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

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WY Dept of Health
JUN 4 2013
Healthcare Licensing and Surveys

PRINTED: 05/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 05/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN: Registered Nurse LPN: Licenced Practical Nurse CNA: Certified Nursing Assistant DON: Director of Nursing MAR: Medication Administration Record MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	**PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF STATE AND FEDERAL LAW**	
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 ensure 1 of 1 sample residents (#72) observed to self-administer medications was assessed as safe for self-administration. The findings were: Review of the medical record for resident #72 showed the resident was admitted to the facility on 5/26/11 with diagnoses including anemia, atrial fibrillation, heart failure, hypertension, gastric reflux, diabetes, hyperlipidemia, hypothyroidism, and arthritis. Observation on 5/6/13 at 3:53 PM showed the resident self-administered a nebulizer treatment (breathing treatment). Interview with	F 176	**<u>F-176 – Resident Self-Administer Drugs If Deemed Safe</u>** **This plan of correction is the facility's credible allegation of compliance.**	

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

Executive Director 6-3-13

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

POC accepted with changes per conversation with Daniel Stackes on 6/14/13 Julie VanDyke, RN

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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 ensure 1 of 1 sample residents (#72) observed to self-administer medications was assessed as safe for self-administration. The findings were: Review of the medical record for resident #72 showed the resident was admitted to the facility on 5/26/11 with diagnoses including anemia, atrial fibrillation, heart failure, hypertension, gastric reflux, diabetes, hyperlipidemia, hypothyroidism, and arthritis. Observation on 5/6/13 at 3:53 PM showed the resident self-administered a nebulizer treatment (breathing treatment). Interview with	F 176	Education was conducted with the nurse involved during survey regarding the facility policy and procedure related to self-administration of medications. The Staff Development Coordinator/Designee will educate nurses regarding the facility policy and procedure related to self-administration of medications.	

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F 176	Continued From page 1 the resident at that time revealed the nurse had brought the Duoneb medication to the resident for the treatment. During an interview with LPN #1 on 5/6/13 at 4:30 PM, she stated she brought the medication to the resident's room at 11 AM, and since the resident was eating, she left the medication at the bedside for the resident to self-administer after completing the meal. Review of the medication order showed it was for Duoneb nebulizer treatments four times each day at 8 AM, 12 noon, 4 PM, and 8 PM. The LPN stated because of the time the resident self-administered the dose, the 4 PM dose would not be administered and the 12 noon dose would be reported as omitted. The following concerns were identified: a. During an interview with the 3rd floor nurse manager, on 5/6/13 at 4:30 PM, she stated the facility policy and procedure for the administration of nebulizer treatments was the nurse would initiate the treatment and return to verify it was completed. b. Review of the medical record showed the resident was never assessed for the capability to self-administer the nebulizer treatment. c. Interview with the DON on 5/8/13 at 5:15 PM verified the facility failed to assess the resident for self-administration of medications. She further stated self-administration of medications should be included in the resident's plan of care.	F 176	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** RN Unit Managers/Designee will conduct an audit to determine if any residents are self-administering medications, and if so, confirming the resident was assessed as safe for self-administration. Care plans will be updated as needed. Based on the results of the audits, education will be provided immediately on an as needed basis.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure 3 of 4 resident areas (first floor, second floor, and the Expressions unit) were maintained to be clean and in good repair. The findings were: Interview and observation on 5/9/13 at 2:45 PM with the housekeeping supervisor and the area facility manager of maintenance verified the following items were in need of additional cleaning and maintenance or upkeep. The following items were observed in the residents' home during the survey from 5/6/13 to 5/9/13: a. Eight upholstered arm chairs on the second floor and 5 upholstered arm chairs in the first floor conference room were noted to be stained and/or soiled with dried rings of liquids and/or food. Interview with the two staff members revealed it was unknown when the chairs were last cleaned. b. The floors in the Expressions unit had soil/food build up along the edges of the room and the section of base board underneath the cabinet and counter area was missing. c. The wall in the main area by the window in the Expressions unit had three areas of white where the wall had been patched and was in need of painting. Interview with CNA #1 on 5/8/13 at 2:20 PM verified the white patches had been in need of paint for about two months. d. The wall and corner near the piano on the second floor main/dining area had a red-painted wall paper which was torn and marred in multiple places. e. The second floor shower room nearest	F 253	**F-253 – Housekeeping and Maintenance Services** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Chairs in the facility will be checked for cleanliness and if needed, appropriately cleaned. Corners and edges in the facility will be checked for cleanliness and if needed, appropriately cleaned. Walls in the facility will be checked and baseboards will be replaced as needed. Walls in the facility displaying a patched area requiring paint will be painted. Wallpaper in the facility will be checked for appropriate condition and replaced/fixed as needed.	

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F 253	Continued From page 3 resident room 223 was not in use at the time of observation on 5/8/13 at 3:45 PM. However, the room smelled strongly of urine. The interior of the toilet was stained and the toilet seat was scratched and scored with discolored markings. The air vent in the ceiling was obstructed with dust and lint. The whirlpool tub located in the room was not hooked up and was being used to store various items. A table lamp located in the room was noted to have the shade removed and a shattered light bulb remaining in the bulb socket. Interview with the two staff members on 5/9/13 at 2:45 PM verified the room needed to be cleaned and had a foul smell. f. The second floor shower room across from the nurse's desk was not in use at the time of observation on 5/8/13 at 3:48 PM. This room smelled strongly of urine, there were dirty under-clothes on the floor, there was dried fecal matter on the floor, the garbage had not been taken out, and the ceiling vent was obstructed with dust and lint. In addition, one of the shower stalls was unusable due to storage of stacked wheelchairs. The cabinet with grooming supplies had both doors hanging off the hinges. When this room was observed in the presence of the two staff on 5/9/13 at 2:55 PM, the room was in the same condition with the exception of the trash and dirty clothes having been removed. The staff verified the unclean smell and poor condition of the shower room. g. The second floor Expressions unit had areas where the rubber piece to cover the floor seam at the threshold of resident rooms 223, 227, and 230 were in poor condition with pieces missing. Additionally, both of the thresholds to the shower rooms had condition problems. h. The third floor shower room across from	F 253	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Executive Director/Maintenance Director/Housekeeping Manager/Designees will conduct environmental rounds, including resident rooms/bathrooms, shower rooms, common areas, etc. to identify issues throughout the facility. Items will be corrected promptly as able; if extended time needed for correction, a plan will be developed and additional resources consulted as needed. These rounds will be incorporated into the preventative maintenance and/or housekeeping rounds currently in place.	

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F 253	Continued From page 3 resident room 223 was not in use at the time of observation on 5/8/13 at 3:45 PM. However, the room smelled strongly of urine. The interior of the toilet was stained and the toilet seat was scratched and scored with discolored markings. The air vent in the ceiling was obstructed with dust and lint. The whirlpool tub located in the room was not hooked up and was being used to store various items. A table lamp located in the room was noted to have the shade removed and a shattered light bulb remaining in the bulb socket. Interview with the two staff members on 5/9/13 at 2:45 PM verified the room needed to be cleaned and had a foul smell. f. The second floor shower room across from the nurse's desk was not in use at the time of observation on 5/8/13 at 3:48 PM. This room smelled strongly of urine, there were dirty under-clothes on the floor, there was dried fecal matter on the floor, the garbage had not been taken out, and the ceiling vent was obstructed with dust and lint. In addition, one of the shower stalls was unusable due to storage of stacked wheelchairs. The cabinet with grooming supplies had both doors hanging off the hinges. When this room was observed in the presence of the two staff on 5/9/13 at 2:55 PM, the room was in the same condition with the exception of the trash and dirty clothes having been removed. The staff verified the unclean smell and poor condition of the shower room. g. The second floor Expressions unit had areas where the rubber piece to cover the floor seam at the threshold of resident rooms 223, 227, and 230 were in poor condition with pieces missing. Additionally, both of the thresholds to the shower rooms had condition problems. h. The third floor shower room across from	F 253	The "Repair Request for Maintenance" form is completed by staff when items are noticed to be in need of repair, replacement, repainting, etc. and provided to the Maintenance Director/Designee for completion. The Maintenance Director/Designee will communicate any issues to the Executive Director that would impair or delay the completion of a requested maintenance item. Each area of the facility is cleaned on a scheduled basis, with additional cleaning done between scheduled times as needed. The housekeeper and/or Housekeeping Manager/Designee are notified of items/areas in need of cleaning.	

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F 253	Continued From page 4 the nurses desk had scrapes and gouges on the door frame. i. The entrance to the small dining room on the 3rd floor behind the nurse's desk had chipped paint and gouged areas on the wall from a height of four feet down to the floor. In addition, the radiator heating unit located on the short wall under the window in this small dining room was bent and pulled away from the wall.	F 253		
F 272 SS=D	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 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;	F 272	**F-272 – Comprehensive Assessments** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #25's physician discontinued the use of the CPAP. The care plan was updated to reflect this. A sleep study has been ordered for resident #25 to determine if the CPAP is needed. Pulse Oximetry checks will be done as ordered at night to evaluate oxygen needs.	

