further stated staff had not provided an individualized activity program since his/her readmission on 5/3/11. During a conversation on 5/10/11 at 9:45 AM, the resident told the occupational therapist s/he wanted "to be six feet under." Interview with the activity director on 5/12/11 at 8:15 AM confirmed the resident used to enjoy reading. He further stated the resident was "not doing much now." The director verified that a program to provide life affirming activities had not been developed for this resident.	F 248	resident's needs and interest will be developed. Life Enrichment Coordinator will audit weekly the care plan and one-to-one programming for those who are medically isolated, and cannot participate in group activities. One-to-one activity program documentation which includes the resident's response to the activity will be placed on the medical record. 4. Weekly audits of participation records and care plan review of readmitted residents will be reviewed by the Quality Assurance Committee monthly for continued compliance and direct further corrective action as needed.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250	**F250** 1. On 5/11/11 the Social Services designee immediately met with resident #24 and assessed the resident to ascertain the residents state of mind. The doctor was notified of statement and resident seen by physician that day. Occupational Therapist #1 was inserviced on 5/11/11 on the need to report to social service designee	06/24/11

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F 250	Continued From page 5 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of medical records, the facility failed to ensure staff reported comments referring to death wishes for 1 of 1 sample resident (#24). The findings were: During a conversation on 5/10/11 at 9:45 AM, resident #24 told OT #1 s/he wanted "to be six feet under." When asked on 5/10/11 at 10:53 AM if s/he had ever made that comment to other staff, the resident replied s/he made the statement to one other person. The resident was unable to positively identify the person, but thought it was a CNA. Detailed review of the medical record showed no documentation of the statement or evidence it had been acted upon. On 5/11/11 at 12:13 PM the director of social services stated she had no knowledge of the resident's comment as it had not been reported to her.	F 250	when a resident makes comments about wanting to die. 2. There are no other residents in medical isolation. 3. Facility staff and contract therapists will be inserviced to report to the Social Service designee and/or Licensed Nurse statements on any psycho-social issues relating to the well being of each resident. Each week the Social Services designee will randomly quiz staff: Has anyone of our residents made suicide statements or comments? Social Services designee will continue to assess mood on admission, readmission, significant change quarterly, and annually. Care Plan will be developed as needed. Social Services designee and Life Enrichment Coordinator will meet weekly to review coordination of care plans for residents in medical isolation. 4. The Quality Assurance Committee will review monthly the weekly quizzes of staff regarding residents comments about wanting to die. Results of quizzes will be reviewed for continued compliance and direct further corrective action as needed.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272	F272 1. Resident #1 analysis of data on the	06/24/11

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F 272	Continued From page 6 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 5 of 12 sample residents (#1, #11, #19, #22, #24) with MDS assessments. The findings were:	F 272	Care Area Assessment was completed for vision, communication, psycho-social and dental completed on 5/27/11. Resident #22 analysis of data on the Care Area Assessment was completed for pressure ulcers on 5/27/11. Resident #19 analysis of data on the Care Area Assessment was completed on 5/27/11 for psychotropic medications. Resident #11 analysis of data on the Care Area Assessment was completed on 5/27/11 for communication. Resident #24 bowel and bladder tracking will be started on 6/2/11 for 72 hrs. Analysis of findings will be done on completion. 2. Triggered Care Area Assessments for residents with admission, annual and significant change assessments will be reviewed by the MDS Coordinator for completion. Any Care Area Assessments found to be incomplete will be addressed and completed. 3. On 5/20/11 Care Plan Team was inserviced on accuracy and proper completion of the MDS. A resident	

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F 272	Continued From page 7 According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, September 2010, "Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions...This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in the MDS data...Use the information gathered thus far to make a clear issue or problem statement." The following concerns were identified: Review of the 1/3/11 annual MDS assessment for resident #1 revealed the following areas triggered and required comprehensive assessments: vision, communication, psychosocial, and dental. Review of the 11/24/10 admission MDS assessment for resident #19 showed the area of psychotropic medications triggered. However, review of the CAAs for both residents revealed no summary or analysis of data for the triggered areas. According to the 2/8/11 annual MDS assessment, resident #11 required comprehensive assessments for communication and bowel incontinence. Review of the information identified as these assessments revealed neither determined the causes and contributing factors, nor analyzed the data itemized in the gathered information. Interview with the MDS coordinator on 5/12/11 at 8:30 AM confirmed the assessments were not comprehensive. According to the 3/15/11 admission MDS assessment, resident #24 was occasionally	F 272	check-off list will be utilized when the MDS and Care Area Assessment comprehensive assessments are completed. Audits of the check-off list will be done weekly by the Director of Nursing or designee to ensure that the MDS and Care Area Assessments are completed. Assessments will be completed for any residents identified as not having assessments completed. 4. Check-off audits will be reviewed monthly by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	

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F 272	Continued From page 8 incontinent of bowel and bladder. However, review of the assessment information showed comprehensive assessments for both were not performed as an analysis of the data was lacking. Interview with the resident on 5/10/11 at 9:30 AM and medical record review revealed the urinary incontinence continued after the indwelling catheter, inserted on 3/15/11, was discontinued on 4/6/11. In addition, the resident was not re-evaluated after the catheter was discontinued. Refer to F315 for information regarding urinary incontinence. According to the 11/15/10 admission MDS assessment, resident #22 triggered for pressure ulcers and required a comprehensive assessment. Review of the assessment information showed data had been collected, but it had not been analyzed to determine causative and contributing factors. During an interview on 5/11/11 at 6:10 PM, the MDS coordinator confirmed the CAAs were not comprehensive assessments without the summary piece. She further stated the back-up MDS coordinator had completed the CAAs for the residents.	F 272		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	**F281** 1. Resident #24 continues to receive IV medication via IV pump utilizing professional standards of practice and following facility policy and procedures for administration for IV medication through central venous line. Dietary supplement order for resident #24 was received on 5/31/11. Order received 6/3/11 for wound care on resident #24's left	06/24/11

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F 281	Continued From page 9 Based on observation, staff interview, and medical record review, the facility failed to ensure staff complied with professional standards of practice. This lack of compliance related to failure to follow physicians' orders for 2 of 11 sample residents (#14, #24) and 1 non-sample resident (#43). In addition, staff failed to immediately sign out narcotics for 2 non-sample residents (#29, #43). Finally, the lack of orders for nutritional support and treatment orders for the pressure ulcer on resident #24's ankle was not clarified. The findings were: 1. Observation on 5/10/11 at 1:15 PM showed RN #2 brought LPN #2 in with her to set up an intravenous (IV) pump so she could infuse an IV medication for resident #24. The RN stated she had never seen or operated this particular kind of IV pump. The LPN set up the pump correctly, and the RN completed preparations for the infusion. However, the RN did not aspirate (pull back a small amount of blood into the tubing to assure patency) the central venous line until asked by the surveyor, nor was she able to calculate the correct rate to infuse the medication in the allotted time period. Refer to F332 for detailed information related to the medication error. In addition on 5/11/11 at 11:17 AM the RN stated she had not been instructed on use of the equipment nor completed a competency check. On 5/12/11 in interview at 9:52 AM, the DON confirmed a system to verify competencies and determine mathematical skills had not been implemented Finally, according to the medical record, resident #24 was transferred to the hospital on 4/29/11 and readmitted to the facility on 5/3/11. Review of the readmission orders showed the	F 281	ankle. RN #2 was immediately inserviced on operations of Z800 IV infusion pump. Narcotics are being signed out for residents #29 and #43 prior to administration. Celexa dosage not given to resident #43 due to telephone order discontinuing medication which was so noted on MAR. RN #1 and #2 were inserviced on signing out narcotics prior to administration. RN #2 inserviced on if a written order is illegible and is questionable for any reason, the physician is to be contacted for clarification. Weight gain for resident #14 was reported to the physician on 5/23/11. 2. Two residents have IV pumps. Review of policy and procedures have been completed and implemented. Each month the Medical Records Supervisor will provide listing of residents with controlled substances so that narcotic count sheet can be audited. Physician's orders will be audited monthly by the Medical Records Supervisor to determine if any other physician has written a order which requires the facility to report weight gain. Physician orders for readmitted residents will be reviewed within 24 hours of	

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F 281	Continued From page 10 resident returned with a wound vacuum that physical therapy was to change every other day. Neither orders to continue the previously ordered dietary supplement, nor for treatment of the pressure ulcer on the resident's left ankle were included. Refer to F325 for information related to nutrition and to F314 for details regarding pressure ulcer. Reference: Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; 1139, "Aspirate for blood return...to check for lumen patency and placement" prior to infusing fluids through a central line. Reference: Wyoming State Board of Nursing Rules and Regulations Chapter 3, revised 7/2/10. Section 2. Standards of Nursing Practice for the Registered Professional Nurse, RNs "shall: (E) Accept responsibility for judgments, individual nursing actions, competence, decisions and behavior; (F) Maintain continued competence through ongoing learning and application of knowledge to nursing practice;" Reference: Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; 568, "If a written order is illegible or is questionable for any reason, the physician must be notified for clarification." 2. Observation on 5/10/11 showed RN #2 prepared and administered medications including the narcotic, morphine sulfate for resident #43 at 8:47 AM. However, the RN failed to immediately sign out for the narcotic on the controlled substance sheet. In addition, at 10:45 AM that	F 281	readmission by Director of Nursing or designee to determine if there are physician orders to treat all assessed conditions. 3. RNs will be inserviced on administration of IV medication via Z800 IV pump utilizing professional standards of practice and following facility policy and procedures for administration of IV medication through central venous line. Nurses will be inserviced on obtaining clarification of orders that are illegible or questionable, to request nutritional supplementation when skin integrity is compromised, and reporting resident weights. Nurses will be inserviced on signing out narcotics prior to administration. Charge nurse will be inserviced to report wounds to the registered dietician. Wound and skin care will be audited - see F309 and F314. Admission and readmission orders will be audited weekly by Director of Nursing or designee for reportable weight gain and possible need for dietary supplementation. IV competency, dosage calculation and tubing changes will be audited three times a week for 90 days and weekly thereafter by Director of Nursing or designee. Medication	

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F 281	Continued From page 11 morning RN #2 viewed the recapitulation (recap) of orders for the resident and confirmed Celexa 20 milligrams (mg) was ordered daily; the physician signed the recap form on 4/12/11. Since this medication was not administered (refer to F332 for information related to the medication error), the RN reviewed the telephone orders and found it was discontinued. Instead of notifying the physician to clarify the order, the nurse wrote "DC'd [discontinued] 4/12/11" beside the order. When questioned, she was unaware this was an unacceptable standard of practice since the physician had already signed the order. On 5/11/11 at 6:45 PM the DON confirmed that a new order was needed to clarify the physician's wishes. Reference: Smith, Duell and Martin in " Clinical Nursing Skills: Basic to Advanced Skills, " Seventh Edition, 2008; 574, "Sign out for the narcotic on the narcotic sheet after taking narcotic out of drawer." Reference: Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; 568, "If a written order is illegible or is questionable for any reason, the physician must be notified for clarification." 3. At 8:17 AM on 5/10/11 RN #1 was observed to prepare and administer medications, including a narcotic and anxiolytic (another controlled substance), for resident #29. However, the RN failed to sign out for either medication on the controlled substance sheets prior to their administration. According to Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; 574,	F 281	administration audits will be completed weekly by Director of Nursing or designee. Medical Records Supervisor will review physician medication orders weekly to assure that orders have been correctly transcribed onto The Medication Administration Record. 4. The Quality Assurance Committee will review weekly wound and skin care audits, admission and readmission orders, IV competency checks, medication administration audits and physician order audits monthly for continued compliance and direct further corrective action as needed.	

