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

PRINTED: 05/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING ______ B. WING ______	C 04/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations ar used throughout this document: CNA - Certified Nurse Aide DON - Director of Nurses LPN - Licensed Practical Nurse RN - Registered Nurse	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	The facility will ensure all injuries of unknown sources will be investigated. This will be accomplished by: Facility investigated resident #86 and resident #95 by social worker unsubstantiated for abuse. a) All Goshen Care Center staff will receive education on how to identify suspected abuse, proper reporting and the reporting structure for suspected abuse by June 2010. This will be reported at the Performance Improvement Committee meeting. b) The Licensed Clinical Social Worker or designee will provide the training to all Goshen Care Center Staff. Training will be on hire and on an annual basis. This will be monitored and reported on an annual basis to the Performance Improvement Committee by the social worker. c) Adult/Elder Abuse and Neglect Assessments will be completed on each resident by the Licensed Clinical Social Worker or designee at each care plan meeting quarterly, significant	

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

[signature], Administrator

RECEIVED Wyoming Dept of Health JUN 2 2 2010 Office of Healthcare Licensing and Surveys

This POC accepted by [illegible] ... Troy Mabry on 6/24/10

6/23/10

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F 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of record keeping logs and investigative reports, the facility failed to ensure 4 injuries of unknown origin were investigated for 2 of 2 sample residents (#86, #95) who had injuries of unknown origin. The findings were: 1. Review of the 7/26/09 initial, the 10/26/09 quarterly, and the 4/8/10 significant change Minimum Data Set (MDS) assessments for resident #86 showed the resident was cognitively impaired. Review of the nursing notes revealed the following concerns: a. Review of the 12/30/09 nursing notes timed at 11 AM showed the resident complained of right wrist pain. The observation made by the nurse revealed there was a discolored area approximately 4 centimeters (cm) by 2 cm of unknown etiology. The nurse noted the resident guarded the area and moaned when it was touched or moved. Review of the 3:30 PM nursing notes for that same day, revealed the resident again complained of pain in the right wrist and requested "something" for pain. The nurse went on to describe the area as increased in size, warm to the touch, and edematous. Review of the 1/4/10 nursing notes written at 9:30 AM showed the resident continued to complain of	F 225	changes and yearly. This will be monitored and reported on a quarterly basis to the Performance Improvement Committee by the social worker.	Overall total tag element completed by: 6/20/10

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F 225	Continued From page 2 pain in the right wrist. b. Review of the 1/4/10 nursing notes written at 5:50 PM showed the resident had a large bruise on the left posterior hip, also of unknown etiology. c. Review of the 1/7/10 timed at 1 AM nursing notes showed the resident had a bruise to the left shoulder of unknown etiology. d. Interview with the social worker on 4/22/10 at 12:15 PM revealed she would be the staff member to investigate the above noted injuries of unknown origin. However, she said she was unaware of them and had therefore performed no investigations, nor had she reported the injuries to the state survey agency as required. e. Review of the investigations and incident logs showed no evidence these injuries were reported or investigated. f. Interview with the DON on 4/22/10 at 1 PM revealed she was unaware of these injuries and was certain they had not been investigated. 2. Review of the 8/2/09 initial, the 10/26/09 quarterly, and the 1/21/10 quarterly MDS assessments for resident #95 showed s/he was cognitively impaired. Review of the 4/1/10 nursing notes written at 11:40 PM showed as the CNAs were changing the resident for bed, they noted blood was dripping from the lateral/dorsal area of the left thigh. Upon assessment by the nurse, three small puncture type wounds were found. "It is not known what caused the wounds, however, they appeared fresh..." Interview with the DON on 4/22/10 at 1 PM revealed she was unaware of the wounds and was certain there had been no investigation into what caused the punctures.	F 225	This page left blank intentionally	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	Tag F241 will begin on Page 4	

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F 241	Continued From page 3 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff maintained the dignity during meals for 1 (#91) of 17 sample and 1 (#90) non-sample residents. The findings were: Observation of the evening meal on Monday, 4/19/10 from 5:30 PM to 6:20 PM showed CNA #1 stood to feed residents #90 and #91 the entire meal. Interview with the CNA at 6:15 PM on 4/19/10 revealed she always stood so she could "wander around" to feed several residents during the same meal. Interview with the DON on 4/22/10 at 1 PM revealed all staff were expected to sit while assisting residents to eat their meals.	F 241	The facility will maintain and enhance each resident's dignity and respect, this will be accomplished by: The staff member has been educated on resident #91 and resident #90 to sit while feeding to ensure and protect dignity. Providing an in-service with staff that assists with resident feeding: Education by DON/RN Coordinators to maintain resident dignity and sit by resident to assist with feeding. The facility will monitor nursing staff on a monthly basis for protection of resident dignity to be fed with staff sitting. This will be reported to Performance Improvement Committee quarterly.	Overall total tag element completed by: 6/20/10
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to design an activities program to meet the needs and interests of 4 of 7 (#74, #83, #91, #95) sample residents, all of whom lived in the locked unit. The	F 248	The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. This will be accomplished by: Facility implemented a resident specific activity for residents #74, #83, #91 and #95 that meet their individual needs. a) The Activity Professionals will complete the About Me form for each resident at Goshen Care Center. Prior to admission if able to obtain from	

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F 248	Continued From page 4 findings were: 1. Review of the 10/7/09 initial and the 2/4/10 significant change Minimum Data Set (MDS) assessments for resident #74 showed s/he triggered for a problem in activities. Review of these same MDS assessments revealed the resident enjoyed talking and watching television. Review of the 2/4/10 Resident Assessment Protocol (RAP) summary showed the resident's activities were limited because of his/her recent health status so one to one visits worked best. The following concerns were identified: a. Review of the 10/6/09 activities care plan showed it did not include a specific, individualized plan for activities. The only approaches were to give the resident the opportunity to experience his/her personal interest if at all possible and to remind the resident who s/he is by calling him/her by the preferred name. b. Periodic observations on 4/19/10 and 4/20/10 showed the resident watched part of a movie on the evening of 4/19/10 and s/he listened to the news being read on 4/20/10. The resident did not participate in any other activities. c. Review of the activity participation records showed the resident received no one-to-one, volunteer, or pastoral visits during March or April 2010. 2. Review of the 10/30/09 activities review for resident #83 showed the resident had vision problems and needed to be assessed for one-to-one interventions. The following concerns were identified: a. Review of the entire medical record showed there had been no further assessment of the resident's visual problems to determine the need for one-to-one activity interventions.	F 248	family/resident. If not able to obtain information will complete on admission day. b) The Activity Professionals will identify those residents needing one-to-one services and compile those residents into a monthly calendar. c) The Activity Professionals will follow the calendar and sign off daily as to which resident received their personalized one-to-one services. d) The Activity Professionals will use the resident's About Me forms to write their care plans and will be available on the ADL C.N.A. resident care plan form on each hall. e) The Activity Professionals will personalize all resident's flow sheets. This will be completed on day of resident admission for new resident and for current residents by June 20, 2010. f) The Care Coordinator/Clinical Educator will review About Me books and resident flow sheets and one-to-one calendar with Activity Director once a month. Items A through F will be reviewed and reported quarterly at Performance Improvement Committee meeting by social services.	Overall total tag element completed by: 6/20/10