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F 272	Continued From page 5 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 observation, medical record review, and staff interview, the facility failed to identify and comprehensively assess the need for treatment of obstructive sleep apnea for 1 non-sample resident (#25). The findings were: Resident #25 was admitted to the facility on 4/19/13. Review of the resident's admission MDS assessment dated 4/25/13 revealed active diagnoses of hypertension, gastroesphogeal reflux disease, thyroid disorder, anxiety disorder, psychotic disorder, and edema. The admission MDS assessment further revealed the resident understands and was understood, and had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, reflecting moderate cognitive impairment. Review of the resident's medical history from the previous facility, dated at 3/22/13, revealed an additional diagnosis of obstructive sleep apnea and the resident was known to use a continuous positive airway pressure (CPAP) machine for this condition. A telephone order dated 4/19/13 and timed 4:46 PM, the day of admission, revealed a physician order authorizing	F 272	The Staff Development Coordinator/Designee will provide education to nurses regarding the policy and procedure regarding: -Monitoring use of respiratory equipment; -Identification of the need to repair or replace the respiratory equipment; and -Respiratory assessment of the resident. The Director of Nursing/Designee will provide education to the MDS Coordinator regarding the placement of active diagnosis on the MDS as well as the location of the active diagnosis on the resident's medical record.	

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F 272	Continued From page 5 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 observation, medical record review, and staff interview, the facility failed to identify and comprehensively assess the need for treatment of obstructive sleep apnea for 1 non-sample resident (#25). The findings were: Resident #25 was admitted to the facility on 4/19/13. Review of the resident's admission MDS assessment dated 4/25/13 revealed active diagnoses of hypertension, gastroesphogeal reflux disease, thyroid disorder, anxiety disorder, psychotic disorder, and edema. The admission MDS assessment further revealed the resident understands and was understood, and had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, reflecting moderate cognitive impairment. Review of the resident's medical history from the previous facility, dated at 3/22/13, revealed an additional diagnosis of obstructive sleep apnea and the resident was known to use a continuous positive airway pressure (CPAP) machine for this condition. A telephone order dated 4/19/13 and timed 4:46 PM, the day of admission, revealed a physician order authorizing	F 272	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** RN Unit Managers/Designee will conduct an audit to determine if there are residents that are not utilizing physician-ordered respiratory equipment. If noted, the resident will be assessed and the physician will be notified. The MDS Coordinator/Designee will review the records for residents utilizing respiratory equipment to determine if diagnosis were correctly coded on the most recent MDS. Diagnosis will be added to the next MDS if appropriate.	

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F 272	Continued From page 5 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 observation, medical record review, and staff interview, the facility failed to identify and comprehensively assess the need for treatment of obstructive sleep apnea for 1 non-sample resident (#25). The findings were: Resident #25 was admitted to the facility on 4/19/13. Review of the resident's admission MDS assessment dated 4/25/13 revealed active diagnoses of hypertension, gastroesphogeal reflux disease, thyroid disorder, anxiety disorder, psychotic disorder, and edema. The admission MDS assessment further revealed the resident understands and was understood, and had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, reflecting moderate cognitive impairment. Review of the resident's medical history from the previous facility, dated at 3/22/13, revealed an additional diagnosis of obstructive sleep apnea and the resident was known to use a continuous positive airway pressure (CPAP) machine for this condition. A telephone order dated 4/19/13 and timed 4:46 PM, the day of admission, revealed a physician order authorizing	F 272	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Residents that utilize respiratory equipment are assessed upon admission, quarterly, and upon change of condition for need and ongoing use. If a resident declines use, re-evaluation is conducted, the physician is notified, and any new orders are followed. Residents are visualized by RN Unit Managers/Designees and Nurses upon routine rounds. If residents are not utilizing respiratory equipment, further evaluation will be conducted and the physician will be notified for further advisement.	

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F 272	Continued From page 5 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.	F 272	Nurses will check equipment for proper functioning when assisting resident/monitoring for use. If problems with the equipment are noted, the equipment will be repaired or replaced as needed.	
	This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to identify and comprehensively assess the need for treatment of obstructive sleep apnea for 1 non-sample resident (#25). The findings were: Resident #25 was admitted to the facility on 4/19/13. Review of the resident's admission MDS assessment dated 4/25/13 revealed active diagnoses of hypertension, gastroesphogeal reflux disease, thyroid disorder, anxiety disorder, psychotic disorder, and edema. The admission MDS assessment further revealed the resident understands and was understood, and had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, reflecting moderate cognitive impairment. Review of the resident's medical history from the previous facility, dated at 3/22/13, revealed an additional diagnosis of obstructive sleep apnea and the resident was known to use a continuous positive airway pressure (CPAP) machine for this condition. A telephone order dated 4/19/13 and timed 4:46 PM, the day of admission, revealed a physician order authorizing		The MDS Coordinator/Designee will review the medical record upon admission and include active diagnosis on the MDS per the RAI manual instructions. The Staff Development Coordinator/Designee will provide education to nurses as needed regarding the policy and procedure regarding: -Monitoring use of respiratory equipment; -Identification of the need to repair or replace the equipment; and -Respiratory assessment of the resident.	

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F 272	Continued From page 6 the possession/use of the CPAP machine. The following concerns were noted: a. Observation of the resident's room on 5/6/13 at 9:58 AM revealed a CPAP machine on a table across the room from the resident's bed. The CPAP machine was not plugged in or set up for use. When asked about the CPAP machine at that time, the resident stated that s/he had sleep apnea, and that s/he needed the CPAP at night. The resident further stated the machine was broken. The resident was unable to state how long the machine had been broken, but stated it had been longer than a month. The resident stated without the CPAP machine s/he had "a hard time at night." When asked if anyone was helping him/her with this problem, the resident stated s/he was "just dealing with it on my own." Also of note, no oxygen concentrator or portable oxygen tank were present in the resident's room at that time. b. Review of the medical record failed to show the respiratory treatment needs for this resident were assessed. c. Interview with the MDS coordinator on 5/9/13 at 1:55 PM verified the active diagnoses section of the MDS assessment should include active diagnoses known from the history and physical and orders documented by the resident's physician during the MDS assessment time frame.	F 272	The RN Unit Managers/Designee will audit residents utilizing respiratory equipment weekly for four (4) weeks to determine if the equipment is properly used, if changes have occurred, and if the equipment is functioning properly. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly for three months for their review, recommendations, and direction as needed. The Performance Improvement Committee will determine the frequency of ongoing monitoring. Date of compliance is June 23, 2013.	
F 281 SS=D	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	F 281		

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F 281	Continued From page 7 by: Based on staff interview and medical record review, the facility failed to ensure staff followed physican's orders for 2 of 14 sample residents (#36, #45). According to the Wyoming Nursing Practice Act of July 2005 and the Administration Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. 1. Review of the medical record for resident #45 showed s/he was admitted on 12/29/11 with diagnoses including diabetes mellitus. Review of the physician's orders showed an order dated 9/25/12 to check the resident's blood sugar twice daily, before breakfast and dinner. In addition there was a physician's order written on 9/26/12 for the resident to receive Novolog Insulin 3 units SQ (subcutaneous) before breakfast and dinner if the resident's blood sugar was greater than 150 mg/dl (milligrams per decliliter). Review of the April 2013 and May 2013 MARs showed the following concerns wih management of the resident's diabetes: a. On 4/2/13 and 4/3/13 the 4 PM finger stick blood sugar (FSBS) was not recorded as being performed. In addition, on 4/22/13 no FSBS was recorded at 7 AM. b. On 4/20/13 the resident received Novolog Insulin 3 units at 4 PM, however there was no evidence the FSBS was performed at that time. c. The resident received Novolog Insulin on 4/14/13 when the blood sugar was not greater than 150 mg/dl at 4 PM; the FSBS was recorded as only 102 mg/dl. In addition, on 4/28/13 at 7 AM the resident was administered 3 units of Novolog	F 281	**F-281 – Services Provided Meet Professional Standards** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The physician for resident #45 was notified of the variance in glucose monitoring and insulin administration. The facility policy for medication variance was followed, which included notification of the physician, for resident #36 on 05/02/13. The Staff Development Coordinator/Designee with provide education to nursing staff regarding the facility policy and procedures related to following physician orders as they relate to blood sugar monitoring and medication administration.	