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F 281	Continued From page 12 nurses are to "Sign out for the narcotic on the narcotic sheet after taking narcotic out of drawer." 4. Refer to F309 regarding the failure of nursing staff to communicate reportable weight gain for resident #14 in accordance with physician's orders. According to the Wyoming Nursing Practice Act, revised July 2010, and Chapter 3, pages 3-8 of the Wyoming State Board of Nursing's Administrative Rules and Regulations, nursing staff must function under the direction of a physician.	F 281	**F282** **1.** Nursing staff has been inserviced on the proper policy of using mechanical lifting devices for resident #1 and resident #11. Refer to F325 for protein powder. The care plan for pressure ulcer prevention and self care deficit on resident #11 has been revised for consistency. Staff has been inserviced about applying red lipstick on resident #11 and floating resident's heels. C.N.A. #9 has been inserviced on proper use of mechanical lifting devices. Resident #24's physician has been notified on 5/31/11 of resident's refusal to wear compression stockings. Staff will be inserviced to encourage good nutritional intake for this resident and all others, as well as providing set up with room trays. Refer to F248 for diversional activities. Refer to F314 for resident #48 for	06/24/11
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure staff followed the care plan for 4 of 11 sample residents (#1, #11, #24, #48). The findings were: 1. Review of the current care plan, revised 5/9/11, revealed staff were instructed to transfer resident #1 using a full body lift and the assistance of two staff. In addition, the care plan for nutrition instructed staff to add one scoop of protein powder in one food item three times per day. The following concerns were identified: a. Observation on 5/10/11 at 7:58 AM revealed CNA #8 transferred the resident from bed to the wheelchair using the full body lift (EZ	F 282		

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F 282	Continued From page 13 mechanical lift). There were no other staff present. b. Observation of the evening meal on 5/9/11 and the noon meal on 5/10/11 revealed no protein powder was added to the resident's food either by kitchen or nursing staff. Refer to F325 for details. c. During an interview on 5/12/11 at 11:15 AM, the DON stated the care plan was current. The DON stated the resident should be transferred with the assist of two staff and protein powder should be added to meals. 2. Review of the 4/26/11 care plan revealed two staff were to transfer resident #11 with a full body mechanical lift. In addition, the care plan provided staff with inconsistent instructions related to floating his/her heels when in bed. One area for pressure ulcer prevention instructed staff to float the residents heels while the plan for impaired skin instructed staff to float heels "prn" (as needed). Finally, the plan for self care deficit listed "Likes to wear red lipstick." This was also listed under "special care needs/requests" on the "Resident Status Sheet." Observations on 5/9/11 at 6:35 PM and on 5/10/11 at 12:55 PM showed CNA #9 used a sit-to-stand lift to transfer the resident into bed. Both observations showed the resident's heels were not floated. Finally, at no time during the survey from 5/9/11 through 5/12/11 was the resident observed wearing red lipstick. On 5/11/11 at 9:52 AM the DON stated the care plan should be followed. She confirmed it did no good to float the resident's heels on a prn basis; they should be floated anytime the resident was in bed. 3. According to the 3/22/11 care plan, resident	F 282	preventative care plan interventions. **2.** The Interdisciplinary Team will audit care plans of current residents with orders for compression stockings, floating heels, protein powder, and self care deficits to assure appropriateness of the care plan. Interventions will be implemented, changed or continued as indicated. **3.** Nursing staff will be inserviced on following the interventions as listed on the care plan. A list of residents who need compression stockings, heels floated, protein powder, and mechanical lifting devices will be compiled and maintained by the Director of Nursing or designee and reviewed weekly at the Interdisciplinary Risk Meeting. An ongoing random tri-weekly observation will be completed by the Director of Nursing or designee to assure compression stockings are applied, heels floated, protein powder provided and mechanical lifting devices are used. Issues identified will be corrected immediately. **4.** Results of observations for application of compression	

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F 282	Continued From page 14 #24 was to wear compression stockings, staff were to encourage good nutritional intake, and diversion activities were to be provided to help control pain. Observation from 5/9/11 through 5/12/11 showed the resident wore only gripper socks and diversion activities were not provided. In addition, observation on 5/10/11 at 9:15 AM showed an unidentified staff member brought in the resident's breakfast, set it down and left. An unidentified staff member was observed to answer the resident's call light at 9:37 AM, but no encouragement to eat the meal was provided. The overbed table holding the remains of the meal had been pushed behind the entrance curtain at 9:52 AM; the resident had eaten under 25 % of the meal. On 5/11/11 at 9:52 AM the DON stated staff were to follow the care plan. 4. Refer to F314 for information regarding the facility's failure to follow care plan interventions for preventive skin care for resident #48.	F 282	stockings, heels floated, providing protein powder and use of mechanical lifting devices will be reviewed by the Quality Assurance Committee monthly for continued compliance and direct further corrective action as needed. Results will be reviewed for three months and re-evaluated.	
F 286 SS=C	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and review of internal documentation, the facility failed to ensure 15 months of assessment data was in the active medical records and accessible to staff for 12 of 12 sample residents who had MDS 3.0 assessments (#1 #5, #11, #12, #14, #18, #19, #22, #24, #28, #48, #49). The findings	F 286	**F286** **1.** MDS 3.0 assessments for residents #1, #5, #11, #12, #14, #18, #19, #22, #24, #28, #48, and #49 have been printed. **2.** Medical records have been audited to ascertain which MDS 3.0's need to be printed. **3.** Printed MDS 3.0 will be filed alphabetically in a file cabinet at the nurses station and be accessible	06/24/11

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F 286	Continued From page 15 were: Review of the medical records for residents (#1, #5, #11, #12, #14, #18, #19, #22, #24, #28, #48, #49) revealed none of the MDS 3.0 assessments in the chart were complete. The only sections in the medical record were sections A, V (if applicable), and Z. During an interview on 5/10/11 at 3:40 PM, the MDS coordinator stated that, due to the amount of paper, she only printed out those few sections to put in the chart. She stated the complete MDS assessments were in the computer, but stated not all staff had access to the computer. Review of a list provided by the MDS coordinator revealed only six staff members, including herself, had access to the MDS assessments in the computer.	F 286	to all caregivers. The MDS Coordinator is responsible for the printing of the MDS 3.0. The Interdisciplinary team will check MDS files each month for complete printing of that month's assessments. **4.** The Interdisciplinary team will report to the Quality Assurance Committee each month on the completion of the prior month MDS task. Any concerns identified will be directed to the MDS coordinator for resolution.	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and review of information from the "Operating Standards Manual," the facility failed to ensure 2 of 3 sample residents (#18, #24) with non-pressure induced wounds received the necessary care and services to promote healing. One of 7 sample	F 309	**F309** **1.** Resident #24 has been assessed for itching. LPN #1 was inserviced on obtaining treatment orders and notifying physician of resident's continued concerns. LPN #1 and #2 have been inserviced on assessments, doctor notifications, and documentation. Resident #11 has been referred to physical therapy for assessment of pain on movement. Based on this assessment a care plan will be developed. Resident #18 treatment orders have been reviewed and physician's orders are being followed. Physical Therapist #1 has been	06/24/11

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F 309	Continued From page 16 residents (#11) reviewed for pain was not evaluated or treated to minimize or prevent pain with movement. The facility also failed to follow physician's orders for 1 of 1 resident (#14) with reportable weight gain. The findings were: 1. Observation during a dressing change on 5/9/11 at 4:45 PM showed resident #24 had three reddened areas on the right upper buttock/lower back area. Two of the areas were approximately 3.5 centimeters (cm) long and the other was approximately 1.5 cm long. The resident stated s/he had scratched the skin in several places because of itching; she also complained of severe itching at the central venous access site. The short scratch and one of the long scratches were open but not bleeding. In addition, the resident had another reddened area approximately 3.5 cm long and 0.7 cm wide with a yellowish colored center. This was located between the skin folds at the resident's posterior waist; LPN #1, present during the procedure, stated the area was new. Observation on 5/11/11 at 5 PM revealed all areas were still present. Detailed review of the medical record showed no evidence the physician was notified and orders obtained for treatment of the wounds or evaluation of the resident's continued complaints of itching. According to the facility's August 2009 "Operating Standards Manual Skin and Wound Management Standard," "Initial identification of a new non-pressure skin change will include an assessment of the condition. Documentation of the findings, assessment results and notification of physician and responsible party will be made in the resident's clinical record. Once a non-pressure skin change has been identified ongoing monitoring, treatment and a	F 309	educated on appropriate protocol for dressing changes. Refer to F441 for details regarding infection control concerns during wound treatments. Resident #14 weight gain for week three of March and week three of April has been reported to doctor on 5/23/11. 2. For residents with compromised skin, see F314. C.N.A.s will be interviewed to ascertain if any other residents have pain during movement and if any are identified, they will be referred to appropriate services. Therapists will be inserviced to use treatment records and follow facility protocol. 3. Nurses will be inserviced on assessments, doctor notification and documentation on non-pressure skin issues. Nurses will be inserviced on pain assessment protocol. Therapists will be inserviced on following orders as indicated on facility treatment records. Audit of documentation on the non-pressure skin condition record of observations of skin condition by Nursing and Therapists while providing treatments will be done each week by Director of Nursing or designee.	