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F 248	Continued From page 6 b. Review of the 11/10/09 activities care plan showed it did not include a specific, individualized plan for activities. The "outcomes" listed included the generalized approaches to encourage to attend activities of choice and maintain satisfactory level of leisure pursuits. c. Periodic observations on 4/19/10 from 5:30 PM until 8:25 PM and on 4/20/10 showed the resident did not participate in any activities. d. Review of the participation sheets for March and April 2010 revealed no evidence one to one, volunteer, or pastoral visits were provided. 3. Review of section V for the 8/4/09 initial MDS assessment for resident #91 showed the resident triggered for a problem with activities. Further review of the MDS assessment revealed the resident enjoyed music and being outdoors. Review of the activities care plan dated 2/18/10 showed it did not include a specific, individualized plan for activities. Generalized Interventions included: encourage the resident to try part of an activity and to encourage the family to join the resident in an activity. Periodic observations on 4/1910 from 5:30 PM until 8:25 PM and on 4/20/10 showed the resident did not participate in any activity. 4. Review of the 8/2/09 initial MDS assessment for resident #95 showed s/he enjoyed music, being outdoors, and visiting. Review of the 8/10/09 care plan revealed the activity goals included: verbally responding to touch, eating his/her favorite foods, and napping. There was no evidence a specific, individualized activity care plan was developed. Periodic observations on 4/19/10 from 5:30 PM until 8:25 PM. On 4/20/10 observation revealed the resident did not	F 248	This page left blank intentionally	

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F 248	Continued From page 6 participate in any activity. 5. Review of the activity calendar for the locked unit for 4/19/10 showed the following activities were scheduled: breakfast, reading of the news, walking club, lunch and crafts. The activities scheduled for 4/20/10 included breakfast, news, book club, lunch, and a piano player (one of the residents). 6. Interview with the activities therapist on 4/22/10 at 12 noon revealed one-to-one visits were not incorporated into any of the residents' care plan on the locked unit. She said she just tried to "work them in" for everybody when she could.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide social services to meet the psychosocial needs for 3 (#74, #91, #95) of 7 sample residents who lived on the locked unit and had special psychosocial needs. The findings were: Interview with the social worker on 4/22/10 at 12:15 PM revealed she did not routinely spend time in the locked unit because the residents were cognitively impaired and unable to benefit from her services. She also stated she did not	F 250	The facility will ensure the psychosocial needs of all residents in the locked secured unit will be met. This will be accomplished by: Social Worker performed depression screen for resident #91, did not meet criteria for depression per DSMIV-TR. Residents #74 and #95 behaviors were investigated and identified as staff driven And education provided to staff by social worker. a) The Licensed Clinical Social Worker or designee will assess each resident's cognition, mood, psychosocial, and behaviors through the comprehensive MDS assessments and care plans.	

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F 250	Continued From page 7 perform any admission assessment for social service needs, but did do the "About Me" questionnaire by discussing the resident's life style and preferences with a family member. This questionnaire helped staff know what the residents' likes, dislikes, and habits were prior to admission. The social worker stated she feared she would disrupt the milieu if she was present on the locked unit. The following concerns with this practice were identified: 1. Review of the 8/2/09 Initial Minimum Data Set (MDS) assessment for resident #95 showed sh/e triggered for problems in the following areas: cognitive loss, mood state, behavioral symptoms, and psychotropic drug use. Review of the 7/20/09 nursing notes, timed at 6:30 PM, the 7/21/09 nursing notes written at 8:30 PM, the 7/22/09 nursing notes written at 10:30 PM, the 7/24/09 nursing notes written at 12 noon, the 7/25/09 timed at 3:30 PM, the 5 AM to 1:30 PM nursing notes on 7/31/09, the 8/30/09 nursing notes timed at 4 PM, the 9/14/09 timed at 2 PM nursing notes, the 9/30/09 nursing notes written at 2:30 AM, the 10/3/09 timed at 8:45 PM, the 10/15/09 written at 1:30 PM, the 11/18/09 notes written at 11 AM, the 11/27/09 at 9 AM, the 12/9/09 written at 3 PM, the 12/10/09 notes written at 9:30 AM, the notes written at 2 PM on 12/11/09, the 1/22/10 notes (untimed), and the 2/17/10 timed at 8 PM all described episodes in which the resident hit, scratched, slapped, pinched, or kicked staff while they provided care. During some of the episodes the resident caused injuries of redness, bruising, or scratching to staff. Medical Record review of the entire interdisciplinary progress notes showed no evidence the social worker had been involved with managing the aggressive behaviors exhibited by this resident.	F 250	b) Prior to admission the Licensed Clinical Social Worker or designee will complete the PASSR screening. c) Upon admission, quarterly, yearly, and upon significant changes the Licensed Clinical Social Worker or designee will administer depression screenings for all residents with or without dementia. d) The Licensed Clinical Social Worker or designee will educate staff on serving residents requiring behavioral intervention plans. e) The Licensed Clinical Social Worker or designee will develop behavioral intervention plans for all residents who require this service. f) A through E will be implemented by the end of May 2010. g) A through E will be monitored with Resident Screening Log and reported quarterly at the Performance Improvement Committee Meeting by the Licensed Clinical Social Worker.	Overall total tag element completed by: 6/20/10

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F 250	Continued From page 8 2. Review of the 8/4/09 initial MDS assessment for resident #91 showed the resident triggered for problems with cognitive loss, psychosocial well-being, mood state and behavioral symptoms. Review of the 7/25/09 nursing notes timed at 8 PM, revealed the resident appeared withdrawn. Review of the 7/27/09 timed at 5:30 PM nursing notes showed the resident appeared depressed. Review of the 7/28/09 nursing notes written at 8 PM showed the resident was very quiet and would not engage in conversation. Review of the nursing notes written on 8/24/09 revealed the resident appeared depressed. Review of the interdisciplinary progress notes showed no evidence the social worker was involved in working with the resident's psychosocial needs. Interview with the social worker on 4/22/10 at 12:15 PM revealed she did not complete a depression scale for this resident, or any dementia residents, because she did not think it would be helpful, even though there were depression scale assessments specifically designed for the cognitively-impaired. 3. Review of 10/7/09 initial and the 2/4/10 Minimum Data Set (MDS) assessments for resident #74 revealed the resident triggered for problems with cognitive loss, psychosocial well-being, mood state, behavioral symptoms, and psychotropic drug use. Further review of these two comprehensive assessments indicated these triggered areas would be care planned. Review of the 2/11/10 care plan showed interventions for this resident's social and behavioral problems included only "observe for withdrawal, encourage activity attendance, [and] support family visits." Review of the 9/28/09 nursing notes written at 11:30 PM showed the	F 250	This page left blank intentionally	

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F 250	Continued From page 9 resident tended to be mildly combative with staff. Review of the 10/8/09 nursing notes written at 9:30 AM showed the resident had increased agitation with care and towards other residents, and was showing signs and symptoms of aggressiveness. Review of the entire medical record revealed no evidence the social worker was involved with managing the resident's specific behaviors.	F 250		
F 272 SS=D	483.20, 483.20(b) 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 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; Documentation of summary information regarding the additional assessment performed through the	F 272	The facility will conduct initially and periodically a comprehensive, accurate, standardized resident assessment addressing physical, social, functional ADL cares of each and every resident. This will be accomplished by: Facility completed a pain assessment for residents #74; #91 and resident #27 expired. Plan: Have a standardized admission, quarterly, annual and significant change of status packet distributed a week prior to assessment. The packet will include current pain management assessment tool and bowel bladder assessment tool. Plan to educate all licensed staff about the standardized packets including current pain management program and bowel bladder program, by June 15, 2010. Pain management assessment will be located with the MAR. Action: Licensed staff will evaluate and re-evaluate pain according to the facilities current policy. All nursing staff will complete a bowel and bladder assessment on admission, annually and with a significant change of status.	