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F 281	Continued From page 7 by: Based on staff interview and medical record review, the facility failed to ensure staff followed physican's orders for 2 of 14 sample residents (#36, #45). According to the Wyoming Nursing Practice Act of July 2005 and the Administration Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. 1. Review of the medical record for resident #45 showed s/he was admitted on 12/29/11 with diagnoses including diabetes mellitus. Review of the physician's orders showed an order dated 9/25/12 to check the resident's blood sugar twice daily, before breakfast and dinner. In addition there was a physician's order written on 9/26/12 for the resident to receive Novolog Insulin 3 units SQ (subcutaneous) before breakfast and dinner if the resident's blood sugar was greater than 150 mg/dl (milligrams per deciliter). Review of the April 2013 and May 2013 MARs showed the following concerns wih management of the resident's diabetes: a. On 4/2/13 and 4/3/13 the 4 PM finger stick blood sugar (FSBS) was not recorded as being performed. In addition, on 4/22/13 no FSBS was recorded at 7 AM. b. On 4/20/13 the resident received Novolog Insulin 3 units at 4 PM, however there was no evidence the FSBS was performed at that time. c. The resident received Novolog Insulin on 4/14/13 when the blood sugar was not greater than 150 mg/dl at 4 PM; the FSBS was recorded as only 102 mg/dl. In addition, on 4/28/13 at 7 AM the resident was administered 3 units of Novolog	F 281	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** RN Unit Managers/Designee will conduct an audit of residents that have Fingerstick Blood Glucose (FSBG) checks and/or insulin based on FSBG results. Based on the results of the audit, corrective action will be taken as indicated. RN Unit Managers/Designee will audit Medication Administration Records (MARs) for the last 30 days to determine if medications were documented to indicate they were given as ordered. Corrective action will be taken as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 8 Insulin when the blood sugar was 141 mg/dl; less than 150 mg/dl. Finally, on 5/6/13 at 8 PM the resident's blood sugar was 121mg/dl yet she received 3 units of Novolog Insulin when none should have been administered. d. On 5/02/13 the resident's blood sugar was 208 mg/dl at 8 PM, however the 3 units of Novolog Insulin was not administered. On 5/03/13 at 7 AM the resident's blood sugar was 157 mg/dl, yet the 3 units of Novolog Insulin was not administered as ordered. Finally, on 5/03/13 at 8 PM the resident's blood sugar was 175 mg/dl, however s/he did not receive the 3 units of Novolog Insulin as ordered. e. An interview with LPN #2 on 5/9/13 at 2:50 PM verified physician orders were not followed as written. 2. Review of the 4/5/13 physician's orders for resident #36 showed an order to discontinue Norco 5/325 two tabs by mouth every four hours but to continue the order for Norco 5/325 one tab by mouth every four hours as needed. Review of the April 2013 MAR showed the resident was administered Norco 5/325 two tablets instead of the one tablet as ordered on 10 occasions after 4/5/13. Review of the controlled drug record and the April 2013 pain monitoring flow sheet verified two tablets were administered at each of these times. Interview with LPN #3 on 5/9/13 at 9:10 AM verified physician's orders were not followed which resulted in the resident receiving double the prescribed dose of pain medication on those 10 occasions.	F 281	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The MARs will be reviewed by the RN Unit Managers/Designee to determine if there were omissions and/or errors. If noted, the Director of Nursing will be notified and corrective action will be taken. This will be done weekly for four (4) weeks and then will be re-evaluated. The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly for three months for their review, recommendations, and direction as needed. The Performance Improvement Committee will determine the frequency of ongoing monitoring.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282	Date of compliance is June 23, 2013.	

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F 282	Continued From page 9 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, medical record review, and staff interview, the facility failed to ensure care was provided as planned for 4 of 14 sample residents (#29, #54, #56, #94). The findings were: 1. Review of the care plan for resident #29 showed the resident had diagnoses that included dementia, depression, and anxiety. The 10/11/12 revised care plan for behaviors showed interventions included encouraging the resident to "engage in an activity of choice, [s/he] loves to read, offer [him/her] a book." Another area of the care plan revised on 3/16/13 was related to "Alteration in Abitity- Colorscapes BLUE R/T Severe Cognitive Impairment..." This area included interventions related to increased anxiety and over-stimulation. The interventions included "Calm [the resident] with gentle "swaddling" (wrap with blanket or soft wrap)...Provide hand massage to promote relaxation." The following concerns were identified: a. Observation on 5/6/13 at 3:05 PM showed the resident was seated in his/her wheelchair in the main area of the Expressions unit. The resident was crying, appeared scared and/or anxious, and was not engaged with staff or in any activity. At 3:10 PM the resident requested the surveyor to help him/her to lay down. Two CNAs were working in the unit, the surveyor passed on this request to CNA #2. At that time the CNA	F 282	**F-282 – Services by Qualified Persons/Per Care Plan** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The interventions identified on the care plan for resident #29 will be communicated to the CNA's to promote use when needed. If CNA's identify additional interventions that are effective, they will be added to the care plan and communicated to other nursing staff for use. Resident #56 will receive mental health counseling in accordance with the therapy treatment plan. seen by LCSW 5/20/13 6/10/13 6/11/13 Resident #94 will receive mental health counseling in accordance with the therapy treatment plan. seen by LCSW 6/11/13 Resident #54 will receive mental health counseling in accordance with the therapy treatment plan. seen by LCSW 6/11/13	

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F 282	Continued From page 9 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, medical record review, and staff interview, the facility failed to ensure care was provided as planned for 4 of 14 sample residents (#29, #54, #56, #94). The findings were: 1. Review of the care plan for resident #29 showed the resident had diagnoses that included dementia, depression, and anxiety. The 10/11/12 revised care plan for behaviors showed interventions included encouraging the resident to "engage in an activity of choice, [s/he] loves to read, offer [him/her] a book." Another area of the care plan revised on 3/16/13 was related to "Alteration in Abitity- Colorscapes BLUE R/T Severe Cognitive Impairment..." This area included interventions related to increased anxiety and over-stimulation. The interventions included "Calm [the resident] with gentle "swaddling" (wrap with blanket or soft wrap)...Provide hand massage to promote relaxation." The following concerns were identified: a. Observation on 5/6/13 at 3:05 PM showed the resident was seated in his/her wheelchair in the main area of the Expressions unit. The resident was crying, appeared scared and/or anxious, and was not engaged with staff or in any activity. At 3:10 PM the resident requested the surveyor to help him/her to lay down. Two CNAs were working in the unit, the surveyor passed on this request to CNA #2. At that time the CNA	F 282	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The RN Unit Managers/Designee will conduct an audit of care plans for residents with behavioral symptoms to identify interventions that need to be communicated to the CNA's. Based on the result of this audit, the information will be communicated to the CNA's utilizing the CNA worksheet. The Social Services Director /Designee, will audit records for residents with orders for mental health services to determine the ordered frequency and if sessions were missed. Residents will be evaluated by the Social Services Director/Designee to determine current mental health needs and contact the practitioner to develop a schedule based on assessed needs. The physicians will be contacted for further advisement.	

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F 282	Continued From page 10 assisted the resident to his/her room. At 3:20 PM the resident was observed seated in his/her wheelchair in the resident's room in the same emotional state, crying and anxious. The resident was alone in the room and there was nothing engaging him/her. b. Interview with CNA #2 on 5/6/13 at 3:20 PM revealed she did not know what to do to calm the resident down. The CNA stated even if the resident was laid down, the behaviors would have been the same. 2. Review of the medical record for resident #56 showed the s/he was admitted to the facility on 10/10/11 with diagnoses including dementia, colitis, hypothyroidism, anxiety, depression, hypertension, congestive heart failure (CHF), osteoporosis, and chronic obstructive lung disease (COPD). Further review of the medical record showed the resident received mental health counseling on 11/27/12. The therapy treatment plan showed the resident should receive "ongoing mental health treatment/psychotherapy 1-2 x's weekly or as clinically indicated." The next documentation of mental health counseling was 3/11/13 (about 3 months). 3. Review of the medical record for resident #94 showed the resident was admitted to the facility 8/8/11 with diagnoses including dementia, diabetes, and osteoarthritis. Further review of the medical record showed the resident received mental health counseling on 10/2/12. The therapy treatment plan showed the resident should receive "ongoing mental health treatment/psychotherapy 1-2 x's weekly or as clinically indicated." The next documentation of	F 282	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Care plans are developed upon admission, quarterly, and with significant change of condition. Care planned interventions are communicated to the CNA's as appropriate, using the CNA worksheets. The RN Unit Managers/Designee is responsible for confirming the worksheets are accurate. When mental health referrals are made, the Social Services Director/Designee is notified and arrangements are made with the practitioner. The Social Services Director/Designee monitors the frequency of visits, the notes of the practitioner, follow-up on recommendations, etc.	