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F 309	Continued From page 17 documentation plan will be initiated...The treatment plan...will be specific for each individual resident as directed by the physician..Pain...should be consistently assessed and addressed..." On 5/11/11 at 6:45 PM, LPN #2 stated she was unaware of the open scratches or the reddened area in the skin fold on the resident's posterior waist. On 5/12/11 at 8:42 AM the DON confirmed the lack of required assessments, notification, and documentation. 2. While resident #11 was transferred from the wheelchair and assisted into bed on 5/9/11 at 6:35 PM, observation showed s/he repeatedly called out when moved. During this provision of care, CNA #9 told the resident he was aware of his/her back pain and was being careful, and the resident was quiet with no symptoms of pain as soon as s/he was still. Review of the 4/9/11 pain assessment showed it was completed without an assessment of pain during movement. Review of the physician's orders showed the resident received two tablets of extra strength Tylenol and Baclofen (muscle relaxant) 5 milligrams every morning and Lortab at night, but nothing else was routinely ordered during the day. Baclofen 5 mg was ordered as needed 30 to 60 minutes before therapy; however, nothing was ordered for pain prior to movement. On 5/11/11 at 9:52 AM the DON confirmed the resident did cry out when moved and that it was probably due to pain at that time. The DON stated the facility had not attempted to minimize the resident's pain with movement by utilizing heat packs, topical ointments, or localized patches. 3. Review of the 3/6/11 readmission MDS assessment revealed resident #18 had a venous	F 309	Director of Nursing or designee will meet weekly with C.N.A.s to evaluate resident response to movement to determine if further assessment and/or care plan interventions are needed. Care plans will be reviewed and modified. Bath aides will be inserviced on use of skin care alert tool to notify charge nurse of skin changes so that further assessment and care plan interventions are developed as needed Director of Nursing or designee will complete head to toe assessments weekly to assure that skin conditions have been identified, assessed and care plan interventions implemented. 4. The Quality Assurance Committee will review audits of treatment observations, weekly C.N.A meetings and head to toe skin assessments. Results of audits will be reviewed monthly to ensure compliance and direct further corrective action as needed.	

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F 309	Continued From page 18 ulcer. Review of the non-pressure skin condition record showed on 10/6/10 a diabetic neuropathic ulcer was observed on the resident's right mid outer foot. Review of physician progress notes dated 3/9/11 and 4/15/11 revealed the resident had a "diabetic foot ulcer", which was slow to heal. The following concerns were identified regarding the treatment of the wound: a. Review of the April 2011 recapitulation of orders showed an order originally dated 1/6/11 for physical therapy to apply "Santyl [enzymatic debriding ointment] to wound bed on right outer aspect of foot." Review of physical therapy notes dated 4/27/11 and 4/29/11 showed the wound was redressed with Santyl and covered with a dressing. However, observation of wound care on 5/11/11 at 6:20 PM revealed PT #1 did not use Santyl on the wound. Instead, he cleansed the wound with Sea-Clens and covered the wound with gauze. During an interview on 5/12/11 at 11:15 AM, the DON stated physical therapy should follow orders for wound care. b. Refer to F 441 for details regarding infection control concerns during the wound treatment on 5/11/11 at 6:20 PM. 4. Review of physician orders for resident #14 showed that on 8/10/10 the physician ordered Furosemide (diuretic) 40 milligrams (mg) every day. The order also contained instructions to monitor weekly weights, and notify the physician for a weight gain of more than three pounds. Review of the weekly weights showed that during the following weeks the resident gained more than three pounds: week 3 of March 2011 (a gain of 4.8 pounds) and week 3 of April 2011 (a gain of 3.9 pounds). Review of the medical record showed no evidence the physician was notified of	F 309		

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F 309	Continued From page 19 the weight gains. During an interview on 5/12/11 at 10:26 AM, the DON stated she was unable to locate evidence the physician was notified of either weight gain. According to the Wyoming Nursing Practice Act, revised July 2010, and Chapter 3, pages 3-8 of the Wyoming State Board of Nursing's Administrative Rules and Regulations, nursing staff must function under the direction of a physician.	F 309	**F312** 1. Resident #11 is receiving oral care per facility protocol. Resident #18 is receiving perineal care per facility protocol. C.N.A. #9 has been inserviced on facility expectation for providing oral care to resident #11. C.N.A. #8 has been inserviced on proper perineal care for resident and how to re-approach. C.N.A.s will be inserviced on how to complete proper perineal care including residents that have behaviors during cares.	06/24/11
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure staff provided appropriate oral and perineal (incontinence) care for dependent residents. This failure affected 1 of 4 residents (#11) observed for oral care and 1 of 5 residents (#18) observed for incontinence care. The findings were: 1. On 5/9/11 at 6:35 PM CNA #9 was observed while providing care for resident #11. The CNA washed the resident's dentures but failed to cleanse the resident's mouth. Interview with the DON on 5/12/11 at 9:52 AM revealed the expectation that mouth care should be provided in the mornings and evenings. The DON stated that both the resident's dentures and mouth were	F 312	2. The facility will ensure that residents will receive appropriate oral and perineal care per facility policy 3. Nursing staff will be inserviced on providing appropriate oral and perineal care per facility policy. Random audits of perineal care and oral care will be done three times weekly by Director of Nursing or designee. Deviations from policy will be corrected immediately. 4. Results of oral and perineal care audits will be reviewed by the Quality Assurance Committee monthly for continued compliance	

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F 312	Continued From page 20 to be cleansed to remove debris. Review of the facility's policy and procedure, "Mouth Care," last revised 10/2010, confirmed mouth care should be provided to the mouth, inner cheeks, tongue, and lips. 2. Observation on 5/10/11 at 12:15 PM revealed resident #18 was incontinent of urine. While providing perineal care CNA #8 used a cleansing wipe to stroke once over the resident's anterior perineum and the left buttock. She failed to cleanse the posterior perineum, groin, or right buttock. The resident yelled "Ouch!" several times during the procedure, but exhibited no other symptoms of pain. When questioned after the procedure, the CNA stated that when the resident starts yelling, she "just does what needs to be done" and leaves. The CNA acknowledged that she should have cleansed the entire perineum. On 5/12/11 at 9:52 the DON stated that all areas in contact with urine or feces should be cleansed, and staff had been trained in proper completion of the procedure.	F 312	and direct further corrective action as needed. **F314** 1. We have updated and reviewed Care Plan on 5/27/11 for resident #28. Resident was provided a Panacea Mattress that is noted for pressure reduction up to and including Stage II. Resident #28 died on June 1, 2011. Wound care has been provided for resident #24 according to facility protocol. Readmission orders were reviewed for completeness for resident #24. Wheelchair cushion has been placed for resident #48.	06/24/11
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314	2. Braden scale assessments which are completed upon admission, weekly for three weeks, then quarterly and PRN will be reviewed to identify those at risk, then Care Plans will be reviewed for interventions. Readmission orders have been reviewed for accuracy, and doctor notified if clarification needed. Residents have been checked for appropriate wheelchair positioning device.	

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F 314	Continued From page 21 by: Based on observation, family and staff interview, medical record review and review of policies and procedures, the facility failed to ensure 3 of 7 sample residents (#24, #28, #48) assessed as being at risk for developing pressure ulcers received the necessary treatment and services to prevent the development of pressure ulcers. This failure resulted in avoidable harm to resident #28. The findings were: According to the policy and procedure entitled "Skin and Wound Management", revised October 2010, once risk has been identified, staff should initiate appropriate preventative measures to ensure minimizing the risk of pressure ulcer development. The preventive measures included the following: (1) Residents should be placed on a pressure reduction sleep surface. If the level of risk is higher, a more specialized mattress may be necessary. (2) Residents should be repositioned every hour while up in a chair. Consider limiting high risk resident's time in one position, such as in wheelchair. (3) Registered dietitians and rehab should be involved as indicated. (4) Residents with moisture issues should have an appropriate plan to keep moisture minimized. 1. Review of the medical record for resident #28 revealed the resident was admitted on 12/20/10 with diagnoses that included heart failure hypertension, cirrhosis and diabetes. At the time of admission, hospice care was initiated due to decline in functional ability; oxygen via nasal cannula was needed to maintain oxygen saturation rates greater than ninety percent; extensive assistance with a walker was needed	F 314	Each resident is provided a Panacea Mattress which is rated as pressure reduction up to and including Stage II. 3. The Director of Nursing has been educated on comprehensive preventative measures of the skin care protocol. Charge nurses will be inserviced on the Skin and Wound Management Standard. Director of Nursing or designee will audit weekly residents at risk as identified by the Braden Scale to ensure appropriate preventative measures are in place. Facility will appoint Wound Care Nurse to oversee that the skin care protocol is implemented and maintained. Director of Nursing or designee will audit three times weekly that preventative measures are instated and in place to ensure compliance of wound standard. 4. Audits of implementation of preventative intervention and audits of skin protocol will be reviewed by the Quality Assurance Committee monthly for continued compliance and direct further corrective action as needed.	