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F 272	Continued From page 10 resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of policies and procedures, the facility failed to ensure pain was assessed for 2 (#74, #91) of 6 sample residents who experienced pain. In addition, the facility failed to perform a comprehensive assessment for 1 (#27) of 11 sample residents who were incontinent of bowel and/or bladder. The findings were: 1. Review of the 1/28/10 quarterly Minimum Data Set (MDS) assessment for resident #91 showed the resident had pain, which was new since the previous MDS assessment. Record review revealed a pain assessment had not been done for this resident since 7/23/09. 2. Review of the 2/4/10 significant change MDS assessment for resident #74 showed s/he had a new onset of pain. Review of the medical record revealed the most recent pain assessment was done on 9/24/09, at which time the resident had no documented pain. 3. Interview with the director of nursing on 4/22/10 at 1 PM confirmed a new pain assessment should have been performed for both of the above noted residents. 4. Review of the policy and procedure on pain management, dated 2/2005, showed the following instructions: a pain assessment "will be completed if pain symptoms are evident or suspected, and if there is a noted change in	F 272	Audit: Audit of 12 residents per month for completion of pain assessment tool and evaluation for effectiveness of pain medication administration, by RN coordinators. The completion of the packets will be monitored every Tuesday and Thursday through the care plan process. The results will be reported to the Performance Improvement Committee quarterly by nursing.	Overall total tag element completed by: 6/20/10

6/22/10

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F 272	Continued From page 11 previously identified pain symptoms or intensity on further assessments." 5. Review of the 1/5/10 significant change and 4/13/10 quarterly MDS assessments for resident #27 showed the resident was occasionally incontinent of bladder and frequently incontinent of bowel. Review of the medical record showed there had been no comprehensive bladder or bowel assessment. On 4/21/10 at 3 PM, the unit secretary confirmed there was no comprehensive bladder or bowel assessment for this resident.	F 272	Tag 276 Resident #74 MDS opened February 4, 2010 for significant changes and May 6, 2010 for quarterly. The facility will comply and complete with the requirements of a resident review every 3 months. This will be accomplished by: Plan: Education for all members of the MDS assessment team, on the process for timely MDS completion, signatures and date, by June 1, 2010. Members of the team are enrolled and will complete an AANAC certification class on the MDS 2.0 by October 31, 2010. MDS calendar will be placed on Outlook computer program for all MDS members to view when assessment dates are due. Action: All Care Plan members will be responsible to view the MDS Resident calendar due dates scheduled in Outlook. Care Plan members will receive a notice of attendance through Outlook. Signing of the MDS will take place at the time of Care Plans on Tuesday and Thursday of every week. Audit: Assessment's that are due will be audited at the time of Resident's Care Plan. Required signatures and dates will also be audited at this time and reported to Performance Improvement Committee quarterly.	Overall total tag element completed by: 6/20/10
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed every 92 days as required for 1 (#74) of 17 sample residents. The findings were: Review of the MDS assessments for resident #74 revealed there had been 103 days between the 10/7/09 initial and the 1/19/10 quarterly assessments. Interview with the DON on 4/22/10 at 1 PM revealed the facility did not have a resident assessment coordinator. She stated each unit manager did his or her own unit's Resident Assessment Instruments and occasionally something was missed.	F 276		
F 278	483.20(g) - (j) ASSESSMENT	F 278		

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F 278 SS=C	Continued From page 12 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments and the corresponding Resident Assessment Protocols (RAPs) were signed and/or dated as required for 17 of 17 sample residents (#8, #14, #17, #27,	F 278	Facility obtained signatures for resident on Minimum Data Set and Resident Assessments Protocols, resident #8 expired; #14; #17 expired; #27 expired; #29; #33; #39: #49; #50; #69; #74; #79; #83; #86; #87; #91 and #95. The facility will comply and complete with the requirements of a resident review every 3 months. This will be accomplished by: Plan: Education for all members of the MDS assessment team, on the process for timely MDS completion, signatures and date, by June 1, 2010. Members of the team are enrolled and will complete a certification class on the MDS 2.0 by October 31, 2010. MDS calendar will be placed on Outlook computer program for all MDS members to view when assessment dates are due. Action: All Care Plan members will be responsible to view the MDS Resident calendar due dates scheduled in Outlook. Care Plan members will receive a notice of attendance through Outlook. Signing of the MDS will take place at the time of Care Plans on Tuesday and Thursday of every week. Audit: Assessment's that are due will be audited at the time of Resident's Care Plan. Required signatures and dates will also be audited at this time. Audit results will be reported quarterly at Performance Improvement Committee meeting by nursing.	Overall total tag element completed by: 6/20/10

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F 278	Continued From page 13 #29, #33, #39, #49, #50, #69, #74, #79, #83, #86, #87, #91, #95). The findings were: Review of the revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, Revised December 2008 (Centers for Medicare and Medicaid Services), page 3-11, revealed that all staff responsible for completing any part of the MDS, and/or tracking forms must enter their signatures, titles, sections they completed, and the date they complete those sections. Review of all 17 sample resident medical records showed at least one section of the forms were not signed or dated. Interview with the DON on 4/22/10 at 1 PM revealed there was not a specific MDS coordinator. She stated all unit managers did their own unit's MDSs and that occasionally something was not completed as required.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure staff followed the care plan for 2 of 17 (#74, #79) sample residents. The findings were: 1. Review of the 8/13/09 significant change, the 2/11/10 quarterly, and the 2/25/10 significant change Minimum Data Set (MDS) assessments for resident #79 showed the resident was	F 282	The facility will comply and complete the requirements for a resident care plan. This will be accomplished by: Plan: Revise current ADL CNA Care Plan form. Form will follow current Plan of Care and will be updated with changes and quarterly at Care Plans by RN Coordinators. CNA staff will be required to review each resident's form on new admissions, quarterly and significant changes. CNA staff will be accountable to read each ADL sheet understanding the care needed for each resident. They will sign the signature sheet in front of the ADL book acknowledging individualized Resident care needs.	

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F 282	Continued From page 14 incontinent of urine all of the time. Interview with CNA #2 on 4/20/10 at 2:20 PM confirmed the resident was incontinent of urine. Review of the 3/4/10 care plan showed the intervention for the resident's incontinence was "check and change at least every 2 hours." Observation on 4/20/10 from 9:23 AM until 12 noon showed the resident was not checked, changed, or toileted. During an interview with the CNA on 4/20/10 at 2:20 PM, she said the resident was not checked, toileted, or changed between 12 noon and 1:45 PM. However, according to the CNA, when the resident was changes at 1:45 PM the resident was found to have been incontinent of bowel. The released time between checks for this resident was 4 hours and 22 minutes. 2. Review of the 10/7/09 initial and the 2/4/10 significant change MDS assessments for resident #74 showed s/he triggered for dental care. Review of the comprehensive assessment for dental care revealed the resident had no teeth. Review of the 1/4/10 care plan showed the resident needed oral care with AM and PM care and that s/he required extensive assistance with oral care by staff. Observation on 4/19/10 at 7:55 PM showed CNAs #3 and #4 assisted the resident with PM cares but did not provide oral hygiene. Interview with the CNAs at the time revealed the resident was in bed for the night and no further bedtime care would be provided.	F 282	Plan for resident #74 and #79 is being addressed in the nursing assistant daily care plan initiated for them and all other residents. Staff will sign on back of form understanding their every two hour bowel and bladder program. Audit: RN coordinators will review signature sheets at the time of Care Plans. Specific issues identified at care plans will be handled by coordinators and results of the audit reports will be reported quarterly at the Performance Improvement Committee meeting.	Overall total tag element completed by: 6/20/10
F 286 SS=D	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.	F 286	The facility will maintain all resident assessments completed within the previous 15 months in the resident's active record. This will be accomplished by: Resident #27 expired and Resident #79 MDS assessments returned to chart for 15 month record.	