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F 282	Continued From page 10 assisted the resident to his/her room. At 3:20 PM the resident was observed seated in his/her wheelchair in the resident's room in the same emotional state, crying and anxious. The resident was alone in the room and there was nothing engaging him/her. b. Interview with CNA #2 on 5/6/13 at 3:20 PM revealed she did not know what to do to calm the resident down. The CNA stated even if the resident was laid down, the behaviors would have been the same. 2. Review of the medical record for resident #56 showed the s/he was admitted to the facility on 10/10/11 with diagnoses including dementia, colitis, hypothyroidism, anxiety, depression, hypertension, congestive heart failure (CHF), osteoporosis, and chronic obstructive lung disease (COPD). Further review of the medical record showed the resident received mental health counseling on 11/27/12. The therapy treatment plan showed the resident should receive "ongoing mental health treatment/psychotherapy 1-2 x's weekly or as clinically indicated." The next documentation of mental health counseling was 3/11/13 (about 3 months). 3. Review of the medical record for resident #94 showed the resident was admitted to the facility 8/8/11 with diagnoses including dementia, diabetes, and osteoarthritis. Further review of the medical record showed the resident received mental health counseling on 10/2/12. The therapy treatment plan showed the resident should receive "ongoing mental health treatment/psychotherapy 1-2 x's weekly or as clinically indicated." The next documentation of	F 282	If a practitioner is unable to visit as ordered, the Social Services Director/Designee will evaluate the resident to determine the urgency of the mental health issues. This information will be communicated to the physician for further advisement.	

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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 282	Continued From page 11 mental health counseling was 3/11/13 (about 4 month). 4. Review of the medical record for resident #54 showed the resident was admitted to the facility on 11/6/12 with diagnoses which included depression. Further review of the medical record showed the resident received mental health counseling on 3/11/13. The therapy treatment plan showed the resident should receive "ongoing mental health treatment/psychotherapy 1-2 x's weekly or as clinically indicated." Review of the medical record failed to show evidence of subsequent counseling. During an interview on 5/8/13 at 5:15 PM with the DON and social services director, they revealed the mental health counselor for these residents had experienced and extended illness. During the extended absence the residents were not evaluated for their mental health needs.	F 282		
F 309 SS=D	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 staff interview and medical record review, the facility failed to ensure the insulin regimen was followed as ordered by the physician	F 309	**F-309 – Provide Care/Services for Highest Well Being** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The facility policy for medication variance was followed, which included notification of the physician, for resident #36 on 05/02/13 The physician for resident #45 was notified of the variance in glucose monitoring and insulin administration.	

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F 309	Continued From page 12 for 1 of 2 sample residents (#45) who were on sliding scale insulin for management of their diabetes mellitus. In addition, the facility failed to ensure staff administered the correct dose of medicine for pain management for 1 of 11 residents (#36) with pain. 1. Review of the medical record showed resident #36 was admitted on 6/22/12 with diagnoses including degenerative joint disease. Review of the 2/12/13 quarterly MDS assessment showed the resident had frequent pain. Review of the 4/5/13 physician's orders for the resident showed an order to discontinue Norco 5/325 2 tabs by mouth every 4 hours but to leave the order for Norco 5/325 1 tab by mouth every 4 hours as needed. The following concerns were identified: a. Review of the April 2013 MAR showed the resident was administered Norco 5/325 two tablets instead of the one tablet as ordered on 10 occasions (4/7/13, 4/8/13, 4/14/13, 4/15/13, 4/17/13, twice on 4/20/13, 4/21/13, 4/23/13, and 4/28/13). Review of the controlled drug record and the April 2013 pain monitoring flow sheet verified two tablets were administered on each of these times, resulting in the resident receiving twice the dose prescribed. b. Review of the controlled drug record showed in May 2013 the resident was administered two Norco 3/325 on 5/2/13 at 5 AM. However the May 2013 MAR showed the resident was administered only one Norco 5/325 tablet at that time. c. Interview with LPN #3 on 5/9/13 at 9:10 AM verified the wrong dose of Norco 5/325 was given to the resident. 2. Review of the medical record for resident #45	F 309	The Staff Development Coordinator/Designee with provide education to nursing staff regarding the facility policy and procedures related to following physician orders as they relate to blood sugar monitoring and medication administration. Resident #45's blood sugar will be monitored in accordance the with the physician's order.	

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F 309	Continued From page 12 for 1 of 2 sample residents (#45) who were on sliding scale insulin for management of their diabetes mellitus. In addition, the facility failed to ensure staff administered the correct dose of medicine for pain management for 1 of 11 residents (#36) with pain. 1. Review of the medical record showed resident #36 was admitted on 6/22/12 with diagnoses including degenerative joint disease. Review of the 2/12/13 quarterly MDS assessment showed the resident had frequent pain. Review of the 4/5/13 physician's orders for the resident showed an order to discontinue Norco 5/325 2 tabs by mouth every 4 hours but to leave the order for Norco 5/325 1 tab by mouth every 4 hours as needed. The following concerns were identified: a. Review of the April 2013 MAR showed the resident was administered Norco 5/325 two tablets instead of the one tablet as ordered on 10 occasions (4/7/13, 4/8/13, 4/14/13, 4/15/13, 4/17/13, twice on 4/20/13, 4/21/13, 4/23/13, and 4/28/13). Review of the controlled drug record and the April 2013 pain monitoring flow sheet verified two tablets were administered on each of these times, resulting in the resident receiving twice the dose prescribed. b. Review of the controlled drug record showed in May 2013 the resident was administered two Norco 3/325 on 5/2/13 at 5 AM. However the May 2013 MAR showed the resident was administered only one Norco 5/325 tablet at that time. c. Interview with LPN #3 on 5/9/13 at 9:10 AM verified the wrong dose of Norco 5/325 was given to the resident. 2. Review of the medical record for resident #45	F 309	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** RN Unit Managers/Designee will conduct an audit of residents that have Fingerstick Blood Glucose (FSBG) checks and/or insulin based on FSBG results. Based on the results of the audit, corrective action will be taken as indicated. RN Unit Managers/Designee will audit Medication Administration Records (MARs) for the last 30 days to determine if medications were documented to indicate they were given as ordered. Corrective action will be taken as indicated.	

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F 309	Continued From page 13 showed s/he was admitted on 12/29/11 with diagnosis including diabetes mellitus. Review of physician's orders showed an order dated 9/25/12 to check the resident's blood sugar twice daily, before breakfast and dinner. In addition there was a physician's order written on 9/26/12 for the resident to receive Novolog Insulin 3 units SQ (subcutaneous) before breakfast and dinner if the blood sugar was greater than 150mg/dl (milligrams per deciliter). Review of the April 2013 and May 2013 MARs identified the following concerns with administration of insulin: a. On 4/02/13 and 4/03/13 at 4 PM the FSBS (finger stick blood sugar) was not recorded on the MAR. b. On 4/14/13 the resident's blood sugar was 102 mg/dl at 4 PM, yet s/he received Novolog Insulin 3 units when s/he should not have received any insulin. c. On 4/20/13 the resident received Novolog Insulin 3 units at 4 PM however, there was no evidence an FSBS was performed at 4 PM. d. On 4/22/13 at 7 AM no FSBS was recorded on the MAR. e. On 4/26/13 at 7 AM the resident's blood sugar was 124 mg/dl, yet s/he received Novolog Insulin 3 units when s/he should not have received any insulin. f. On 4/28/13 at 7 AM the resident's blood sugar was 141 mg/dl, yet s/he received Novolog Insulin 3 units when s/he should not have received any insulin. g. On 5/02/13 the resident's blood sugar was 208 mg/dl at 8 PM, however the 3 units of Novolog Insulin was not administered as ordered. h. On 5/03/13 at 7 AM the resident's blood sugar was 157 mg/dl, yet the 3 units of Novolog Insulin was not administered as ordered.	F 309	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Fingerstick Blood Glucose (FSBG) checks are conducted by nurses and based on the result, insulin administered as ordered. This is documented on the MAR. Medications are administered as ordered and documented on the MAR. Changes to orders are made on the Medication Administration Records (MAR).	

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F 309	Continued From page 13 showed s/he was admitted on 12/29/11 with diagnosis including diabetes mellitus. Review of physician's orders showed an order dated 9/25/12 to check the resident's blood sugar twice daily, before breakfast and dinner. In addition there was a physician's order written on 9/26/12 for the resident to receive Novolog Insulin 3 units SQ (subcutaneous) before breakfast and dinner if the blood sugar was greater than 150mg/dl (milligrams per deciliter). Review of the April 2013 and May 2013 MARs identified the following concerns with administration of insulin: a. On 4/02/13 and 4/03/13 at 4 PM the FSBS (finger stick blood sugar) was not recorded on the MAR. b. On 4/14/13 the resident's blood sugar was 102 mg/dl at 4 PM, yet s/he received Novolog Insulin 3 units when s/he should not have received any insulin. c. On 4/20/13 the resident received Novolog Insulin 3 units at 4 PM however, there was no evidence an FSBS was performed at 4 PM. d. On 4/22/13 at 7 AM no FSBS was recorded on the MAR. e. On 4/26/13 at 7 AM the resident's blood sugar was 124 mg/dl, yet s/he received Novolog Insulin 3 units when s/he should not have received any insulin. f. On 4/28/13 at 7 AM the resident's blood sugar was 141 mg/dl, yet s/he received Novolog Insulin 3 units when s/he should not have received any insulin. g. On 5/02/13 the resident's blood sugar was 208 mg/dl at 8 PM, however the 3 units of Novolog Insulin was not administered as ordered. h. On 5/03/13 at 7 AM the resident's blood sugar was 157 mg/dl, yet the 3 units of Novolog Insulin was not administered as ordered.	F 309	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The MARs will be reviewed by the RN Unit Managers/Designee to determine if there were omissions and/or errors. If noted, the Director of Nursing will be notified and corrective action will be taken. This will be done weekly for four (4) weeks and then will be re-evaluated. The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly for three months for their review, recommendations, and direction as needed. The Performance Improvement Committee will	