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F 314	Continued From page 22 for toileting; and daily doses of Prednisone and multivitamins were included in the medication regime. Further review revealed the only open skin area that the resident had, at that time, was an "ulcerated" toe on the left foot. Review of the 12/28/10 admission MDS assessment and CAT showed the resident was assessed as being at risk for developing pressure ulcers due to the following risk factors: occasional bladder incontinence related to the need for extensive assist with transfers and pain; the resident required assistance when turning around and walking with an assistive device, existing pressure ulcer, immobility, cognitive loss, anxiety medications, diabetes, pain, chronic/end-stage renal disease, liver disease, heart disease, depression, and devices that can cause pressure such as oxygen. The CAA analysis of findings revealed, "resident was admitted with a pressure ulcer and has the potential for further breakdown related to diagnosis of diabetes, pain and weakness. ... will care plan skin care, pressure ulcer treatment and prevention of further breakdown." Review of the 3/22/11 quarterly MDS assessment showed the resident did not have diabetic ulcers, open lesions or rashes, but continued to be at risk for developing pressure ulcers due to the following: The resident had a urinary catheter, but wore disposal briefs due to episodes of bowel incontinence. The functional status for balance during transition and walking declined to "walking with an assistive device did not occur." The active diagnosis section of the assessment revealed the same diagnosis as the previous assessment.	F 314		

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F 314	Continued From page 23 Review of the 12/29/10 and 1/12/11 Braden Scale for predicting pressure sore risk showed limited or impaired sensory perception, occasionally moist skin, severely limited ability to walk, very limited ability to make changes in position, adequate nutrition and moving required moderate to maximum assistance. With the exception of skin being rarely moist, review of the 3/22/11 Braden Scale showed the same risks that were identified on 12/29/10 and 1/12/11. Review of the plan of care revealed a bowel program, the interval for position changes while up in the wheelchair, possible moisture in abdominal folds and other areas of the body, issues regarding the resident's refusals, and protecting the resident from pressure related to oxygen and catheter tubings were not addressed. Concerns identified by family were revealed during an interview on 5/10/11 at 12:15 PM. At that time the family member stated the resident was able to use a walker with assistance when s/he was admitted; however, in the past month family members had noted the increased amount of time the resident remained in bed. The family member also stated s/he and other family members had observed the resident refusing to get up, eat or do anything; and staff responded by not doing it instead of providing the additional encouragement that was needed. The family concerns were verified during the following staff interviews: Interviews with CNAs #2 and #5 on 5/9/11 at 6:59 PM revealed the resident used a walker with staff assistance when admitted, but had not been able to do that in the past three months. The CNAs also stated the resident spent more time in bed than s/he did in past months,	F 314		

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F 314	Continued From page 24 but they were unable to identify changes in interventions that occurred as a result of the resident's declining mobility. Interview with CNAs #1 and #3 on 5/12/11 at 10 AM revealed the resident frequently refused to eat and/or get out of bed. Both stated sometimes they were able to encourage the resident and sometimes they had to just leave him/her alone. They also stated they were aware of the decline in the resident's condition. Concerns regarding the facility's failure to address treatment orders, and the need for an appropriate pressure relieving mattress and nutrition assessment in a timely manner were identified as follows: Review of the 4/29/11 interdisciplinary progress notes showed, "decubitus ulcer discovered to resident's gluteal cleft [the groove between the buttocks that runs from just below the sacrum to the perineum] 2 centimeters (cm) x 1 cm appears to be stage II." According to the April 2011 treatment administration record, treatment for the pressure ulcer started on 4/29/11. At that time the treatment was clean with SEA-CLENS, apply hydrocolloid ointment and cover with gauze, Tegaderm or coversite every four days and prn. Review of the 5/3/11 physician's orders showed an order for PT to evaluate the pressure ulcer and apply Santyl (used for enzymatic debridement) as needed. However, review of the May 2011 treatment record showed the santyl treatment that was ordered on 5/3/11 was not initiated until 5/11/11 (eight days later). Review of the interdisciplinary progress note showed the resident was placed on an air mattress on 5/2/11, three days after s/he developed the pressure ulcer. On 5/11/11, the surveyor asked whether a	F 314		

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F 314	Continued From page 25 nutritional assessment had been completed by a registered dietitian that addressed nutritional needs related to the newly developed pressure ulcers, but the facility was unable to provide evidence of this. Continuous observation on 5/9/11 from 5:05 PM to 7:05 PM, and again on 5/10/11 from 8 AM until 10:30 AM revealed the resident sat in the wheelchair without repositioning. Observation on 5/9/11 at 7:05 PM revealed CNA #2 and #5 removed the resident's disposal brief and provided peri-rectal cleansing due to fecal incontinence. Observation of RN #1 and the DON providing pressure ulcer care for the resident on 5/10/11 at 12:18 PM revealed the resident had a larger pressure ulcer on the gluteal cleft that had a necrotic center and a smaller reddened stage II pressure ulcer on the right buttocks. A dime size stage I area of redness was located directly above the stage II pressure ulcer. Review of Skin and Wound Management policy and procedure showed the following documentation should be recorded in the resident's medical record: date and time the dressing was changed, the type of dressing used and care given, pressure ulcer appearance, and all assessment data obtained when inspecting the pressure ulcer (i.e. wound bed color, size, drainage, etc.). Concerns identified regarding the failure to follow the aforementioned policy and procedures were as follows: Review of the 5/3/11 documentation in the pressure ulcer record showed the resident had one stage II pressure ulcer on the "coccyx" that measured 8 cm x 6 cm with a red wound bed and serosanguineous drainage. However, according to the	F 314		

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F 314	Continued From page 26 documentation on the 5/4/11 wound measurement chart, there were three pressure ulcers on the coccyx area: one 2.2 cm by 2.8 cm on the gluteal cleft with 80% slough, one 1.8 cm by 1.5 cm, and one 1 cm by .5 cm. Review of the PT note, dated 5/4/11, showed the therapist changed the dressing; however, additional documentation regarding the appearance of the pressure ulcers was lacking. The 5/6/11 PT documentation showed "removal of devitalized tissue from sacral wound through blunt debridement to promote wound healing. Wound measurements not taken with 80% slough in main wound and granulation in other two close sights." The documentation in the 5/11/11 wound measurement chart showed two pressure ulcers were on the coccyx area: one 9.3 cm x 6.3 cm x 0.3 cm on the gluteal cleft and a second area close by that wasn't measured or described. The documenting did not mention the third area that was identified on 5/4/11. Review of the physician's progress note dated 5/10/11 showed the following documentation: "stage III decub gluteal cleft - discussed with hospice, nursing and PT - will change dressing to santyl collagenase, 4 x 4 and coversite. Needs close attention." Review of the physician's orders dated 5/11/11 revealed orders for skilled physical therapy five times a week for six weeks for dressing changes and debridement of necrotic tissue on sacral wounds." Interview with the DON on 5/12/11 at 8:30 AM revealed she was unable to provide evidence that the facility had a system for ensuring comprehensive preventive measures were consistently implemented as early as possible for residents who were identified at risk for developing pressure ulcers.	F 314		

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F 314	Continued From page 27 2. According to the medical record, resident #24 was admitted to the facility on 3/8/11 with pressure ulcers on the left lower buttock and left medial ankle. The orders instructed that physical therapy (PT) was to provide wound care for both ulcers with Santyl ointment as necessary per PT recommendation. Further review showed the resident was transferred to the hospital on 4/29/11 and readmitted to the facility on 5/3/11. Review of the readmission orders showed the resident returned with a wound vacuum to the buttock that PT was to change every other day. This was the only instruction included for ulcer care. Observation on 5/9/11 at 4:45 PM showed neither PT #1 nor LPN #1 provided wound care for the ulcer on the resident's ankle. Review of PT's wound information showed no documentation the dressing on the ankle had been changed since 5/4/11. However, in interview on 5/10/11 at 9:30 AM, the resident stated the dressing on his/her ankle was last changed on 5/6/11. The following deficient practice was identified: a. The resident's readmission orders were not clarified to include treatment for the ankle ulcer or for continuation of the dietary supplement. Refer to F325 for information regarding nutrition. Interview with the DON on 5/11/11 at 3:10 PM revealed new orders were required any time a resident was out of the facility longer than 24 hours. At that time, the DON reviewed the readmission orders dated 5/3/11 and verified the absence of treatment orders for the pressure ulcer on the resident's ankle. b. According to available PT documentation, therapy last changed the dressing and treated the resident's ankle ulcer on 5/4/11; there was no documentation indicating who changed the	F 314		

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F 314	Continued From page 28 dressing on 5/6/11. On 5/4/11 therapy performed blunt debridement and documented "wound measures not taken today with good granulation of wound bed." The treatment after debridement was "...santyl, alginate and 3X3 mepilex border light dressing." Prior to this date, the last documented measurements were recorded by nursing on 4/20/11. At that time the facility's description was of a "stage 3" pressure ulcer measuring 1.1 cm long by 1.2 cm wide by 0.5 cm deep with a small amount of serosanguinous drainage, and a normal wound bed. There was no indication of eschar (brown, black, or grey dead tissue on a wound) in this description, or in previous descriptions. Measurements and descriptions were not documented on the records dated 4/29/11 or 5/4/11. c. On 5/11/11 at 5 PM PT #1 stated he had forgotten about the ankle ulcer on 5/9/11. He removed the old dressing on the resident's left medial ankle, and observation showed it was dated as placed on 5/6/11. The ulcer had not been evaluated or treated during the past five days. Per the therapist, the ulcer measured 1.5 centimeters (cm) in diameter. Continued observation showed black eschar approximately 1 cm wide around the edges with red, puffy looking tissue in the middle. Without using any cleansing agent, the therapist scrubbed the wound with dry gauze, placed a new dry gauze 2 X 2 pad over it, and wrapped the resident's foot with Kerlix (stretchy gauze). Refer to F441 for details regarding lack of aseptic (clean) technique during this procedure. d. Review of all available information completed by therapy revealed no documentation related to this ulcer after 5/4/11. Further, there was no evidence the physician was notified of the	F 314		

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F 314	Continued From page 29 worsened appearance of the ulcer or approved the treatment provided by therapy. 3. According to the 4/25/11 admission MDS assessment and CAA for resident #48, the resident did not have pressure ulcers, but s/he was assessed as being at risk for developing pressure ulcers due to decline in mobility and use of oxygen. Review of the care plan showed interventions for preventive skin care included pressure relieving device in wheelchair and bed. Periodic observations on 5/9/11 - 5/12/11 revealed the resident sat in the wheelchair without a pressure relieving device. Interview with the DON on 5/12/11 at 8:30 AM revealed the resident should have a pressure relieving device and she did not know why staff had not placed one in the resident's wheelchair.	F 314	**F315** **1.** Care Plan for resident #24 concerning psycho-social needs, skin issues, incontinent needs, and weight concerns have been revised. Also see F248, F250, and F272. Resident #28 died on 6/1/11. C.N.A. #5 and #6 were inserviced on urinary catheter bag to be placed below level of bladder at all times.	06/24/11
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to ensure 1 of 5 sample residents (#24)	F 315	**2.** No other residents have been identified as having a catheter removed in the last 30 days that would require a bladder training or 72 hour bowel and bladder tracking. At present time there are no other residents in medical isolation. By observation one resident has been identified as having a catheter drainage bag. The medical record of each resident will be audited to assure a bladder assessment has been completed. An individualized plan of care will be developed as needed. **3.** Nurses will be inserviced on policy and procedure for removal of catheter and bladder protocol.	