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F 286	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain 15 months of Minimum Data Set (MDS) assessments in the active medical record for 2 of 17 sample residents (#27, #79). The findings were: 1. Review of the medical record for resident #27 showed that 3/25/09 was the last date for an annual MDS assessment on the record. Interview with the 300 hall unit manager on 4/20/10 at 10:30 AM showed the facility had completed a computerized 1/5/10 significant change MDS assessment for the resident but it was not printed and in the record because they had not yet obtained the required signatures. 2. Review of assessments for resident #79 showed the following MDS assessments were available in the active medical record: 8/13/09 significant change, 11/12/09 quarterly, 2/11/10 quarterly, and the 2/25/10 significant change which is less than fifteen months of assessments. Fifteen months for this resident started on 11/8/08. Interview with the director of nursing on 4/22/10 at 1 PM revealed there was not a specific MDS coordinator. She stated all unit managers did their own unit's MDS's and that occasionally something was missed.	F 286	Resident MDS assessments will be maintained in the active chart for the 15 month period. Chart thinning will be the removal of records greater than 3 months and will be maintained in active record files such as nurse's notes, physical/wound therapy notes, and medication sheet s. This process will begin and be maintained by HUS from Date of survey April 2010. The MDS assessment will be will be scheduled in the outlook system. The complete MDS will be printed off and taken to care plans for signatures and dates. This will be reported quarterly to Performance Improvement Committee. The facility will monitor all resident charts that are thinned monthly and are recorded quarterly at Performance Improvement Committee.	Overall total tag element completed by: 6/20/10
F 309 SS=G	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	F 309	Pain Assessment Completed for resident #74 and #86. Resident #83 and #86 were placed on daily stool softener and laxative. The facility will provide and maintain care and services needed to achieve the highest physical, mental, and psychosocial well being for the resident's.	

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F 309	Continued From page 16 and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of policies and procedures, the facility failed to ensure nursing staff provided the necessary assessments, monitoring, and nursing measures for adequate pain management for 2 of 6 sample residents (#74, #86) who had pain. The facility also failed to ensure 2 of 2 sample residents (#83, #86) with constipation were provided an as needed laxative to prevent an impacted or painful, constipated stool. Additionally, the facility failed to ensure 3 of 9 sample residents (#83, #86, #91) who experienced falls resulting in injuries, were assessed to determine the root cause in order to implement interventions to prevent future falls. Finally, 1 of 17 sample residents (#74) was not adequately assessed or monitored for a swollen, and painful hand condition. The combined results of these systems failures resulted in harm to 3 of 17 sample residents (#74, #83, #86,). Findings were: In regard to inadequate pain management: 1. Review of the "as needed" (PRN) medication records and all nursing notes for resident #86 showed s/he experienced frequent and severe pain. The following concerns were identified: a. Review of the medical record showed on 10/28/09 at 7:30 AM, 11/4/09 at 1:45 PM and at 9:30 PM, 11/5/09 at 12:45 PM and 4:45 PM, 11/7/09 at 1:30 PM, 11/8/09 at 9:45 AM, 11/10/09 at 10:15 AM and 4:15 PM, 11/12/09 at 9:30 AM,	F 309	This will be accomplished by: Residents on pain management medications that have side effect of constipation will have a laxative/stool softener as a scheduled medication. Standing orders for management of bowel program will have specific steps of intervention. Education to all nursing staff by June 10, 2010. Audit monthly of the residents on medications for pain and bowel maintenance using bowel movement sheets. Residents #83, #86 and #91 had a review of falls assessing any identifiable factors. Implement the fall huddle program. Fall huddle will assess resident factors to fall, interventions, effectiveness of interventions, follow up care and addressed in care plan. Education to all staff by June 10, 2010. RN Coordinators/DON will audit all falls using the post fall safely huddle tracking form and the fall calendars assessing contributing factors for fall. Facility completed a comprehensive pain assessment for resident #86. Educate staff on the current pain management program, assessing pain admission, quarterly, annual and significant change of status. Pain management tool will be located in the MAR. Licensed nursing staff will be evaluated and monitored for the completion of the pain medication	6/10/10 6/10/10

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F 309	Continued From page 17 11/14/09 at 3:10 PM, 11/16/09 at 9 AM, 11/18/09 at 6 AM, 11/21/09 at 7:35 AM, 11/24/09 at 9 AM, 12/13/09 at 11 PM, 12/14/09 at 7 AM, 12/16/09 at 6 PM, 12/17/09 at 11:15 AM and 4:30 PM, 12/19/09 at 4:30 AM and 9 PM, 12./20/09 at 4:30 PM, 12/23/09 at 4:30 AM, 12/24/09 at 3 PM, 12/25/09 at 9 AM, 12/27/09 at 5:30 PM, 1/25/10 at 11:30 AM, 1/29/10 at 11:50 AM, 2/10/10 at 1 PM and 3/21/10 at 9 PM, the resident was administered pain medications. Review of the nursing notes showed examples of comments the resident made to describe the intensity and severity of pain included: 12/15/09, "I just want everything to be over;" 12/16/09, "I want to just go so I will stop hurting;" 12/17/09, "I hurt, I hurt, I hurt;" and wanted something to "knock me out;" 12/18/09, at 6:15 AM "Just give me something to knock me out;" at 10 AM "Can you just shoot me;" and at 2 PM, "Could you just shoot me in the head," 12/20/09, "Please just shoot me and get me out of this pain;" 12/23/09, "Just kill me..." 12/24/09, requesting "Something for all this damn pain;" 1/1/10 "It hurts so bad;" and 1/3/10, "Knock me out." Review of the nursing notes also revealed the resident was frequently "crying" with pain. Review of the PRN pain flowsheet and the nursing notes showed no evidence the resident's pain was re-assessed to determine the effectiveness of the medication on these dates and times. b. The following days and times, the resident received pain medications, had a re-assessment which determined the medication did not relieve the pain but there was no evidence other measures were taken to promote pain relief: 11/19/09 at 5:30 PM, 12/7/09 at 6:30 PM, 12/18/09 at 6:15 AM and 7 PM, 12/23/09 at 6:10 PM, 12/24/09 at 9 AM, 12/27/09 at 3 PM, 11/2/10 at 2:15 AM, and on 2/10/10 at 1 PM.	F 309	administration form and process at resident care plans and audit results will be reported quarterly at Performance Improvement Committee meetings. The full data will be reported monthly at Performance Improvement Committee meetings by nursing.	6/10/10

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F 309	Continued From page 18 c. Review of the resident's current care plan dated 4/13/10 showed pain was not addressed. 2. Review of the nursing notes for resident #74 showed s/he was administered a pain medication [Tylenol] on 4/7/07 at 1 AM and again at 5 AM. Review of the medical record revealed no evidence the resident's pain was re-assessed afterward to determine if the pain medication was effective either time it was given. In addition, there was no description or location of the pain in the medical record. Review of the resident's current care plan dated 2/11/10 showed pain was not addressed. 3. Interview with the DON on 4/22/10 at 1 PM revealed she expected nursing to re-assess a resident's pain within 30 to 60 minutes after administration of a pain medication. 4. Review of the facility's February 2005 policy and procedure on pain management showed the following information and instructions: "....center recognizes the right of resident to receive adequate pain relief and pain management in order to enhance their quality of life. In support of this right, each resident will be assessed for pain, including, severity, location, type of pain, duration, aggravating factors, alleviating factors, and response to medications and treatment directed toward the relief and management of pain. In the course of providing care, pain will be prevented or minimized to the extent possible...Documentation of pain, interventions, and response to interventions will be kept for each resident identified as having pain. The documentation will be ongoing, easily retrievable by care givers and will reflect the success or lack of success of the interventions. The plan of care will be adjusted as	F 309	This page left blank intentionally	