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F 309	Continued From page 14 i. On 5/03/13 at 8 PM the resident's blood sugar was 175 mg/dl, however s/he did not receive the 3 units of Novolog Insulin as ordered. j. On 5/06/13 at 8 PM the resident's blood sugar was 121 mg/dl, yet s/he received 3 units of Novolog Insulin when none should have been administered. k. During an interview on 5/9/13 at 2:50 PM with LPN #2, she verified blood sugars were not performed as noted above and the Novolog Insulin was not administered as prescribed.	F 309	determine the frequency of ongoing monitoring. Date of compliance is June 23, 2013.	
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, medical record review, and staff interview the facility failed to provide assistance with ADLs to 1 of 14 sample residents (#60) requiring assistance with hygiene and bathing. The findings were: Resident #60 was most recently admitted to the facility on 12/22/12 with diagnoses of traumatic brain injury, Stevens-Johnson syndrome (a skin disease), contracture of the left hand, urinary tract infection, seizures, and malnutrition. Review of the resident's quarterly MDS assessment dated 2/6/13 showed the resident required extensive physical assistance with personal hygiene and total physical assistance with bathing. Review of	F 312	**F-312 – ADL Care Provided for Dependent Residents** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The fingernails for resident #60 were trimmed and cleaned. The Staff Development Coordinator/Designee will provide education to nursing staff on providing proper fingernail care.	

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F 312	Continued From page 15 the resident's care plan revealed an intervention dated 11/7/12 that showed "Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short." Another intervention on the care plan, dated 11/15/12, read "Resident is dependent on staff with bathing 2X a week and PRN." The following concerns were identified: a. Continuous observation of the resident on 5/6/13 beginning at 3:20 PM revealed the resident was up in his/her wheelchair watching a movie in the small dining room behind the 3rd floor nurse's station. The resident's fingernails were noted to be long and dirty. At 4:52 PM the resident was wheeled from the small room behind the nurse's station to the main dining room, where s/he was positioned at a table prior to dinner being served. The resident was not offered an opportunity or assisted to cleanse his/her hands. At 5:33 PM the resident was noted to be scratching at him/herself, particularly the left upper arm, to the point of drawing blood. Fingernails of the right hand were again noted to be long, with dark matter caked underneath the fingernails. At 5:38 PM, the resident's meal arrived, and s/he was noted to eat with his/her right hand. b. Observation of the resident on 5/8/13 at 9:20 AM revealed the fingernails on the resident's right hand were shorter, and clean. However, observation on 5/9/13 at 5:12 PM revealed the resident's right hand was again dirty-appearing and had dark matter caked under the fingernails. The resident was again noted to eat with his/her right hand. c. Interview with the DON and the 3rd floor unit manager, RN#3 on 5/9/13 at 7:00 PM verified the resident's fingernails should be cleaned with baths and as needed, and that the resident needs	F 312	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The RN Unit Managers/Designee will conduct weekly rounds to determine if residents are in need of fingernail care. Care will be provided as needed.	

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	535013	A. BUILDING _____ B. WING _____	C 05/09/2013

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F 312	Continued From page 15 the resident's care plan revealed an intervention dated 11/7/12 that showed "Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short." Another intervention on the care plan, dated 11/15/12, read "Resident is dependent on staff with bathing 2X a week and PRN." The following concerns were identified: a. Continuous observation of the resident on 5/6/13 beginning at 3:20 PM revealed the resident was up in his/her wheelchair watching a movie in the small dining room behind the 3rd floor nurse's station. The resident's fingernails were noted to be long and dirty. At 4:52 PM the resident was wheeled from the small room behind the nurse's station to the main dining room, where s/he was positioned at a table prior to dinner being served. The resident was not offered an opportunity or assisted to cleanse his/her hands. At 5:33 PM the resident was noted to be scratching at him/herself, particularly the left upper arm, to the point of drawing blood. Fingernails of the right hand were again noted to be long, with dark matter caked underneath the fingernails. At 5:38 PM, the resident's meal arrived, and s/he was noted to eat with his/her right hand. b. Observation of the resident on 5/8/13 at 9:20 AM revealed the fingernails on the resident's right hand were shorter, and clean. However, observation on 5/9/13 at 5:12 PM revealed the resident's right hand was again dirty-appearing and had dark matter caked under the fingernails. The resident was again noted to eat with his/her right hand. c. Interview with the DON and the 3rd floor unit manager, RN#3 on 5/9/13 at 7:00 PM verified the resident's fingernails should be cleaned with baths and as needed, and that the resident needs	F 312	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Fingernail care is provided with bathing and as needed. The Staff Development Coordinator/Designee will provide education to nursing staff on providing proper fingernail care as needed. The RN Unit Managers/Designee will conduct weekly rounds to confirm resident fingernails are properly cleaned and trimmed. Nail care will be performed as needed. The results of the rounds conducted by the RN Unit Managers/Designee will be documented 2-3 times/week for four (4) weeks and will then re-evaluate.	

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F 312	Continued From page 15 the resident's care plan revealed an intervention dated 11/7/12 that showed "Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short." Another intervention on the care plan, dated 11/15/12, read "Resident is dependent on staff with bathing 2X a week and PRN." The following concerns were identified: a. Continuous observation of the resident on 5/6/13 beginning at 3:20 PM revealed the resident was up in his/her wheelchair watching a movie in the small dining room behind the 3rd floor nurse's station. The resident's fingernails were noted to be long and dirty. At 4:52 PM the resident was wheeled from the small room behind the nurse's station to the main dining room, where s/he was positioned at a table prior to dinner being served. The resident was not offered an opportunity or assisted to cleanse his/her hands. At 5:33 PM the resident was noted to be scratching at him/herself, particularly the left upper arm, to the point of drawing blood. Fingernails of the right hand were again noted to be long, with dark matter caked underneath the fingernails. At 5:38 PM, the resident's meal arrived, and s/he was noted to eat with his/her right hand. b. Observation of the resident on 5/8/13 at 9:20 AM revealed the fingernails on the resident's right hand were shorter, and clean. However, observation on 5/9/13 at 5:12 PM revealed the resident's right hand was again dirty-appearing and had dark matter caked under the fingernails. The resident was again noted to eat with his/her right hand. c. Interview with the DON and the 3rd floor unit manager, RN#3 on 5/9/13 at 7:00 PM verified the resident's fingernails should be cleaned with baths and as needed, and that the resident needs	F 312	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of the rounds to the Performance Improvement Committee for three months for their review, recommendations, and direction as needed. The Performance Improvement Committee will determine the frequency of ongoing monitoring. Date of compliance is June 23, 2013.	

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F 312	Continued From page 16 hand hygiene before meals.	F 312		
F 315 SS=D	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, medical record review, and staff interview, the facility failed to ensure proper placement of the drainage tubing to prevent infection for 1 of 2 sample residents (#72) with an indwelling urinary catheter. The findings were: Review of admission orders for resident #72 showed s/he was admitted to the facility following a hospitalization from 4/2/13 through 4/18/13. The orders showed an indwelling catheter was inserted on 4/20/13 because of skin care issues. Observation on 5/6/13 at 5:25 PM showed the resident was transferred with a mechanical lift device by CNA #3 from a recliner to the bedside commode. The resident used the commode, received perineal care, and was transferred back to the recliner. During the entire process, the drainage bag for the indwelling catheter was	F 315	**F-315 – No Catheter Prevent UTI, Restore Bladder** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Staff Development Coordinator provided education to the CNA involved in the transfer of resident #60. The RN Unit Managers/Designee will conduct education with nursing staff regarding the policy and procedure of proper placement of catheter drainage tubing.	

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	535013	A. BUILDING _____ B. WING _____	C 05/09/2013

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F 312	Continued From page 16 hand hygiene before meals.	F 312		
F 315 SS=D	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, medical record review, and staff interview, the facility failed to ensure proper placement of the drainage tubing to prevent infection for 1 of 2 sample residents (#72) with an indwelling urinary catheter. The findings were: Review of admission orders for resident #72 showed s/he was admitted to the facility following a hospitalization from 4/2/13 through 4/18/13. The orders showed an indwelling catheter was inserted on 4/20/13 because of skin care issues. Observation on 5/6/13 at 5:25 PM showed the resident was transferred with a mechanical lift device by CNA #3 from a recliner to the bedside commode. The resident used the commode, received perineal care, and was transferred back to the recliner. During the entire process, the drainage bag for the indwelling catheter was	F 315	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The RN Unit Managers/Designee will conduct weekly observations for four (4) weeks during care/transfers for residents that utilize catheters to determine if catheter bags are appropriately placed. Based on the results of the audits, additional training will be done.	