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F 315	Continued From page 30 with urinary incontinence received the necessary care and treatment to restore bladder function. This failure resulted in avoidable psychosocial harm for the resident. In addition, the facility failed to ensure 1 of 2 sample residents (#28) with a urinary catheter received appropriate catheter care. The findings were: 1. On 5/10/11 an unidentified housekeeper was observed donning personal protective equipment at 8:40 AM prior to entering the room of resident #24. When questioned, the housekeeper stated she was going to wash the resident's bed as the resident had been incontinent of urine. Observation at 8:50 AM that morning showed the resident's bed had been stripped and was still damp; the resident was sitting in a wheelchair and stated the bed needed to be washed and changed as s/he had been incontinent of urine and it "went through again." The resident further stated, the urge to urinate "...sneaks up real fast. I'm like a big baby. You wouldn't think a [man/woman] my age would wet the bed." Review of the medical record showed a comprehensive assessment for bladder incontinence had not been completed. Refer to F272 for details. Review of the care plan showed no individualized care plan for toileting that would promote continence and enhance the resident's self esteem. With additional observation, interviews, and medical record review, indicators of psychosocial outcome related to incontinence were identified. According to the medical record, the resident was admitted on 3/8/11 for rehabilitation and wound care after falling at home. Further review showed the resident's indwelling urinary catheter was	F 315	Staff will be inserviced on psycho-social aspect of incontinence and importance of answering call-lights promptly. Staff will be inserviced on completion of bladder assessment and how a care plan is written per assessment results. Nursing staff will be inserviced on positioning catheter bag below level of bladder at all times. Staff Development Coordinator or designee will do random audits upon catheter removal and bladder protocol. Staff Development Coordinator or designee will do random audits of the promptness of call-light answering three times a week for 90 days and weekly thereafter. Staff Development Coordinator or designee will do random audits of catheter drainage bag positioning weekly for 90 days and weekly thereafter. A deviation from standard will be corrected immediately. 4. Audits of catheter removal and bladder protocol, promptness of call-light answering, and catheter drainage bag positioning will be reviewed monthly by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	

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F 315	Continued From page 31 discontinued on 4/6/11 so therapy could work on increasing the resident's mobility. However, the resident's wound became infected, surgical debridement was required, and s/he returned to the facility on 5/3/11 with a wound vacuum. Although the incontinence assessments were incomplete, review showed the facility developed an incontinence care plan. Per that plan, staff were to assist with toileting by "pivot c [with] assist" and "assist me with toileting by providing pericare and incontinence product as needed." Even though the resident was not on a weight reduction plan, review of the resident's weight showed a loss of 7.5 pounds since admission. Review of the life enhancement (activity) care plan showed staff were to do one-to-one visits, the resident would work on word search and read books/newspaper, and pet therapy would be encouraged during pet visits. These were all individual activities that did not assist the resident in becoming more "socially active," a desire expressed by the resident and documented by social services in the 3/8/11 discharge plan. Observation throughout the survey showed the resident's room was dark with the dividing and entrance curtains partially pulled, but no individual activities occurred. Interview with the resident on 5/10/11 at 9:30 AM, revealed it frequently took twenty minutes for staff to answer lights, especially at night and during meals. The resident stated that because of the wait, "I pee the bed." S/he reiterated that it made him/her feel "...like a baby" as "can't hold it [urine]." Additionally, the resident stated, that due to a fear of falling, s/he wanted staff present before trying to get out of bed and that the lack of independence was frustrating. Review of the fall care plan showed	F 315		

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F 315	Continued From page 32 staff were to remind the resident to ask for assistance with all ambulation and provide stand-by assistance with ambulation. At 9:45 AM OT #1 entered the room and tried to get the resident to attend therapy. The resident refused at first because s/he was "...afraid to walk..." as "...will pee my clothes." During this interaction, the resident told the therapist s/he wanted "to be six feet under." The following concerns were identified: a. Although indicators of psychosocial outcome were present (weight loss, decreased social interaction and inability to leave the room without assistance, loss of interest in previous activities, indicators of depression and frustration), the facility failed to identify and address them. b. The facility failed to develop and implement an individualized toileting care plan that would enhance the resident's self esteem. c. Refer to F272 for details related to incomplete bowel and bladder assessments for this resident. d. Refer to F248 for detailed information related to lack of a life enhancement plan for this resident. e. Refer to F250 for information related to failure to address medically related social service issues for this resident. 2. Observation of staff providing care for resident #28 on 5/9/11 at 5:05 PM showed the resident had an indwelling urinary catheter. During the observation, CNAs #5 and #6 attached the catheter drainage bag to the mechanical lift while transferring the resident from the bed to the	F 315		

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F 315	Continued From page 33 wheelchair. Continuous observation revealed the attached catheter bag was positioned at the level of the resident's head during the transfer, and urine drained back toward his/her bladder. Interview on 5/11/11 at 1:45 PM with the DON confirmed this was not an acceptable standard of practice for catheter care.	F 315	**F318** 1. Occupational Therapy and Interdisciplinary Team reviewed and revised care plan for use of splints for resident #22. Splints are being applied to resident #22 per Occupational Therapy and Restorative plan of care.	06/24/11
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to consistently apply splints to prevent further decline in range of motion for 1 of 4 sample (#22) residents with range of motion limitations. The findings were: Observation of the sign posted on the closet door in resident #22's room revealed instructions for direct care staff to apply a wrist/hand orthotic after breakfast and lunch to prevent contractures because the resident's "hand is starting to tighten up." Review of the 2/8/11 quarterly MDS assessment showed the resident had functional limitations and upper and lower extremity impairment on one side. Review of the care plan showed staff were to apply wrist/hand orthotic	F 318	2. Other residents with splints/orthotics will be identified by reviewing physicians' orders and observed for placement of these devices by Director of Nursing or designee. 3. Direct care staff will be inserviced by Occupational Therapy on applying splints/orthotics for residents with orders for these devices. Random weekly audits will be performed on proper application of splints by Director of Nursing or designee. Deviations from standard will be corrected immediately. 4. Audits of splint application will be reviewed monthly by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	

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F 318	Continued From page 34 three times daily for two hours each time as tolerated and apply night splint to wear while sleeping as long as tolerated. Observation on 5/10/11 at 9:45 AM revealed CNA #4 and #7 transferred the resident from wheelchair to bed and departed without attempting to apply the wrist/hand orthotic. Interview with the OT #1 on 5/10/11 at 11:45 AM revealed the wrist/hand orthotic was needed to prevent worsening of the contractures. She stated she did not know why staff had not applied it after breakfast that day, but it should have been done according to the posted OT instructions. She stated she knew that sometimes the resident removed it, but she had instructed staff that even if the resident tolerated it for a short period of time it was better than not at all. Then she showed the surveyor how it should be applied. During the demonstration she unfolded the resident's contracted hand and applied the wrist/hand orthotic without verbal or physical resistance from the resident. Interview with CNA #4 revealed staff did not consistently apply the wrist/hand orthotic because sometimes the resident refused. Periodic observations of the resident on 5/11/11 showed the resident was in bed after breakfast; and the wrist/hand orthotic was not applied.	F 318		
F 325 SS=D	483.25(i) 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	F 325	**F325** **1.** Resident #1 and #24 will have protein powder delivered on meal tray so staff can add it to the food of resident's choice. **2.** Residents with orders for protein powder will have it delivered on meal tray for nursing staff to add it to food of resident's choice and track consumption of such food. Orders for new admissions and readmissions have been audited to determine if nutritional supplementation is needed. **3.** Nursing staff and dietary staff will be inserviced on procedures for protein powder. Adherence to procedure will be added to the dining room audit to be audited by the Interdisciplinary Team three times per week. Licensed Nurses will be inserviced to be cognizant of the thoroughness of readmission	06/24/11

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F 325	Continued From page 35 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of diet cards, the facility failed to ensure interventions were implemented to maintain nutritional status for 2 of 7 sample residents (#1, #24) reviewed. The findings were: 1. Review of a 3/29/11 note by the registered dietitian (RD) showed resident #1 had a significant weight loss (5.1%) in the past 30 days. Review of the May 2011 recapitulation of physician orders and the 1/4/11 nutrition risk review showed one scoop of protein powder was ordered to be added to a food item three times per day. Review of the diet card in the kitchen confirmed one scoop of protein powder was supposed to be added to one pureed food item at each meal. The following concerns were identified: a. Observation in the kitchen on 5/9/11 at 5:45 PM revealed cook #1 did not add protein powder to the resident's food. During an interview on 5/9/11 at 6:18 PM, the cook stated protein powder was to be added during trayline, but "I forgot [resident] tonight." b. Observation of trayline service on 5/10/11 at 12:31 PM revealed cook #2 did not add protein powder to the resident's food. During an interview on 5/11/11 at 2:05 PM, the cook stated she "forgot." c. During an interview on 5/11/11 at 2:10 PM,	F 325	orders and to contact physician and registered dietician as appropriate. Admission and readmission orders will be reviewed by the Interdisciplinary care team weekly. 4. Audits of protein powder distribution, consumption, audits of admission and readmission will be reviewed by the Quality Assurance Committee monthly for continued compliance and direct further corrective action as needed. Results will be reviewed for six months and re-evaluated.	