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F 309	Continued From page 19 necessary until the optimum pain solution is reached." In regard to constipation: 1. Review of the 11/15/09 initial Minimum Data Set (MDS) assessment for resident #83 showed s/he experienced constipation. Review of the medication administration record (MAR) showed the resident had standing physician orders written on 11/3/09 for Milk of Magnesia, Dulcolax, Colace or a Fleets enema PRN (as needed) for constipation. Review of the 2/28/10 nursing notes written at 4:15 PM showed the resident had a "large impacted stool that required manipulation to remove," which was "painful" to the resident. Review of the bowel record for February 2010 revealed it had been four days (2/23/10) since the resident had a bowel movement. Review of the February 2010 MAR revealed the resident was not administered a PRN laxative until 3 PM on 3/28/10. Further review of the February 2010 MAR showed the resident was receiving a Fentanyl patch and Ferrous Sulfate. Review of the 2008 edition of the Nurse's Drug Handbook, pages 616 and 620, showed constipation was a side effect of both medications. 2. Review of the 3/29/10 nursing notes written at 8:30 PM for resident #86 showed a CNA observed the resident removing stool from the rectum with his/her own fingers. According to the CNA, the resident said "Just get it out of there." Continued review of the nursing notes showed the nurse digitally examined the rectum and found hard stool. Review of the bowel record for March 2010 showed the resident had not had a bowel movement since 3/24/10 (4 days prior to the resident feeling constipated). Review of the	F 309	This page left blank intentionally	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	C 04/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

(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 309	Continued From page 20 March 2010 MAR showed the resident had Colace (laxative) prescribed as needed for constipation but had received none during the month. Further review of the March 2010 MAR showed the resident was receiving a Fentanyl patch and Roxanol for pain. Review of the 2008 edition of the Nurse's Drug Handbook, pages 616 and 1050, showed constipation was a side effect of both medications. In regard to falls: 1. Review of the 11/15/09 Initial MDS assessment, section V, for resident #83 showed s/he triggered for falls. Review of the nursing notes for the resident showed s/he had three falls in December (12/8, 12/23, and 12/26/09), another one on 1/19/10, 3/6/10, two on 4/4/10 (8 AM and 8 PM), and another one on 4/19/10. The following concerns were identified: a. The fall on 12/26/09 at 4:15 AM showed the resident received three large skin tears to the right arm which caused the resident discomfort. b. Review of the 1/19/10 timed at 5:30 PM nursing notes showed the resident fell and sustained an injury to the left wrist with bruising noted. c. Review of the 3/6/10 nursing notes written at 10:40 PM revealed the resident fell against the bathroom door, which resulted in back pain, a skin tear to the left shin and to the lower right leg. d. Review of the 4/4/10 nursing notes written at 8 PM showed the resident was found sitting on the floor. A physical assessment at the time revealed a small area on the mid upper back where the resident's clothing hooks tore off a mole. In addition, there was a small red area on the spine between the lower lumbar and lower thoracic areas. Further review of this note	F 309	This page left blank intentionally	

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F 309	Continued From page 21 revealed the family requested a urinalysis be performed to see if a urinary tract infection contributed to the fall. A urinalysis was performed and showed the resident had an infection, which was treated with antibiotics. e. Review of the 4/19/10 nursing notes written at 6:45 AM showed the resident fell and complained of right-sided pain. Other injuries included a skin tear to the upper left arm, and a skin tear to the right knee. The resident required a transfer to the emergency room for evaluation. f. Despite this resident's history of falls the facility did not conduct a comprehensive assessment of this issue until 4/4/10, after the family requested an assessment be done. 2. Review of the 7/26/09 initial MDS assessment, section V, for resident #86 showed s/he triggered as a fall risk. Review of the 7/13/09 care plan showed the resident was a high risk for falls due to an unsteady gait, psychotropic drug use, dementia, and walking without assistance. Review of the 12/20/09 nursing notes written at 10 AM showed the resident was found on the floor in the bathroom. A nursing note written on 1/23/10 at 10:40 AM revealed the resident had another fall in the bathroom and was found sitting on the floor. Review of the 3/15/10 nursing notes written at 7:20 PM showed the resident was discovered lying on the right side on the floor next to the wheelchair. The resident complained of left hip pain and said s/he could barely move without it hurting. The resident was transferred to the emergency room where it was determined the resident had a fractured left hip. Review of the incident report for this fall showed "Assessment of whole body. No injuries noted to entire body." Review of the entire medical record showed no evidence an assessment had ever been done to	F 309	This page left blank intentionally	

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F 309	Continued From page 22 determine the cause of the resident's falls. Only the facts surrounding the falls had been noted. 3. Review of the nursing notes for resident #91 showed s/he experienced two falls on 10/28/09, and one fall on each of the following dates: 11/27/09, 12/5/09, and 1/21/10. Review of the nursing notes showed no evidence staff assessed the possible causes of the fall to determine what measures to implement in order to prevent future falls. Review of the incident reports for theses dates revealed only the falls on 10/28/09, 12/5/09 and 1/21/10 were reported. Further review of the incident report revealed only the facts of the falls on 10/28/09 and 12/5/09 were noted and what action was taken, i.e., assessment for any injury. Review of the incident report for the fall on 1/21/10 showed interventions were reviewed and one new recommendation for a "buddy" pillow was made. However, review of the care plan showed it had not been updated to reflect the new intervention. Also, periodic observations on 4/19 and 4/2010 showed there was no buddy pillow in the resident's bed. Finally, there was no evidence the causative and contributing factors for this resident's falls were assessed. 4. Interview with the QAPI departmental committee on 4/22/10 at 9:45 AM and again with the DON on 4/22/10 at 1 PM revealed a new fall program was in the process of being developed and would include the "Post Fall Huddle" evaluation to better evaluate the causes of resident falls. In regard to the lack of adequate and timely nursing assessment and monitoring: Review of the nursing notes for resident #74	F 309	This page left blank intentionally	

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F 309	Continued From page 23 showed that on 11/10/09 the nurse noted the resident's right hand was swollen, especially the thumb and finger. There was no evidence this condition was assessed again until 12/29/09 (49 days) at which time the nursing notes noted the right hand was "very" swollen and the resident complained of pain in the right index finger. Review of this note also showed the physician was notified of the resident's tachypnea (rapid breathing), but nothing was documented in regard to the swollen and painful hand and finger. Review of the 2/6/10 (thirty-nine days later) nursing notes written at 2 PM showed there was no apparent injury or trauma; however, the right hand was again noted to be swollen. Review of the entire medical record showed no evidence of an assessment as to what caused the swelling and pain in the resident's right hand. Review of physician's orders showed no treatment or testing was ordered to determine the cause. Interview with the DON on 4/22/10 at 1 PM revealed she was unaware there was a problem with the resident's right hand.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff provided adequate personnel hygiene for 2 of 13 (#79, #74) and oral hygiene for 1 (#74) of 13	F 312	The facility will provide the necessary services for residents who are unable to carry out activities of daily living to assure good nutrition, grooming, and personal and oral hygiene is maintained. This will be accomplished by: Facility provided mandatory staff education for personal ADL cares to resident #79 and #74. Implement of a revised ADL CNA resident care plan form that will include the restorative Care, activities specific for the resident and available for any staff member	