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F 312	Continued From page 16 hand hygiene before meals.	F 312		
F 315 SS=D	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, medical record review, and staff interview, the facility failed to ensure proper placement of the drainage tubing to prevent infection for 1 of 2 sample residents (#72) with an indwelling urinary catheter. The findings were: Review of admission orders for resident #72 showed s/he was admitted to the facility following a hospitalization from 4/2/13 through 4/18/13. The orders showed an indwelling catheter was inserted on 4/20/13 because of skin care issues. Observation on 5/6/13 at 5:25 PM showed the resident was transferred with a mechanical lift device by CNA #3 from a recliner to the bedside commode. The resident used the commode, received perineal care, and was transferred back to the recliner. During the entire process, the drainage bag for the indwelling catheter was	F 315	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Indwelling catheter-collecting bags are maintained below the level of the bladder at all times. Indwelling catheter-collecting bags are stored off of the floor. The Staff Development Coordinator/Designee will conduct education with CNAs regarding the policy and procedure for proper positioning of indwelling catheter bags as needed. RN Unit Managers/Designee will conduct weekly rounds to observe care/transfers for residents that utilize catheters to determine if catheter bags appropriately placed.	

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F 312	Continued From page 16 hand hygiene before meals.	F 312		
F 315 SS=D	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, medical record review, and staff interview, the facility failed to ensure proper placement of the drainage tubing to prevent infection for 1 of 2 sample residents (#72) with an indwelling urinary catheter. The findings were: Review of admission orders for resident #72 showed s/he was admitted to the facility following a hospitalization from 4/2/13 through 4/18/13. The orders showed an indwelling catheter was inserted on 4/20/13 because of skin care issues. Observation on 5/6/13 at 5:25 PM showed the resident was transferred with a mechanical lift device by CNA #3 from a recliner to the bedside commode. The resident used the commode, received perineal care, and was transferred back to the recliner. During the entire process, the drainage bag for the indwelling catheter was	F 315	The results of the rounds will be documented 2-3 times a week for four (4) weeks and based on the results of the rounds, additional training will be done. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of the rounds to the Performance Improvement Committee for three months for their review, recommendations, and direction as needed. The Performance Improvement Committee will determine the frequency of ongoing monitoring. Date of compliance is June 23, 2013.	

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F 315	Continued From page 17 hooked to the top bar of the lift, approximately 36 inches above the resident's bladder. During an interview with the 3rd floor nurse manager, on 5/8/13 at 10:55 AM, she verified the facility practice was for the drainage bag and tubing of an indwelling catheter to be positioned below the bladder.	F 315		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview with staff and family, the facility failed to ensure respiratory treatment and care was provided for 1 non-sample resident (#25). The facility failed to assess the respiratory needs and equipment required for the resident's diagnoses of obstructive sleep apnea. The findings were: Resident #25 was admitted to the facility on 4/19/13. Review of the resident's admission MDS assessment dated 4/25/13 revealed active	F 328	**F-328 – Treatment/Care for Special Needs** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #25's physician discontinued the use of the CPAP. The care plan was updated to reflect this. A sleep study has been ordered for resident #25 to determine if the CPAP is needed. Pulse Oximetry checks will be done as ordered at night to evaluate oxygen needs.	

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F 328	Continued From page 18 diagnoses of hypertension, gastroesphogeal reflux disease, thyroid disorder, anxiety disorder, psychotic disorder, and edema. The admission MDS assessment further revealed the resident understands and was understood, and had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, reflecting moderate cognitive impairment. Review of the resident's medical history from the previous facility, dated 3/22/13, revealed an additional diagnosis of obstructive sleep apnea and that the resident was known to use a CPAP machine for this condition. A telephone order dated 4/19/13 and timed 4:46 PM, the day of admission, revealed a physician order authorizing the possession/use of the continuous positive airway pressure (CPAP) machine. Review of the medical record failed to show the respiratory treatment needs for this resident were assessed. Interview with the MDS coordinator on 5/9/13 at 1:55 PM verified the active diagnoses section of the MDS assessment should include active diagnoses known from the history and physical and orders documented by the resident's physician during the MDS assessment time frame. The following concerns were identified related to this resident's respiratory therapy: a. Observation of the resident's room on 5/6/13 at 9:58 AM revealed a CPAP machine on a table across the room from the resident's bed. The CPAP machine was not plugged in or set up for use. When asked about the CPAP machine at that time, the resident stated that s/he had sleep apnea, and that s/he needed the CPAP at night. The resident further stated that the machine was broken. The resident was unable to state how long the machine had been broken, but stated that it had been longer than a month. The	F 328	The Staff Development Coordinator/Designee will provide education to nurses regarding the facility policy and procedure regarding: -Monitoring use of respiratory equipment; -Indication of the need to repair or replace the respiratory equipment as needed; and -Respiratory assessment of the resident. The Director of Nursing/Designee will provide education to the MDS Coordinator regarding the placement of active diagnosis on the MDS as well as the location of the active diagnosis on the resident's medical record.	

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F 328	Continued From page 19 resident stated that without the CPAP machine s/he had "a hard time at night." When asked if anyone was helping him/her with this problem, the resident stated that s/he was "just dealing with it on my own." Also of note, no oxygen concentrator or portable oxygen tank were present in the resident's room at that time. b. During an interview with the DON on 5/9/13 at 3:50 PM, she stated she had set the CPAP machine up next to the resident's bed on 5/6/13, after the survey tour, to "see if it worked or not," and then spoke with the unit manager about it, after which the unit manager, RN #2 obtained an order to discontinue the CPAP machine. The DON also stated at this time the interdisciplinary team along with the resident's family member had decided the resident did not need the CPAP machine. c. Review of nursing notes dated 4/20/13, timed at 8:01 AM, revealed the resident was "very anxious on nocs [night shift]. Got out of bed and asked this nurse to turn off the channels. Said the voices were bothering him. Asked where the voices were and s/he said 'They're in my head.'" Nursing notes dated 4/20/13, timed at 10:59 AM, revealed the resident was "difficult to awaken...very confused." Nursing notes dated 4/20/12, timed at 5:58 PM revealed the resident was "very confused when awake." Nursing notes regarding nocturia (waking during the night in order to urinate) were made on 4/27/13, and 4/29/13. According to the National Heart, Lung and Blood Institute (http://www.nhlbi.nih.gov/health/health-topics/topics/sleepapnea/, retrieved 5/13/13) obstructive sleep apnea is a chronic condition. Sleep is disrupted when the airway collapses or becomes blocked during sleep. The CPAP machine is the	F 328	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** RN Unit Managers/Designee will conduct an audit to determine if there are residents that are not utilizing physician-ordered respiratory equipment. If noted, the resident will be assessed and the physician will be notified. The MDS Coordinator/Designee will review the records for residents utilizing respiratory equipment to determine if diagnosis were correctly coded on the most recent MDS. Diagnosis will be added to the next MDS if appropriate.	

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F 328	Continued From page 20 most common treatment for moderate to severe sleep apnea in adults. Sleep apnea is a leading cause of daytime sleepiness. Untreated sleep apnea can increase the risk of hypertension, myocardial infarction, cerebrovascular accident, obesity and diabetes. Other signs and symptoms of sleep apnea include morning headaches, memory or learning problems and not being able to concentrate, feeling irritable, depressed or having mood swings or personality changes, and waking frequently to urinate. d. Observation of the resident's room on 5/9/13 at 10:27 AM revealed the resident's CPAP machine was placed on the bedside table, plugged in, with a hose running from the machine to a plastic bag hanging on the side of the resident's bed. Inside the plastic bag a CPAP mask and associated head gear were seen. The machine was noted to power on and blow air through the attached hose. The resident stated at the time of observation that the head strap did not fit correctly, so s/he was unable to use the machine. At no time during this interview did the resident indicate s/he no longer needed the machine. e. Review of a physician's telephone order dated 5/6/13, untimed, showed, "Clarification of CPAP - D/C CPAP due to resident statement of claustrophobia and ability to maintain sat's [oxygen saturation] on RA [room air]." f. Review of medical records, both paper-based and electronic, revealed 10 instances between the admission date of 4/19/13 and 5/9/13 when the resident's oxygen saturations were measured and recorded: 4/20/13 at 8:01 AM, 4/22/13 at 7:21 AM, 4/24/13 at 11:56 PM, 4/28/13 at 3:34 AM, 4/29/13 at 6 AM, 5/3/13 at 7:32 AM, 5/5/13 at 6:30 AM, 5/6/13	F 328	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Residents that utilize respiratory equipment are assessed upon admission, quarterly and upon change of condition for need and ongoing use. If a resident declines use, re-evaluation is conducted, the physician is notified, and any new orders are followed. Residents are visualized by RN Unit Managers/Designee and nurses upon routine rounds. If residents are not utilizing respiratory equipment, further evaluation will be conducted and the physician will be notified for further advisement. Nurses will check equipment for proper functioning when assisting resident/monitoring for use. If problems with the equipment are noted, the equipment will be repaired or replaced as needed.	