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F 325	Continued From page 36 the dietary manager stated it was the responsibility of the kitchen staff to add the protein powder to the resident's food. She further stated it was not documented which food item contained the protein powder; therefore, there was no way to monitor whether or not the resident consumed it. 2. Medical record review showed resident #24 was transferred to the hospital on 4/29/11 and was readmitted on 5/3/11 after surgical debridement of a pressure ulcer. Review of the readmission orders showed the nutritional supplement, originally ordered on 3/8/11, was not continued with the new orders. Review of the diet order list provided by the dietary manager showed resident #24 received a regular diet. No supplements were listed. During an interview on 5/11/11 at 2:25 PM, the dietary manager stated the resident had received supplemental shakes three times per day prior to going to the hospital. Upon returning from the hospital, there was no physician's order for supplements. She further stated, "I was not aware of it." In addition, she stated the registered dietitian (RD) usually recommended orders for supplements, but there was not a system in place to notify the RD of a resident's return from the hospital. Review of a note by the RD dated 5/10/11 confirmed the dietary manager's statement. It showed "Current diet is regular. RD informed res. [resident] had Stage IV debridement past week. RD recommends 1 tab Z-bec (vitamin) and 1000 mg [milligrams] Vitamin C daily." This recommendation did not occur until a week after the resident's readmission.	F 325		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332	**F332** 1. For resident #4 the Loperamide has been received and is being administered. LPN #2 was inserviced 5/10/11 on ordering medication timely. For resident #5 Calcium Citrate in the correct dose has been obtained. RN #2 was inserviced 5/17/11 on ordering medication of the correct dose timely. For resident #43 see F281. For resident #22 Alphagan eye drops dosage was clarified and corrected on the Medication Administration Record. RN #1 was inserviced 5/17/11 on needed dosage specification by physician of eye drops.	06/24/11

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F 332	Continued From page 37 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain a medication error rate under five percent (%). Five errors occurred out of 42 opportunities for error, resulting in an error rate of 11.9 %. Residents affected by these errors were sample resident #24 and non-sample residents #4, #22, #43, and #45. The findings were: 1. While preparing medications for resident #4 on 5/9/11 at 6:10 PM, LPN #2 was observed to circle Loperamide on the medication administration record after she checked the medication cart and stock room for the medication. She stated she had circled the medication because it was not available and would not be given. Reconciliation of the medication pass revealed Loperamide 4 milligrams (mg) was ordered daily and scheduled for 6 PM. Review of the medication administration record (MAR) on 5/10/11 verified the medication was not administered at a later time the previous evening. An error of omission occurred with this pass. 2. Observation on 5/10/11 showed RN #2 prepared and administered one tablet of Calcium Citrate with Vitamin D at 8:38 AM for resident #45. While preparing the medication, the RN said the company was no longer making that strength of Calcium Citrate, and she had no more to administer. Reconciliation of the pass with the	F 332	**2.** All Medication Administration Records and Treatment Administration Records have been reviewed for Medication Administration omissions for all residents. At present time only a resident has an IV pump. Review of policy and procedures for Medication Administration and Medication Errors have been completed and implemented. All other eye drops have been examined for specification of dosage. **3.** Medication Administration Records and Treatment Administration Records will be audited weekly by Director of Nursing or designee for any omissions. Nursing staff will be inserviced on facility protocol for medication administration and reordering medications. Nursing staff will be inserviced on medication error policy. **4.** The results of weekly audits of Medication Administration Record and medication error will be reviewed by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	

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F 332	Continued From page 38 physician's orders showed the resident was to receive two tablets of the medication twice daily. This error was administration of an incorrect dose. 3. At 8:47 AM on 5/10/11 RN #2 was observed as she administered medications she previously prepared to resident #43. Reconciliation of the medication pass with the physician's 4/12/11 recapitulation of orders revealed the resident should have also received Celexa 20 mg. When questioned at 10:45 AM, the RN reviewed the order sheet and verified the order was signed but not on the MAR. She confirmed she had not administered the medication, an error of omission. 4. Observation on 5/10/11 at 11:25 AM showed RN #2 hung intravenous (IV) Vancomycin 1.7 grams (Gm) to be administered so that 441 milliliters (ml) infused over 60 to 90 minutes for a total dose of 1.5 Gm. The RN set the rate on the IV pump to infuse at 200 ml per hour, a rate that would not have completed the infusion in the correct time period. When asked about the incorrect rate, the RN stated she did not know what it should be. This error was an incorrect dose as the medication would not have been infused in the allotted time period. 4. At 10:20 AM on 5/10/11 RN #1 was observed administering Alphagan eye drops 0.15 % for resident #22. Reconciliation of the medication pass showed the physician did not order a specific strength for the eye drops. After checking with the pharmacy, the DON reported that Alphagan eye drops were manufactured in two strengths, 0.1 % and 0.15 %. Since it was not	F 332		

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F 332	Continued From page 39 known which strength the physician wanted the resident to receive, an incorrect dose was administered.	F 332	**F363** 1. Cook #1 was inserviced 5/10/11 on following menus as written or to document menu substitutions on the substitution list. 2. Cooks have been observed for their adherence to following menus. 3. Cooks and dietary aides were inserviced 5/20/11 and 5/24/11 on adherence to menus and substitution documentation. The Dietary Manager will observe meal service three times weekly for adherence to follow the menu. Deviation from standard will be immediately corrected. 4. The results of random weekly audits will be reviewed monthly by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	06/24/11
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of the menu and diet orders, and staff interview, the facility failed to ensure the planned menu was followed during one of two meal observations. The findings were: The following concerns were identified regarding the facility's failure to follow the planned menu for the evening meal on 5/9/11: 1. Review of the menu showed a cream pie was to be served for dessert. According to the menu, residents who were on a pureed and dysphagia diet were supposed to receive a #10 scoop of pureed cream pie. Observation in the kitchen on 5/9/11 at 5:20 PM revealed slices of lemon meringue pie on plates. Cook #1 was observed scooping applesauce into bowls. When asked why the applesauce was served, he replied it was going to be given to residents on pureed and dysphagia diets. Further observation of the tray line showed the residents who were on pureed and dysphagia diets received applesauce instead	F 363		

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F 363	Continued From page 40 of pureed pie. According to the diet order list, seven residents were on pureed or dysphagia diets. During an interview on 5/11/11 at 2:05 PM, the dietary manager stated she was not aware the cook did not prepare the pureed pie. She stated he was a relief cook, and she was unsure why he served applesauce instead of the menued item. 2. According to the menu, one slice of bread was to be served for all diets except pureed and dysphagia. Observation of the tray line from 5:30 PM until 6:18 PM revealed only a half of slice of bread was served to residents. On 5/11/11 at 2:05 PM the dietary manager confirmed a full slice of bread should have been served.	F 363	**F371** **1.** Cook #1 was inserviced 5/27/11 concerning safe food handling and hand hygiene. Cook #2 was inserviced 5/10/11 on safe food handling, hand hygiene and thermometer sanitizing. **2.** Cooks have been observed for their adherence to safe food handling, hand hygiene, and thermometer sanitizing. **3.** Cooks and dietary aides will be inserviced on safe food handling, hand hygiene and thermometer sanitizing. The Dietary Manager will observe meal service three times weekly for adherence to safe food handling, hand hygiene and thermometer sanitizing. Deviation from standard will be corrected immediately. **4.** The results of random weekly audits will be reviewed monthly by the Quality Assurance Committee for continued compliance and	06/24/11
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies, and staff interview, the facility failed to ensure staff followed safe food handling procedures, including handwashing and sanitizing equipment, during 2 of 2 meals observed. In addition, the facility failed to ensure non-food contact surfaces	F 371		

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F 371	Continued From page 41 in the kitchen were maintained in a clean manner. The finding were: 1. The following concerns with handwashing and/or glove use were identified: a. Observation in the kitchen on 5/9/11 at 6:05 PM revealed cook #1 put a pan onto the counter of the three compartment sink, and then rinsed his hands under water at that sink. No soap was used, and then he used his hands to turn off the faucet. The cook then went back to tray line activities, including handling bread with his bare hands. At 6:10 PM, the cook again put a pot on the counter of the three compartment sink, and then went to the handwashing sink. He did not use soap, but rinsed his hands under the water, and then turned off the faucet using his hands. He then returned to plate food at the steam table. b. Observation in the kitchen on 5/10/11 at noon revealed cook #2 handled scissors, took a pan to the dishwashing room, and rested her hands on top of the shelf of the steam table. Then, without washing her hands, she put away clean utensils, pans, and bowls. Next, she handled the plastic bag containing tortillas, and without washing her hands, put on gloves and started plating food at the steam table. At 12:15 PM, the cook touched the handle of a drawer with her gloved hand, and without changing her gloves, she continued tray line activities including touching tortillas with the same gloved hand. c. During an interview on 5/11/11 at 2:10 PM, the dietary manager stated handwashing should be done in accordance with the facility policy. Review of the facility's "Hand Washing" policy (undated) showed hands should be washed "...after handling soiled equipment or utensils;	F 371	direct further corrective action as needed.	

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F 371	Continued From page 42 During food preparations, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks...Before donning gloves for working with food; After engaging in other activities that contaminate the hands." The policy further stated hands should be washed with an antibacterial soap, and the faucet should be turned off with the towel. Review of the policy "Bare Hand Contact with Food and Use of Plastic Gloves" (undated) showed plastic gloves were to be worn when handling food directly with the hands. Furthermore, "...gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed." According to Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE SERVICE and SINGLE-USE ARTICLES and...(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands. 2. Observation on 5/10/11 at 11:35 AM revealed cook #2 did not sanitize the thermometer between taking temperatures of two different food items. According to the facility's policy "Taking Accurate Temperatures" (undated), "...The thermometer must be sanitized between uses in different foods." During an interview on 5/11/11 at 2:10 PM, the dietary manager confirmed the thermometer should be sanitized between food	F 371		

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F 371	Continued From page 43 items. According to Food Code 2009, U.S. Public Health Service, 4-602.11 Equipment Food-Contact Surfaces and Utensils: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned:...(4) Before using or storing a FOOD TEMPERATURE MEASURING DEVICE. 3. Observations in the kitchen on 5/9/11, 5/10/11, and 5/11/11 revealed the three nozzles to the fire suppression system located directly above the range had an accumulation of dust. Strands of dust were observed to be hanging from all three nozzles. During an interview on 5/11/11 at 2:10 PM, the dietary manager stated the nozzles were to be cleaned on a monthly basis. When asked for documentation to show when the nozzles were last cleaned, she stated she did not have any documentation. According to Food Code 2009, U.S. Public Health Service, 4-601.11, Equipment, Nonfood-Contact Surfaces. (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425	**F425** **1.** Resident #4 had Loperamide ordered and received by facility and it is being administered per order. LPN #2 has been inserviced on reordering medications and documenting rationale if medication is not given. Resident # 24 had Nystatin ordered and received by facility and is being administered per order. **2.** Medication cartridges and treatment ointments have been cross referenced for availability. Nurses have been inserviced on ordering medications per facility protocol. **3.** Random weekly audits of medication administration records and treatment administration	06/24/11

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F 425	Continued From page 44 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and review of policies and procedures, the facility failed to ensure medications were available for administration. The findings were: 1. While preparing medications for resident #4 on 5/9/11 at 6:10 PM, LPN #2 was observed to circle Loperamide after checking the medication cart and stock room. She stated the medication was not available. According to the physician's orders, the resident was to receive the medication daily. Review of the medication administration record (MAR) on 5/10/11 showed the medication had not been administered at a later time the previous evening. The LPN had written on the back of the MAR that the medication was not available. In addition, the resident did not receive the medication on 5/8/11, but the rationale was not indicated. 2. During an observation on 5/9/11 at 5:55 PM, resident #24 complained of itching under the	F 425	records will be completed by Director of Nursing or designee for available medications. Random weekly audits by Director of Nursing or designee will be done on medication cartridges and treatment ointments for availability. Charge Nurses will be inserviced on notifying Director of Nursing and doctor if medications are unavailable and how to document rationale if medications are not given. 4. The Quality Assurance Committee will review random weekly audits of medication administration records, treatment administration records and medication cartridge audits. Results will be reviewed for three months for continued compliance and direct further corrective action as needed.	