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F 312	Continued From page 24 sample resident who were dependent upon staff to provide activities of daily living The findings were: 1. Review of the 8/13/09 significant change, the 2/11/10 quarterly, and the 2/25/10 significant change Minimum Data Set (MDS) assessments for resident #79 showed the resident was incontinent of urine all of the time. Observation on 4/20/10 at 9:23 AM, revealed the resident was incontinent of urine and feces. CNAs #2 and #5 provided perineal care, but cleansed only the anal area. Neither CNA cleansed the anterior perineal area which was in contact with the urine. Interview with CNA #5 on 4/22/10 at 10:30 AM revealed she was aware of the proper technique for providing perineal care, including cleansing all areas that were in contact with the urine. 2. Review of the 10/7/09 initial and the 2/4/10 significant change MDS assessments for resident #74 showed s/he triggered for dental care. Review of the comprehensive assessment for dental care revealed the resident had no teeth. Review of the 1/4/10 care plan showed the resident needed oral care with AM and PM care and that s/he required extensive assistance with oral care by staff. Observation on 4/19/10 at 7:55 PM showed CNAs #3 and #4 assisted the resident with PM cares, however, observation showed the resident did not receive oral hygiene. Interview with the CNAs at the time revealed the resident was in bed for the night and no further bedtime care would be provided. Observation on 4/19/10 at 7:55 PM revealed the resident was incontinent of urine. CNA #3 was observed providing perineal care for the resident. The CNA did not clean all areas of the genitals that had been in contact with urine.	F 312	providing ADLS cares for resident Education to all staff for competency of Oral/Peri cares by May 28, 2010, by Joyce Hinze RN, BSN, CWN. Three in-services are arranged for May. Education by Wendy Miller IP to all staff on Hand Hygiene per regulatory guidelines Complete by May 28, 2010. Hand Hygiene monitoring is already a PI process and will be continued. Data is trended to ensure 90 % of all staff is monitored in a quarter. The responsibility of the PI process is quality and Infection Prevention. CNA education held every 3rd Monday will be structured as 30 minutes of didactics and 30 minutes for hands on skill competency assessment and skills performance. This will begin June 2010. New Competency assessment program already implemented in April 2010. The competency assessment will be on-going educating and demonstration of competency of skills for all staff. Yearly dental education by dental hygienist for all staff – Presentation was May 4, 2010. The above will be reported at June Performance Improvement Committee meeting and on an annual basis by social services.	Overall total tag element completed by: 6/20/10

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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, staff interview and medical record review, the facility failed to ensure 1 (#79) of 8 sample residents who were incontinent of urine received the care and services to prevent urinary tract infections. The findings were: Review of the 8/13/09 significant change, the 2/11/10 quarterly, and the 2/25/10 significant change Minimum Data Set (MDS) assessments for resident #79 showed s/he was incontinent of urine all of the time. Interview with CNA #2 on 4/20/10 at 2:20 PM confirmed the resident was incontinent of urine. Review of the 3/4/10 care plan showed the intervention for the resident's incontinence was "check and change at least every 2 hours." The following concerns were identified: a. Review of the 3/26/10 physician's orders showed an order for a repeat urinalysis next week to determine if the resident's urinary tract infection was resolved. b. Observation on 4/20/10 from 9:23 AM until	F 315	The facility will 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 UTI's and to restore as much normal bladder function as possible. This will be accomplished by: Facility provided education to staff for personal ADL care for resident #79. Education will be provided to staff on current lab test log process to include not only the scheduled/unscheduled lab orders that are obtained for any residents. This will ensure all labs ordered will be obtained and completed. Education to all staff on following the plan of care specific to resident ADL utilizing the CNA resident care plan and following plan to ensure ADLS are completed. IP education by June 2010 on UA collection, prevention and follow up care for the residents to all nursing staff. Monitoring will be done by labs test log and surveillance sheets monthly by RN Coordinators/IP. Data will be reported at Performance Improvement Committee monthly by Infection Preventionist.	Overall total tag element completed by: 6/20/10

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F 315	Continued From page 26 12 noon showed staff did not check or change this resident. The CNA was interviewed on 4/20/10 at 2:20 PM. She stated the resident had not been toileted between 12 noon and 1:45 PM, at which time the resident was found to be incontinent of bowel. The elapsed time between checks for this resident was 4 hours and 22 minutes.	F 315		
F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 2 of 2 sample residents (#74, #83,) who lived in the locked unit, and had experienced a decline in range of motion (ROM) received restorative services. This lack of services resulted in an avoidable decline in these residents' physical capability. The findings were: 1. Interview with the restorative CNA on 4/22/10 at 11:40 AM revealed no restorative services were performed by the restorative staff in the locked unit. She said services were not provided because the belief was that cognitively impaired residents were unable to be part of a planned restorative program. She further stated activities the resident participated in were considered to be	F 318	The facility will ensure resident's with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This will be accomplished by: Facility completed a Restorative Care Assessment for residents #74 and #83. a) The Restorative Care Aides will administer a restorative care assessment to all residents upon admission, quarterly, yearly, and upon significant changes. b) The restorative care plan will be available to all staff on the ADL CNA resident care plan form on each hall. c) The Restorative Care Aides will educate and work with staff on the resident's restorative care plan. d) The Restorative Care Aides will review the scheduled care plans on every Tuesday and Thursday during care plan meetings with the comprehensive review team.	

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F 318	Continued From page 27 the restorative program for those residents. Periodic observations on 4/19 and 4/20/10 showed no evidence restorative services or exercises were provided to these residents. 2. Review of the 10/7/09 initial Minimum Data Set (MDS) assessment for resident #74 showed s/he had no limitation in ROM in the neck, hand, and foot. Further review revealed there was limited ROM in both legs, hips and knees with partial loss of voluntary movement. Review of the 1/19/10 quarterly MDS assessment showed the resident had a decline in ROM of the neck with limitation on both sides and partial loss of voluntary movement. In addition, there was newly identified limited ROM in one hand with partial loss, and partial loss of voluntary movement in one foot. Periodic observations on 4/19 and 4/20/10 showed the resident required the assistance of one or two staff for ambulation. Review of restorative records showed the resident did not receive restorative services during the months of October, November, and December 2009. Review of the 1/18/10 restorative nursing assessment revealed the resident should be ambulated to and from meals by staff. Review of the 2/4/10 significant change MDS assessment (performed one month after restorative services were started), showed the resident maintained the same ROM functionality once restorative walking was started. 3. Review of the initial 11/15/09 and the quarterly 2/11/10 MDS assessments for resident #83 showed s/he had functional limitations of the left wrist with partial loss of voluntary movement and limited ROM of both feet and partial loss of voluntary movement. In addition, review showed there was no limitation but there was partial loss	F 318	e) The Restorative Care Aides will review their individual restorative care logs with their supervisor monthly. The results will be reported quarterly at Performance Improvement Committee by nursing.	Overall total tag element completed by: 6/10/10