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F 328	Continued From page 20 most common treatment for moderate to severe sleep apnea in adults. Sleep apnea is a leading cause of daytime sleepiness. Untreated sleep apnea can increase the risk of hypertension, myocardial infarction, cerebrovascular accident, obesity and diabetes. Other signs and symptoms of sleep apnea include morning headaches, memory or learning problems and not being able to concentrate, feeling irritable, depressed or having mood swings or personality changes, and waking frequently to urinate. d. Observation of the resident's room on 5/9/13 at 10:27 AM revealed the resident's CPAP machine was placed on the bedside table, plugged in, with a hose running from the machine to a plastic bag hanging on the side of the resident's bed. Inside the plastic bag a CPAP mask and associated head gear were seen. The machine was noted to power on and blow air through the attached hose. The resident stated at the time of observation that the head strap did not fit correctly, so s/he was unable to use the machine. At no time during this interview did the resident indicate s/he no longer needed the machine. e. Review of a physician's telephone order dated 5/6/13, untimed, showed, "Clarification of CPAP - D/C CPAP due to resident statement of claustrophobia and ability to maintain sat's [oxygen saturation] on RA [room air]." f. Review of medical records, both paper-based and electronic, revealed 10 instances between the admission date of 4/19/13 and 5/9/13 when the resident's oxygen saturations were measured and recorded: 4/20/13 at 8:01 AM, 4/22/13 at 7:21 AM, 4/24/13 at 11:56 PM, 4/28/13 at 3:34 AM, 4/29/13 at 6 AM, 5/3/13 at 7:32 AM, 5/5/13 at 6:30 AM, 5/6/13	F 328	The MDS Coordinator/Designee will review the medical record upon admission and include active diagnosis on the MDS per the RAI manual instructions. The Staff Development Coordinator/Designee will provide education to nurses regarding the facility policy and procedure regarding: -Monitoring use of respiratory equipment; -Indication of the need to repair or replace the respiratory equipment as needed; and -Respiratory assessment of the resident. The RN Unit Managers/Designee will audit residents utilizing respiratory equipment weekly for four (4) weeks to determine if the equipment is properly being used, if changes have occurred, and if the equipment is functioning properly.	

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F 328	Continued From page 21 at 10:38 PM, 5/7/13 at 11:45 PM, and 5/8/13 at 8:33 AM. All of these measurements were greater than 90%. However, there was no evidence of continuous monitoring of the resident's oxygen saturation while sleeping that might indicate an ability to maintain oxygen saturations on room air while sleeping (the problem associated with sleep apnea). When asked about this on 5/9/13 at 3:50 PM, the DON had no comment. g. Interview with a family member on 5/9/13 at 11:37 AM revealed that s/he resided in another state. S/he stated s/he had only recently become the resident's guardian, and was "still getting information on [his/her] medical history." S/he did not think the resident used his/her CPAP machine while at the previous facility. S/he stated that s/he was uncertain whether the resident used his/her CPAP machine in other facilities, but stated the resident had used the CPAP machine when living at home. h. Review of a progress note, provided by the DON dated 5/9/13, and timed 4:27 PM, revealed notes made by the social service associate indicating that a care plan meeting was held on 5/1/13 at 4:30 PM. According to this care plan note, the interdisciplinary team had discussed the resident's use of the CPAP machine with his/her family member, and the resident had refused to use the CPAP machine at his/her previous facility. Additionally, the note showed the family was informed the facility would "continue to do hx [history] on the use and need of the CPAP." There was no indication the resident was present at this meeting. i. Review of the resident's medical record showed information from the previous facility, dated 3/22/13. These notes revealed that while there the resident "did not have [his/her] CPAP	F 328	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly for three months for their review, recommendations, and direction as needed. The Performance Improvement Committee will determine the frequency of ongoing monitoring. Date of compliance is June 23, 2013.	

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F 328	Continued From page 22 with [him/her]" and instead oxygen was provided via nasal cannula during sleep.	F 328		
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, and staff interview, the facility failed to ensure sanitary conditions in the kitchen related to hand washing techniques as well as equipment cleanliness. The findings were: 1. Observation of the noon meal preparation on 5/8/13 starting at 11:36 AM showed the following concerns related to hand hygiene: a. Dietary aide #1 was preparing sandwiches. The aide wore disposable gloves while making the sandwiches, at 11:43 AM the aide opened the walk-in refrigerator door which was visibly soiled. The aide did not change her gloves before continuing to prepare and handle the sandwiches. At 11:49 AM the aide again handled the walk-in door and failed to perform any hand hygiene before returning to working with the food. b. At 11:51 AM the cooks assistant came into the kitchen and washed her hands at the hand washing sink. The cook assistant handled the	F 371	**F-371 – Food Procure, Store/Prepare/Serve - Sanitary** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** No residents were affected by this deficient practice. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** No residents were affected by this deficient practice.	

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F 371	Continued From page 23 soiled garbage can lid as she threw away the paper towel used to dry her hands. The assistant then proceeded to don gloves, and with gloved hands she handled the walk-in freezer door to retrieve a box of cookies. The assistant then proceeded with out any hand hygiene to place the frozen cookies onto sheet pans handling the food with the soiled gloves. c. At 11:53 AM dietary aide #2, walked into kitchen from the dining room and handled the visibly soiled garbage can lid to throw an item away. Without performing hand hygiene the aide grabbed parchment paper and clean plates and left the kitchen area. 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... (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 5/6/13 at 9:45 AM showed the outside of three oven doors and two range top gas burners were unclean. The outside of the ovens were sticky to the touch with accumulated grease and food. The burners had accumulated food and grease in, on, and around them. Observation of these items on 5/8/13 at 11:36 AM showed they remained in the unclean condition. According to Food Code 2009, U.S. Public Health Service 4-601.11: "...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."	F 371	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Staff Development Coordinator/Designee will provide education to dietary staff addressing the proper procedures for changing gloves, hand washing, and the identification of clean and dirty areas of the kitchen. The Nutrition Services Manager/Designee will conduct random audits to confirm the correct utilization of hand washing procedures, utilization of gloves in regards to infection control, and the recognition of the clean and dirty areas of the kitchen. The Nutrition Services Manager/Designee will conduct random audits to confirm that the oven doors and range top gas burners are clean.	

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	535013	A. BUILDING _____ B. WING _____	C 05/09/2013

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F 371	Continued From page 24 3. Interview with the dietary manager on 5/8/13 at 3:15 PM verified she provided reminders related to hand washing and glove use frequently to the staff. She stated the last in-service education related to the subject was in November 2012. The manager also verified the ovens and range top were in need of better cleaning.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to act on pharmacist recommendations for 2 of 14 sample residents (#70, #85). The findings were: 1. Review of the medication regimen review for resident #85 revealed a pharmacist's recommendation, dated 3/16/13, to discontinue the resident's levothyroxine (a medication for hypothyroidism) and Lexapro (an anti-depressant). Further review of the resident's medical record revealed a "Note to Attending Physician/Prescriber" dated 3/16/13 from the	F 428	**F-428 – Drug Regimen Review, Report** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The pharmacy recommendation for residents #70 and #85 has been addressed by the physician.	

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F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to act on pharmacist recommendations for 2 of 14 sample residents (#70, #85). The findings were: 1. Review of the medication regimen review for resident #85 revealed a pharmacist's recommendation, dated 3/16/13, to discontinue the resident's levothyroxine (a medication for hypothyroidism) and Lexapro (an anti-depressant). Further review of the resident's medical record revealed a "Note to Attending Physician/Prescriber" dated 3/16/13 from the	F 428	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** RN Unit Managers/Designee will review the 2013 pharmacy recommendations to confirm they have been addressed by the physician timely. Based on the results of the audits, communication will be provided to the pharmacist and physician for resolution. The District Director of Clinical Operations/Designee will provide education the Director of Nursing/Designee regarding the policy and procedure for follow-up on pharmacist recommendations.	

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F 428	Continued From page 25 pharmacist suggesting that the levothyroxine, Lexapro and spironolactone (a diuretic) prescribed for the resident were potentially unnecessary. Review of the resident's April 2013 and May 2013 physician's orders revealed that all three medications continued to be prescribed for the resident. The facility was unable to produce any documentation showing a physician response to or acknowledgement of the pharmacist's recommendations. 2. Review of a 3/16/13 pharmacist's recommendation for resident #70 showed he asked the physician to consider discontinuing the resident's levothyroxine. Review of the resident's May 2013 physician's orders revealed that the medication continued to be prescribed for the resident. The facility was unable to produce any documentation showing a physician response to the pharmacist recommendations. Interview with the DON, and the 3rd floor unit manager, RN #3 on 5/9/13 at 6:30 PM confirmed that pharmacist recommendations were routed to the unit manager for action, and the unit manager was then responsible for following up on the physician's response to the recommendation. The DON and RN #3 confirmed these pharmacist recommendations were overlooked and had not yet been acknowledged by the physicians.	F 428	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The consulting pharmacist conducts a review of drug regimens monthly and provides recommendations to the Director of Nursing/Designee and physician. The written recommendations are reviewed by the Director of Nursing/Designee and RN Unit Managers. The physician is contacted, as indicated, and action taken based on the direction provided by the physician. Documentation is made in the medical record to reflect the recommendations, physician notification, and action taken.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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F 441	Continued From page 26 (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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure proper handwashing was implemented during one random observation of resident care. Further, the facility failed to ensure	F 441	**F-441 – Infection Control, Prevent Spread, Linens** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The Staff Development Coordinator educated the CNA that provided peri-care to resident #70 regarding proper hand washing and glove use procedures. The Staff Development Coordinator/Designee will provide education to nursing staff regarding the facility policy and procedure for proper hand washing and glove procedures while providing peri-care. The insulation hanging in the laundry room has been reattached to the duct work. The items found in the Reflections Unit employee bathroom have been removed.	