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F 425	Continued From page 45 abdominal skin fold. A previous observation at 5:10 PM that evening revealed the resident's skin had a red rash all across the lower abdominal area with the right side worse than the left. The DON observed the resident's skin and said she would apply Nystatin. However, she was unable to locate any in the resident's room. After leaving and looking elsewhere, the DON returned and stated there was none in the facility. 3. According to the facility's 1/1/10 policy and procedure, "Medication Ordering and Receiving from Pharmacy," medications were to be ordered "(three to four) days in advance of need to assure an adequate supply is on hand."	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	**F431** **1.** The pharmacy was immediately contacted about labeling of medication with expiration date. It was explained by the pharmacy that the expiration date and lot number are on the back of the card, a practice approved by the Wyoming Board of Pharmacy. **2.** All medication from the pharmacy was checked. Expiration dates were found on the back of all cards. **3.** Licensed Nurses will be inserviced to be observant of expiration date of medication to include reading the back of the card. A random monthly audit of medications for	06/24/11

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F 431	Continued From page 46 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications in 1 of 2 medication carts were labeled appropriately. This failure affected 3 non-sample residents (#9, #14, #43). The findings were: Observation on 5/11/11 at 10:42 AM showed the following medications in Hall A medication cart lacked expiration dates on the labels: a. Resident #9 - Vicodin 5/500 milligrams b. Resident #14 - Cheratussin AC syrup c. Resident #43 - Cheratussin AC syrup During the observation, LPN #1 confirmed the labels lacked expiration dates and that the medications were administered to the listed residents. When the surveyor commented that all the medications were from the same pharmacy, the LPN stated this was the "backup" pharmacy. However, she also stated that a few of the residents routinely used this pharmacy to fill/refill prescriptions.	F 431	expiration dates will be done by the Director of Nursing or designee. 4. Random monthly audits of pharmacy labels will be reviewed by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=E	Continued From page 47 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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F441** **1.** Resident #18 and #24 continue to receive wound care as ordered utilizing professional standards of practice and following facility infection control policy and procedure to prevent the spread of infection. Physical Therapist Assistant #1, LPN #1, RN#1, and Physical Therapist #1 were inserviced 5/13/11 on following orders for wound care and implementing effective infection control techniques. Physical Therapist Assistant #1, LPN #1, RN#1, Physical Therapist #1, and Director of Nursing #1 were inserviced 5/19/11 on performing hand hygiene and utilizing professional standards of practice and following facility policy for dressing changes and utilizing proper personal protective equipment. Resident #11 is receiving perineal care per facility protocol. C.N.A. #9 and RN #1 were inserviced 5/19/11 on facility protocol for use of personal protective equipment – glove use.	06/24/11

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F 441	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to sustain an effective infection control program. The facility failed to ensure staff adhered to infection control guidelines during 3 of 3 observations of wound care for sample residents (#18, #24). The facility also failed to ensure staff complied with recognized standards for hand hygiene, use of personal protective equipment (PPE), sanitizing of equipment, and the handling of dirty linen. The findings were: As related to improper wound care: 1. Review of physician progress notes dated 3/9/11 and 4/15/11 revealed resident #18 had a "diabetic foot ulcer", which was slow to heal. Review of the April 2011 physician orders showed physical therapy was to perform wound care on the right outer aspect of the foot. In addition, dry dressings were to be placed between the toes of the left foot. Further review of physician orders, dated 4/4/11, showed the physician ordered Bactrim DS (antibiotic) twice per day for ten days to treat an infection in the wound. PT #1 was observed on 5/11/11 at 6:20 PM providing wound care for the resident. During the observation PT #1 touched various surfaces in the room including the treatment cart, and without handwashing, put on gloves. He removed the dressing to the left foot, and cleansed the wound and applied the new dressing while wearing the same gloves. The PT removed those gloves, but	F 441	C.N.A. #9 was inserviced 5/19/11 on infection control protocol which includes management of soiled laundry. Hospice Aide #1 was inserviced 5/17/11 on proper cleaning protocol of whirlpool. Staff was inserviced 5/19/11 on infection control protocol of soiled laundry. The Infection Control Nurse or designee will be auditing dressing changes, care of IV's, staff sanitizing whirlpools, appropriate use of personal protective equipment, infection control and management of soiled laundry. C.N.A. #9 was inserviced 5/19/11 on hand hygiene and proper use of personal protective equipment. RN #2 was inserviced 5/23/11 on following the protocol for changing IV tubing. 2. Resident #24 is the only resident in contact isolation. The facility has one resident on an IV at this time. Audit of treatment records will be done to identify residents with wounds for proper infection control practices. Nursing and contract staff will be inserviced on proper procedure for dressing changes and wound management. Nursing staff will be inserviced on proper hand hygiene and glove use when	

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F 441	Continued From page 49 did not perform hand hygiene. He put on a new pair of gloves; then removed the dressing to the right foot. He cleansed the wound on the right foot, and applied a new dressing wearing the same gloves. He removed those gloves and left the room. During the same observation, the PT sat on the floor to perform the dressing change on the right foot. While seated, he placed gauze pads on top of his jeans. The pads dropped to the floor. The PT picked up the pads from the floor, and used them to cleanse the wound of the right foot. Immediately following the observation, the PT was interviewed after he left the room. When asked about hand hygiene, the PT stated he "forgot" to wash his hands before he left the room. When asked if he routinely changed gloves and washed his hands between handling the soiled dressing and cleansing the wound and applying a new dressing, he replied "no...maybe I should." 2. According to the medical record, resident #24 was admitted to the facility on 3/8/11 with pressure ulcers on the left lower buttock and left medial ankle. Those orders instructed that physical therapy (PT, for therapy or therapist) was to provide wound care for both ulcers with Santyl (for enzymatic debridement) ointment as necessary per PT recommendation. Further review showed the resident was transferred to the hospital on 4/29/11 and readmitted with Methicillin-resistant Staphylococcus aureus (MRSA), a drug-resistant bacterium, on 5/3/11 after surgical debridement of the ulcer on the buttock. Review of the readmission orders showed the resident returned with a wound	F 441	changing dressings. Nursing staff will be inserviced on proper use of personal protective equipment. Contract staff were inserviced 5/17/11 and 5/26/11 on proper procedure for sanitizing whirlpool tubs. Nursing and contract staff were inserviced 5/19/11 on proper management of soiled laundry. Nursing staff were inserviced 5/23/11 on IV administration and tubing changes. Refer to F314. **3.** Director of Nursing or designee will audit hand hygiene and glove use with dressing changes weekly. Director of Nursing or designee will audit whirlpool tub cleaning procedure two times a week. Director of Nursing or designee will audit proper management of soiled laundry weekly. Director of Nursing or designee will audit for proper use of personal protective equipment two times weekly. Issues identified will be corrected immediately. **4.** The audits of hand hygiene, personal protective equipment, whirlpool tub cleaning, and management of soiled laundry will be reviewed by the Quality Assurance Committee monthly for six months for continued	

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F 441	Continued From page 50 vacuum to the buttock that PT was to change every other day; however, no orders were included for the ulcer on the resident's ankle. Observation on 5/9/11 at 4:45 PM showed PT #1, assisted by LPN #1, changed the wound vacuum and dressing to the resident's buttock. The following deficient practices were identified during observations of staff performing the procedure: a. Neither PT #1 nor LPN #1 tied their isolation gowns at the waist. Therefore, the gowns hung open, flapping around and rubbing against the linens, dressings, and wound vacuum equipment, thus contaminating sterile equipment and exposing the wearers to possible bacterial contamination with every movement. b. The wound vacuum packing, dressings, and suction equipment were packaged as a sterile unit. Both the therapist and the LPN handled all sterile equipment using non-sterile technique; furthermore, aseptic (clean) technique was not maintained. c. The therapist removed the old dressing and packing, removed his gloves, and, without performing hand hygiene, donned new, non-sterile gloves to re-pack the wound and apply the dressing and suction equipment. d. LPN #1 removed her gloves, washed her hands, and then held the isolation gown away from herself with one hand as she removed scissors from the pocket of her uniform with the other. Without cleansing the scissors, the LPN cut the sterile foam packing (contaminating it) for the wound vacuum and then laid the scissors on the bed linen and protective pad placed under the resident's wound. e. While wearing non-sterile gloves, the therapist used his hands to pack the foam into the resident's wound. Measurements were not	F 441	compliance and direct further corrective action as needed.	