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F 318	Continued From page 28 of voluntary movement in the neck, arm, including the shoulder and elbow, and the leg. Review of the initial restorative nursing assessment dated 11/11/09 it was noted the resident needed an evaluation for restorative services. Review of the 2/1/10 restorative nursing assessment revealed both wrists were now limited in ROM. Review of the comprehensive MDS assessment confirmed no restorative/rehabilitative nursing services were being provided.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	To address the resident identified in the survey and other residents at risk for unnecessary medications because of not having a gradual dose reduction attempted all residents currently receiving therapy with antipsychotics, anxiolytics, or sedative/hypnotics will be reviewed at the CRT meeting by the multidisciplinary team for indication, effectiveness and adverse effects. A summary of their status will then be forwarded to the physician with a request for a gradual dose reduction attempt and confirmation of their continued need for the medication. The prescribers will be provided updated information regarding the documentation needed for continued use of the medications and what is necessary to consider a dose reduction clinically contraindicated. In the future, a gradual dose reduction will be added to the care plans at the time the medication is started on a resident. This will then be tracked	

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F 329	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimen for 1 of 17 sample residents (#17) was free of unnecessary medications. The resident was receiving two medications for the diagnosis of anxiety. The findings were: Review of medical record revealed resident #17 was admitted to the facility on 7/24/09 with several diagnoses including anxiety. Admission orders included several medications including two medications for anxiety: Buspar 5 mg every eight hours and Clonazepam 0.5 mg twice a day. Review of physician notes revealed the following comment dated 10/1/09: "anxiety - continue on current meds." Another physician comment, dated 4/18/09, also stated "anxiety - continue on current meds." Review of the medical record showed a dosage reduction had never been attempted and a physician's rationale for use of the medications was lacking. Further review failed to reveal a physician's statement delineating the risks versus the benefits of continued use of the two antianxiety medications at their continued doses. The DON reviewed the record on 4/20/10 at 4 PM and confirmed the lack of a medical rationale.	F 329	and scheduled with the ongoing Care Plan process. The consultant pharmacist will provide the CRT /Care Plan Team a list of residents with medications requiring a gradual dose reduction by June 20, 2010 at which time the team will prioritize the residents and schedule them for review over the next 6 weeks. Thereafter the review will coincide with the resident's quarterly Care Plan review. The consultant pharmacist will present to the GCC Performance Improvement committee a quarterly report of the residents receiving one of these medications and the number of residents who have had a gradual dose reduction attempted. Resident #17 expired.	overall total tag element completed by: 6/20/10
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	F 353	The facility will have sufficient nursing staff to provide and maintain care and services needed to achieve the highest physical, mental, and psychosocial well being for the resident's. This will be accomplished by: Facility providing staff for care of resident #79.	

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F 353	Continued From page 30 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans; Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure there were sufficient staff members to provide the needed care for 1 (#79) of 2 sample residents who resided on the west end of the locked unit. The findings were: 1. Observation on 4/20/10 at 9:23 AM showed resident #79 was in bed; no staff were in the area. At 9 AM the resident had a loose sounding cough, which continued intermittently until 9:15 AM when CNA #2 entered the resident's room to check on him/her. At this time the resident was sitting on the edge of the bed. The CNA placed the resident back down in bed and told the resident she would be back after helping another resident. At 9:23 AM, CNAs #2 and #5 returned to assist this resident with morning care, which they completed at 9:53 AM. During this observation, no other staff were present on this end of the hall to assist the remaining thirteen residents.	F 353	Staffing plan for sufficient nursing care on the Alzheimer's unit is to have one licensed member with four CNA'S/Training assistants per twelve hour shift. This will provide a minimum of two care providers for 14 residents per hall. Currently staff are meeting residents needs per resident ADL Care Plan flow sheet with extra shifts and contract labor. This will be monitored and reported monthly at Performance Improvement Committee meeting by nursing.	Overall total tag element completed by: 6/20/10

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F 353	Continued From page 31 2. Review of the 8/13/09 significant change, the 2/11/10 quarterly, and the 2/25/10 significant change Minimum Data Set (MDS) assessments for resident #79 showed the resident was incontinent of urine all of the time. Interview with CNA #2 on 4/20/10 at 2:20 PM confirmed the resident was incontinent of urine. Review of the 3/4/10 care plan showed the intervention to address this resident's incontinence was "check and change at least every 2 hours." Observation on 4/20/10 from 9:23 AM until 12 noon showed the resident was not checked, changed, or toileted. During an interview with the CNA on 4/20/10 at 2:20 PM, it was revealed that the resident was also not toileted between 12 noon and 1:45 PM. The CNA stated when the resident was toileted s/he was found to have been incontinent of bowel. 3. Interview with CNA #2 on 4/20/10 at 2:20 PM revealed she was the only CNA assigned to that end of the hall and she had 14 residents to care for. She said there was a "float" CNA assigned to assist the entire unit but she was busy on another wing. She said sometimes there were two CNAs on each wing and that worked much better. 4. Observation on 4/19 and 4/20/10 revealed it was not possible to observe all the residents on both wings from any one point in the unit.	F 353		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425	Facility Pharmacist completed drug regimen for residents #14; #17 expired; #27 expired; #29; #33; #39; #49; #50; #69; #74; # 79; #83; #86; #87; #91 and #95. An additional pharmacist will be hired to assist the pharmacy consultant in both hospital and nursing home duties. The position was approved 5/12/10 and posted	

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F 425	Continued From page 32 law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to conduct a monthly drug regimen review for 16 of 17 sample residents (#14, #17, #27, #29, #33, #39, #49, #50, #69, #74, #79, #83, #86, #87, #91, #95) as required. The findings were: Review of the monthly drug regimen reviews (DRR) for 17 sample residents showed the facility failed to complete the reviews in a timely manner as follows: a. Resident # 14 did not have a DRR after 7/26/09 until 9/16/09. b. Resident #17 did not have a DRR after 7/26/09 until 9/16/09, after 11/9/09 until 1/20/10, and after 1/20/10 until 3/27/10. c. Resident #27 did not have a DRR after 5/22/09 until 7/30/09, after 8/23/09 until 10/30/09, after 10/30/09 until 12/30/09, and after 12/30/09 until 3/2/10.	F 425	on the Banner job website 5/13/10. A calendar for each resident will be kept by the consultant pharmacist with the date of last review for each resident and the date scheduled for the next review. DON and RN coordinators will audit the charts and notify the consultant pharmacist if any resident has gone more than 35 days without a review. The consultant will have 48 hrs to complete the review from time notified. The number of residents going more than 35 days without a review will be presented to the GCC Performance improvement team on a quarterly basis.	Overall total tag element completed by: 6/20/10

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F 425	Continued From page 33 d. Resident #29 did not have a DRR after 8/23/09 until 10/30/09, and after 12/30/10 until 3/2/10. e. Resident #33 did not have a DRR after 8/23/09 until 10/30/09. f. Resident #39 did not have a DRR after 8/23/09 until 10/30/09. g. Resident #49 did not have a DRR after 10/7/09 until 12/23/09, and after 1/6/10 until 3/10/10. h Resident #50 did not have a DRR after 10/7/09 until 12/23/09, and after 1/6/10 until 3/18/10. I. Resident #69 did not have a DRR after 10/7/09 until 12/23/09 and after 1/6/10 until 3/10/10. j. Review of the monthly DRRs for resident #74 showed the pharmacist did not review the resident's medication regimen during the months of November 2009, January 2010, and March 2010. k. Review of the monthly DRRs for resident #79 revealed no evidence the pharmacist reviewed the resident's medications during the months of December 2009 and January 2010. l. Review of the DRRs for resident #83 showed his/her medication regimen was not evaluated during the month of January 2010. m. Record review revealed the monthly DRRs for resident #86 were not done in November 2009 and March 2010. n. Review of the DRRs for resident #87 revealed an evaluation of the resident's medication regimen was not done during the months of September 2009, November 2009, and January 2010. o. Review of the monthly DRRs for resident #91 revealed during the months of November 2009 and March 2010 no evaluations were	F 425	This page left blank intentionally	