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F 441	Continued From page 27 accepted infection control standards in the maintenance of clean resident clothing in the facility laundry and the storage of resident use supplies on the Reflections Unit. The findings were: 1. Observation on 5/6/13 at 5:25 PM showed CNA #3 provided perineal care to resident #70. The CNA removed her gloves after completing the perineal care and transferred the resident back to the recliner using a lift device. She then reapplied gloves prior to cleaning the bedside commode. The CNA failed to wash her hands prior to and after removing the gloves. Interview on 5/8/13 at 9 AM with the Infection control preventionist verified facility practice was to perform hand hygiene with an alcohol based product prior to and after removing gloves. Interview with the 3rd floor nurse manager, on 5/8/13 at 10:55 AM also verified that the CNA should have performed hand hygiene between glove changes as specified in the facility policy. 2. Observation on 5/8/13 at 7:45 AM in the laundry room showed two large bins of clean resident clothing were stored directly under the ceiling vent coming from the dryers. The outer covering of the vent was torn in several areas, leaving insulation hanging from the vent 1-3 inches directly over the clean resident clothing. Interview with laundry employee #1 and the housekeeping supervisor at 8 AM verified that the insulation was hanging directly over the clean resident clothing with the potential of falling into the bins. 3. Observation during the survey tour on 5/6/13	F 441	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Peri-care is provided using proper hand washing and glove use. Resident care and personal items are not stored in employee bathrooms. RN Unit Managers/Designee will observe nursing staff providing peri-care during weekly routine rounds to determine if proper technique, including hand washing and glove use, is followed. These observations will be documented 2-3 times/week for four (4) weeks. Based on the results of the observations, additional training will be provided to the nursing staff. RN Unit Manager/Designee will conduct weekly rounds for four (4) weeks to confirm there are not resident-related items stored in employee bathrooms.	

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KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 28 at 9:30 AM with the nurse manager of the Reflections Unit showed resident care items, including lotions, curling irons, denture cleanser tablets, shaving cream, oxygen cannulas, assorted dressings, and disposable isolation gowns/masks were stored in the employee bathroom. In addition, resident dentures were kept over night in the same area in individual denture cups. Interview on 5/8/13 at 5:15 PM with the DON verified this was "not the best place for resident supplies" and verified they needed to be moved.	F 441	**F-465 – Safe/Functional/Sanitary/ Comfortable Environment**	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment in a variety of areas for staff, residents and visitors to the facility. The findings were: 1. Observation on 5/8/13 at 3:48 PM, and on 5/9/13 at 2:55 PM of the second floor shower room located across from the nurse's desk showed two safety hazards to staff and residents. Located near the grooming supply cabinet was a floor-mounted radiator heater. The heater was fully exposed with no covering. There were visible wire connections and metal parts with sharp looking edges. In addition, the ceiling light located	F 465	**Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The floor-mounted heater located in the 2nd floor shower room across from the nurse's desk had a cover placed, wire connections appropriately placed, and sharp metal parts were removed and/or fixed. The ceiling light located in the 2nd floor shower room across from the nurse's station had its plastic shade cover replaced. The stairwell between first and second floor was cleaned and is odor free.	

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F 465	Continued From page 29 in this same area of the room had a plastic shade cover which was falling down. Interview with the area facility manager of maintenance on 5/9/13 at 2:55 PM verified these were safety hazards. 2. Observations throughout the survey from 5/6/13 to 5/9/13 showed the stairwell leading from the first floor to the second floor was not clean. The stairwell smelled of urine and there was visible soil build up and dried liquids on the steps. 3. Observation of the facility dish room on 5/6/13 at 9:45 AM and on 5/9/13 at 3:20 PM showed the following: a. Visible dried and splattered food on the walls and the ceiling. Two ceiling tiles were damaged and had peeling material hanging down. In addition, the paint on the walls of the room was gouged and chipping in multiple areas. b. There was a black substance visible on the wall behind the dish sprayer and on the plumbing underneath the counter on this same wall. Interview with the dietary manager on 5/7/13 at 3:40 PM verified she and her staff had to keep cleaning the black substance because it spread up the wall and would come back if not cleaned frequently. She stated the chemical company (EcoLab) representative was contacted the previous week and they were in the process of finding the right cleaner to take care of the problem. c. The dish room wall near the handwashing sink was soiled with black/brown spatters and mares. Near the floor on this wall the sheetrock was visible in a damaged area. d. The back door leading from outside into the dish room had a small entry way. The backdoor and the walls of this entry way were	F 465	The ceiling tiles in the dish room were cleaned. The ceiling tiles in the dish room that were damaged were replaced. The walls in the dish room where the paint was gouged and chipped were repainted. The black substance in the dish room will be scraped off the wall, treated with bleach and water, and repainted. The dish room wall by the hand washing sink will be cleaned and repainted. The sheetrock by the hand washing sink will be repaired. The back door in the dish room will be cleaned, repainted, and new weather stripping placed at the door. The ventilation duct insulation in the housekeeping supervisors office will be sealed to confirm that no fiberglass insulation is exposed.	

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F 465	Continued From page 29 in this same area of the room had a plastic shade cover which was falling down. Interview with the area facility manager of maintenance on 5/9/13 at 2:56 PM verified these were safety hazards. 2. Observations throughout the survey from 5/6/13 to 5/9/13 showed the stairwell leading from the first floor to the second floor was not clean. The stairwell smelled of urine and there was visible soil build up and dried liquids on the steps. 3. Observation of the facility dish room on 5/6/13 at 9:45 AM and on 5/9/13 at 3:20 PM showed the following: a. Visible dried and splattered food on the walls and the ceiling. Two ceiling tiles were damaged and had peeling material hanging down. In addition, the paint on the walls of the room was gouged and chipping in multiple areas. b. There was a black substance visible on the wall behind the dish sprayer and on the plumbing underneath the counter on this same wall. Interview with the dietary manager on 5/7/13 at 3:40 PM verified she and her staff had to keep cleaning the black substance because it spread up the wall and would come back if not cleaned frequently. She stated the chemical company (EcoLab) representative was contacted the previous week and they were in the process of finding the right cleaner to take care of the problem. c. The dish room wall near the handwashing sink was soiled with black/brown spatters and mares. Near the floor on this wall the sheetrock was visible in a damaged area. d. The back door leading from outside into the dish room had a small entry way. The backdoor and the walls of this entry way were	F 465	The "Repair Request for Maintenance" form is completed by staff when items are noticed to be in need of repair, replacement, repainting, etc. and provided to the Maintenance Director/Designee for completion. The Maintenance Director/Designee will communicate any issues to the Executive Director that would impair or delay the completion of a requested maintenance item. Each area of the facility is cleaned on a scheduled basis, with additional cleaning done between scheduled times as needed. The housekeeper and/or Housekeeping Manager/Nutrition Services Manager/Designee are notified of items/areas in need of cleaning.	

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F 465	Continued From page 30 visibly dirty and had the paint gouged and chipping. The weatherstrip under the back door was damaged and daylight was visible underneath the door to the outside. 4. The housekeeping supervisors office was observed on 5/9/13 at 2:30 PM. A large box like ventilation duct cut through the small room and was at a height that was even with the door. When the door was opened it scraped against the duct work. Additionally, the ducts were covered with a soft flexible silver colored material that contained or provided the insulation. Some of the seams were not fully intact. Interview with the housekeeping supervisor on 5/9/13 at 2:35 PM stated she did not spend much time in the office; however, the vents obstructed the light making it difficult to work in the room. Interview and observation with the area facility manager of maintenance on 5/9/13 at 2:45 PM revealed he was not aware the office had duct work running through it.	F 465	The Housekeeping Manager/Nutritional Services Manager/Designee conducts rounds to inspect the cleanliness of the facility and kitchen each week for the facility and daily for the kitchen. If during the rounds, areas and/or items are in need of cleaning, the housekeeper assigned to the area is notified and the area/item in need of cleaning is added to their cleaning schedule. Areas needing attention in the kitchen will be addressed by the Nutrition Services Manager and dietary staff. The Housekeeping Manager/Nutrition Services Manager/Designee checks the area during rounds to confirm the work is completed.	

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