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F 441	Continued From page 51 taken, but the therapist inserted three fingers completely into the wound. Using the same contaminated scissors, the LPN cut the Tegaderm dressing, and the therapist used them to cut a slit in the Tegaderm for the suction equipment. The therapist also laid the uncapped end of the suction tubing on the pad and bed linens. Observation on 5/11/11 at 5 PM showed PT #1, assisted by PTA #1, changed the dressings on the resident's left ankle and the wound vacuum. The following deficient practices were identified during observations of staff performing the procedure: a. The therapist again did not tie the isolation gown at his waist and the gown hung open and flapped around. b. The therapist used the same measuring sheet to measure two wounds completely covered with eschar on the resident's great toe and the top of the foot, and then used the same sheet to measure the open ulcer on the ankle. c. The therapist changed gloves but performed no hand hygiene before donning a new pair. He then placed a bottle of Sea-Cleans on the bedside commode, picked it up and placed a hand towel over the commode, replaced the cleansing agent and added more gloves and a measuring sheet. d. While wearing the same gloves the therapist helped the resident turn and moved the incontinence brief to expose the dressing. Without changing gloves, the therapist then removed the old wound vacuum dressing and packing, unrolled toilet tissue, and used a 4 by 4 gauze pad to scrub inside the wound with Sea-Clens. The PTA stated that the toilet tissue	F 441		

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F 441	Continued From page 52 was not sterile so she held the old vacuum pump cannister tubing. e. Wearing the same contaminated gloves, the therapist measured the wound as 13 centimeters (cm) deep. Prior to obtaining other measurements, the therapist touched the measuring sheet against the bio-hazard trash bag. The other wound measurements were 4 cm long (head to toe) and 8 cm wide. This converts to over 1.5 inches long, 3 inches wide, and 5 inches deep. After completing the measurements, the therapist again inserted his fingers into the wound and wiped it with a dry 4 X 4 while wearing the contaminated gloves. f. The therapist changed into new non-sterile gloves but performed no hand hygiene before so doing. The therapist took the old vacuum pump cannister tubing from the PTA, and while holding it, removed the sterile wound vacuum contents from the pre-package container. Prior to connecting the old tubing to the new, the therapist touched the bio-hazard trash bag, handled all equipment using non-sterile technique, and touched the new suction tubing to the bed, the protective pad, and the floor As related to improper use of PPE and lack of hand hygiene: 1. Observation at 5:10 PM on 5/9/11 showed LPN #1 removed her isolation gown and gloves, washed, and re-gloved. She then applied a new incontinence brief and pad and adjusted the bed linens for resident #24. After the resident complained of itching under the abdominal fold, the LPN checked the skin (which was irritated with a red rash), and washed the area with water. When the resident next complained of itching at	F 441		

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F 441	Continued From page 53 the central venous access site in his/her right clavicle area, the LPN examined the site while wearing the same contaminated gloves. 2. At 6:35 PM on 5/9/11, the DON was observed to don a gown and mask prior to entering resident #24's room to check the IV tubing and pump. After donning gloves, the DON stopped the wound vacuum pump from beeping, stated the dressing on the resident's buttock needed patched, and left the room to obtain supplies. When re-entering the room at 5:45 PM, the DON did not don a gown prior to leaning against the bed to apply a re-enforcing dressing to the wound on the resident's buttock. Throughout the survey staff were observed to be inconsistent in donning gowns or masks although all wore gloves. 3. The CNA #9 assisting the DON on 5/9/11 at 5:45 PM was observed to reach around his isolation gown, reach into his uniform pocket and remove trash bags while wearing the gloves he used to assist with adjusting resident #24's brief and turning and caring for him/her. The CNA proceeded to wear the same gloves while touching the call light, bed controls, and overbed table. 4. Observation on 5/10/11 at 11:25 AM showed RN #2 was connecting an intravenous (IV) antibiotic to the central IV line for resident #24. The RN hung the IV tubing with an uncapped connecting site over the IV pole, but it slid off and the connecting site came in contact with the IV pole and the bedside table. Without changing the tubing or cleansing the site the RN connected it to the central IV line.	F 441		

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F 441	Continued From page 54 5. On 5/9/11 at 6:35 PM CNA #9 was observed while providing care for resident #11. The CNA first donned gloves and then twice picked an electric cord up off the floor to allow him to push the lift up to the bed. Without changing gloves, the CNA then completed perineal care as the resident was incontinent of bowel and bladder. While providing care, the CNA also threw dirty laundry onto the floor. 6. Observation on 5/10/11 at 11:30 AM revealed RN #1 used a glucometer to perform glucose testing for an unidentified resident. Observation of the RN during the procedure revealed she removed the bloody testing strip with her hands after she had removed her gloves. Interview with the RN at that time revealed she was aware of the proper procedure, but she "forgot" and removed her gloves too soon. As related to improper cleaning technique and improper handling of dirty linen: 1. On 5/10/11 at 9:20 AM hospice aide #1 was observed coming out of the tub room. When asked how she cleaned the whirlpool tub she replied that she dumped some disinfectant, approximately 1/4 to 1/2 cup (2 to 4 ounces, respectively), into the tub and filled it with water. She described the amount of water as being as much as used for bathing a resident and to assure the tub chair was covered (multiple gallons as she indicated the tub was over 3/4 full). She stated she ran the jets or moved the water by hand if the jets were not working and allowed 10 to 15 minutes contact time. According to the label on the disinfectant, Classic Whirlpool Cleaner, the ratio for mixing the disinfecting	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 55 solution was 1:64, or two ounces of disinfectant to one gallon of water. Review of the instructions posted in the bathing room for cleaning the Century Tub showed they were for Penner Disinfectant, not the brand currently being used, but this brand also required two ounces of that disinfectant to one gallon of water. However, the instructions were for an automatic system that required much less water that the hospice worker described as using; the tub and chair were to be scrubbed with, not immersed in, the disinfectant solution.	F 441		
	2. Dirty linen was observed on the floor in rooms 205 and 210 on 5/12/11 at 8:30 AM and again at 8:45 AM. During the observation neither residents nor staff were in the rooms. Additional evidence of the facility's inability to sustain an effective infection control program was revealed during an interview on 5/12/11 at 10:25 AM with the infection control (IC) nurse. During the interview the following concerns were identified: 1. The IC nurse stated she did not monitor non-nursing staff for appropriate infection control practices during wound care, "...I didn't even think about it." She stated the therapy staff were contract employees, therefore, she had not included them in any monitoring activities. When described the scenarios for wound care with residents #18 and #24, she stated it angered her, because she was concerned for the residents' well-being. 2. The IC nurse also stated she did not monitor staff for care of IV's. 3. According to the IC nurse, she did not monitor			

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	535034	A. BUILDING _____ B. WING _____	PP 05/12/2011

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F 441	Continued From page 56 hospice staff with regards to sanitizing the tub. She stated "...I forget they are doing baths." 4. The IC nurse stated she did not monitor staff for the appropriate use of PPE for residents in isolation. She further stated she was "disappointed" with staff, because she discussed PPE and isolation during orientation. 5. In regards to staff not having gloves on when removing the bloody test strip from the glucometer, she stated "I don't understand how that happened...I have gloves on when I do it." 6. Finally, she stated dirty linen should never be put on the floor, but should be bagged immediately.	F 441	**F502** **1.** For Resident #1 a Complete Blood Count and Basic Metabolic Panel laboratory tests were drawn on 5/25/11. Physician wrote order for discontinuation of further labs. **2.** Lab orders for all hospice residents will be reviewed by the Director of Nursing or designee for continuation or discontinuation. **3.** Licensed Nurses will be inserviced to complete laboratory tests as ordered. Physician's orders for laboratory tests for Hospice residents will be audited quarterly by interdisciplinary team. **4.** Results of quarterly audit for Hospice residents will be reviewed monthly by the Quality Assurance Committee for continued compliance and direct further corrective action as needed.	06/24/11
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory tests were completed as ordered by the physician for 1 of 11 sample residents (#1) with orders for laboratory tests. The findings were: Review of physician orders for resident #1 showed an order for an annual CBC [complete blood count] and BMP [basic metabolic panel]. Review of the medical record showed the last laboratory tests were completed on 9/2/09. During an interview on 5/12/11 at 8:10 AM the DON confirmed there had not been any laboratory tests since then. She stated hospice	F 502		

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WESTWARD HEIGHTS CARE CENTER	160 CARING WAY LANDER, WY 82520

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F 502	Continued From page 57 staff was supposed to get an order to discontinue the laboratory tests, but had not done so.	F 502	**F520** **1.** Facility management has met with the management of The Therapy contractor and Hospice provider concerning the coordination of services, competency checks, and inservicing of staff. **2.** Audits and competency checks for prior year Quality Assurance activity have been reviewed for accuracy and thoroughness. Policies and procedures for completion of quality assurance program have been reviewed. **3.** Department Managers and Interdisciplinary care team will be inserviced on appropriate methods of observation, audit completion, identification of issues, action plans and employee discipline when deviation from standard are found. The team will focus on preventions of wounds, wound healing, pain assessment and management, incontinent care, oral care, catheter care, restoration of bladder function after catheter removal, decline in	06/24/11
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		
	The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations of care, staff interview, medical record review and review of the quality assurance performance improvement (QAPI) program, the facility failed to ensure the QAPI was effective in identifying problems and			

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F 520	Continued From page 58 Implementing action to resolve problems. The findings were: During interview on 5/12/11 at 10:10 AM, the administrator stated the QAPI did not include issues involving the therapy department staff because they were contracted employees. A review of the documented QAPI activities, projects and staff participation verified that issues regarding care and services provided by the therapy staff had not been identified. Failure to identify quality of care deficiencies prior to the survey were identified as follows: 1. Refer to F309 for information related to lack of implementation of the necessary care and services to promote wound healing and lack of effective pain management. 2. Refer to F312 for information regarding inappropriate incontinence and oral care. 3. Refer to F314 for information regarding the failure to implement preventive measures and provide appropriate care and monitoring of pressure ulcers. 4. Refer to F315 for detailed information related to lack of appropriate catheter care and failure to provide care necessary to restore normal bladder function. A deficiency citation under this category was written during each of the last three surveys. 5. Refer to F318 for information related to the failure to prevent further decline in range of motion. 6. Refer to F325 for information related to the failure to address nutritional concerns. A deficiency citation under this category was written during the last survey. 7. Refer to F322 for information related to the failure to maintain a medication error rate under	F 520	range of motion, nutritional supplementation, following menus, medication administration accuracy and infection control. 4. The Quality Assurance Committee reviews negative outcomes and also has a preventative function to enhance the quality of care and the quality of life for the residents. The Quality Assurance Committee is a facility wide management process with the purpose of continuous evaluation of facility systems that: Keeps systems functioning; includes maintenance of current practice standards; prevents deviation from care process, identifies issues and concerns and corrects inappropriate processes.	

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F 520	Continued From page 59 five percent. Other deficiencies of significant concern included three in quality of life (refer to F246, F248, F250), and two in dietary services (refer to F363, F371), F363 was cited during the last survey, and infection control (refer to F441) cited during the last four surveys.	F 520		