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F 425	Continued From page 34 performed by the pharmacist. p. Review of the DRRs for resident #95 showed his/her medications were not evaluated by the pharmacist during the months of November 2009 and March 2010. Interview with the pharmacist on 4/22/10 at 1:30 PM showed she had gotten behind with the DRRs due to a pharmacy staffing shortage.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	All multidose vials of medication will have a sticker added to the vial stating the date the vial was opened. All vials will be discarded 28 days after the date opened. Weekly checks done on a random basis will be done by the Consultant pharmacist, the DON, and the RN Coordinators. Any vials not dated will be discarded. Results of weekly checks will be presented to the Performance Improvement team on a quarterly basis.	Overall total tag element completed by: 6/20/10

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F 431	Continued From page 35 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure all used medications available for patient use were unexpired. Expired medications were stored in 3 of 4 medication refrigerators and in 1 of 4 medications storage cabinets. The findings were: During an observation of the medication refrigerator for the 200 nursing station on 4/22/10 at 8 AM, two partly used multi-dose vials of Lantus insulin and one partly used multi-dose vial of Humulin R insulin had not been dated and were still available for use. During an observation of the medication refrigerator for the 300 nursing station on 4/22/10 at 8:15 AM, three multi-dose vials of Lantus insulin and one multi-dose vial of Humalog insulin were partly used, but had not been dated and were still available for use. Also, observation of the 300 nursing station medication storage cabinet showed two used multi-dose vials of 2% Lidocaine (local anesthetic) that were not dated, and were available for use. During an observation of the medication refrigerator for the 400 nursing station on 4/22/10 at 8:30 AM, four multi-dose vials of Humalog insulin and one multi-dose vial of Lantus insulin were partly used, but had not been dated and were still available for use.	F 431	This page left blank intentionally	

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F 431	Continued From page 36 During interviews with RNs #4, #5, and #6 immediately after each observation, they confirmed the used vials were not dated. Also, they could not determine how long the vials had been opened. They all stated that each of the used vials were still available for use. According to the facility policy and procedure entitled, Multiple Dose Vials "The beyond use date after initially entering or opening (e.g. needle puncture) multiple-dose containers is not to exceed 28 days..." and "Discard multiple dose vials if there is any question related to the medication storage conditions, medication integrity, or beyond date of use." According to Smith, Duell, & Martin, Clinical Nursing Skills Basic to Advanced Skills, 7th Ed. Upper Saddle River, NJ; Prentice Hall; 2007:605 "If multi-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials."	F 431		
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. (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	F 441	The facility will 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. This will be accomplished by: Facility provided training to staff per organization policy for glucometer cleaning for resident s #23; #27 expired; #44; #50 and #62.	

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F 441	Continued From page 37 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, staff interview, medical record review, and review of policies and procedures, the facility failed to ensure staff followed appropriate infection control practices during 4 random observations. The findings were: 1. Observation on 4/20/10 at 11:25 AM showed RN #7 used a glucometer to perform a glucose test on resident #23. The RN did not clean the glucometer before or after use. During an interview with the RN immediately after the observation, it was revealed the lab cleans the facility's glucometer every three months. She further stated she would only clean a glucometer	F 441	Proper cleaning and maintenance of equipment will be performed by all staff. New draft policy is in progress at system IP level. Preliminary education to roll out with staff will be initiated. System Policy for Sure Step Flex Whole Blood glucose Testing will be implemented by May 28, 2010 to all licensed nursing staff. Education will be provided to all licensed nursing staff by a qualified laboratory staff member. Competencies will be completed on all licensed nursing staff by qualified laboratory staff member. Complete by June 20 2010. Monitored and reported quarterly to Performance Improvement Committee by Infection Preventionist.	Overall total tag element completed by: 6/20/10

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F 441	Continued From page 38 if it was visibly soiled and not between uses. 2. Observation on 4/20/10 at 4 PM showed LPN #1 used the same glucometer to perform glucose tests for two residents (#27, #44). The LPN did not clean the glucometer between residents. During an interview with the LPN immediately after the observation, it was revealed the lab cleans the facility glucometer about every three months. She further stated the glucometer would be wiped with a Sani-wipe cloth if visibly soiled. 3. Observation on 4/20/10 at 4:30 PM showed RN #3 used the same glucometer to perform glucose tests on two residents (#50, #62). The RN did not clean the glucometer between residents. During an interview with the RN immediately after the observation, she stated the lab cleans the facility's glucometer every three months. She further stated she had never cleaned the facility glucometer and would do so only if visibly soiled. 4. Interview with the director of laboratory services on 4/21/10 at 10:15 AM showed the laboratory staff thoroughly cleaned the glucometer every three months. The laboratory director also stated her expectation was for facility staff to cleanse the outer surface of the glucometer with a wipe containing 10% bleach between each resident use. Interview with the DON on 4/21/10 at 11:15 AM revealed staff were to wipe the glucometer down between each run, which consisted of several residents most of the time. She further stated the facility was working on a policy update for cleaning the glucometer. According to the manufacturer's instructions, the glucometer should be cleansed on the exterior with a cloth that has been dampened with a 10%	F 441	This page left blank intentionally	

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F 441	Continued From page 39 bleach solution. The manufacturer's instructions also showed the glucometer should be cleansed "as defined by your institution's infection control policies." Upon request for the facility policy and procedure concerning the cleaning of glucometer, the DON provided the manufacturer's instructions, which do not include frequency the of cleaning. 5. On 4/19/10 at 7:13 PM, observation showed CNA #6 provided perineal care for resident #95, after the resident had a bowel movement. The following concerns were identified: a. Once the perineal care was completed, without removing her soiled gloves, the CNA pulled the wheelchair closer to the toilet, touching the arms, seat, and back of the wheelchair. She then assisted the resident to transfer from the toilet to the wheelchair, touching the resident's skin and clothing with the same soiled gloves. Once the CNA had the resident positioned in the wheelchair, she then removed her soiled gloves. b. Interview with the infection control coordinator on 4/22/10 at 8:45 AM revealed the staff had been taught to always remove their gloves and wash their hands after providing perineal care. c. Review of the policy for hand hygiene, dated May 2005, showed the following instructions: "Hand cleansing is to be done: Between patient contacts; after contact with....body fluids....excretions and equipment or articles that may be contaminated, immediately after gloves are removed, ...between tasks and procedures on the same patient to prevent cross-contamination of different body sites...."	F 441	This page left blank intentionally	
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY	F 502	Tag F502 begins on Page 41	

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F 502	Continued From page 40 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory tests were performed as ordered for 1 (#79) of 17 sample residents who had laboratory tests ordered. The findings were: Review of the 3/26/10 physician's orders for resident #79 showed a repeat urinalysis was ordered for the following week to see if the resident's urinary tract infection had resolved. Review of the entire medical record showed the repeat urinalysis was not performed as ordered. Interview with the DON on 4/22/10 at 2:30 PM confirmed the test had not been performed.	F 502	The facility will provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This will be accomplished by: Facility implemented a lab log to ensure treatment of resident #79 complete and timely. Education to all licensed staff on current process in place to follow the lab test log sheet that all labs ordered, scheduled or unscheduled are obtained and results received to ensure proper treatment or follow up is initiated. Monitoring will be done with lab test flow sheet by RN Coordinators/DON. Date for education and monitoring June 20, 2010. Monitored and reported quarterly to Performance Improvement Committee by nursing.	Overall total tag element completed by: 6/20/10

6/23/11