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Wyoming Dept of Health
AUG 10 2009
Office of Healthcare Licensing and Surveys

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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
	53A050	A. BUILDING _____ B. WING _____	06/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	112 HOSPITAL LANE AFTON, WY 83110

(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 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide maintenance services to ensure sanitary and cleanable bathing rooms for the residents. The findings included: During observation on 6/25/09 at 11:00 AM with the Administrator and Departmental Leads from Maintenance and Environment, the following issues were identified: The floor covering (linoleum) under each tub in both East and West bathing rooms was damaged. The seam in the flooring running under each tub was split and separated, exposing the cement floor going to the floor drain. The East tub room had an area approximately one foot in length on each side of the drain which had split flooring. The areas were also noted to be wet and holding water. The damaged area does not present a smooth cleanable surface and leaves an area for build up and harborage of bacteria. The presence of these findings was confirmed by the Administrative staff.	F 253	F253 The facility will provide housekeeping & Maintenance services necessary to maintain A sanitary, orderly, and comfortable interior. The split in the tub room flooring will be Repaired by July 31, 2009. The integrity of the Floor area will be re-established with a smooth Cleanable surface & will discourage build up & Harborage of bacteria. Flooring inspection has Been placed on the maintenance QA calendar & will be monitored on a monthly basis. New Flooring replacement will be put on the 2010 Capital budget. The Maintenance Director will Oversee the repair.	July 31, 2009
F 309 SS=E	483.25 QUALITY OF CARE 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.	F 309	F309 The facility will see that each resident will Receive and the facility will provide the necessary Care and services to attain or maintain the high-Est practicable physical, mental, & psychosocial Well-being, in accordance with the comprehensive assessment & plan of care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean Linter	administrator	07-22-09

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.

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F 309	Continued From page 1 This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to monitor/manage residents' bowel movements, to assess and provide care/services in a timely manner for a resident with an acute illness, and to ensure a resident received his/her medications as ordered for five of ten sample residents (#1, #7, #2, #10, and #6). These failures affected the residents' abilities to reach their highest practicable level of physical, mental, and/or psychosocial functioning. The findings included: BOWEL MOVEMENT MANAGEMENT 1. Review of the facility's BM List revealed the following information for residents #1, #7, #2, and #10 (dates with no BM charted, number of days between BMs, intervention if any was utilized with the date): Resident #1 1/5 - 1/9/09 - 4 days - no intervention 1/10 - 1/18/09 - 8 days - Dulcolax on 1/18 1/20 - 1/24/09 - 4 days - Dulcolax on 1/24 2/7 - 2/11/09 - 4 days - Dulcolax on 2/11 3/13 - 3/17/09 - 4 days - no intervention 3/24 - 3/28/09 - 4 days - no intervention 4/15 - 4/26/09 - 11 days - 4/24 Senna, 4/25 and 4/26 Dulcolax 4/29 - 5/4/09 - 5 days - 5/3 Senna-S 5/18 - 5/24/09 - 6 days - 5/19 Senna 5/27 - 6/1/09 - 5 days - 6/1 Senokot 6/4 - 6/13/09 - 10 days (out of facility 6/9 - 6/10/09), 6/4 - 6/9 - 5 days - 6/5 and 6/9 Senokot. Resident #7	F 309	The facility will utilize the bowel monitoring Program on a daily basis. All residents' bowel Movement status will be assessed daily by the Night & day shift nurse. The proper forms will Be completed per the bowel monitoring program. The policy is attached. All staff have been and will be inserviced on the bowel monitoring program (completing of forms & policy). Aug.14, 2009 The bowel monitoring program will be added to The Nurses & CNA orientation checklist. All staff will be in-serviced on constipation. This will be completed. Aug.14, 2009 Residents at risk for constipation will have an Individualized careplan written. Identifying factors Will be medications, low dietary fiber, immobility, Muscular weakness, neuromuscular disorders, Altered mental status, depression, decreased fluid Intake. All of the above, (bowel movement policy/forms, Inservices on BM & constipation will be added to the facility QI plan & reported to the QI committee. The D.O.N. will monitor this. Completed by August 14, 2009	

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F 309	Continued From page 2 1/10 - 1/15/09 - 5 days - no intervention 2/25 - 3/3/09 - 6 days - no intervention 3/22 - 3/26/09 - 4 days - no intervention 5/9 - 5/18/09 - 9 days - no intervention 5/22 - 5/30/09 - 8 days - no intervention 6/10 - 6/17/09 - 7 days - no intervention 6/20 - 6/24/09 - 4 days - no intervention. Resident #2 5/7 - 5/11/09 - 4 days 5/16 - 5/20/09 - 4 days 6/13 - 6/17/09 - 4 days. Resident #10 3/17 - 3/23/09 - 6 days 3/24 - 3/28/09 - 4 days 3/29 - 4/6/09 - 8 days 4/7 - 4/15/09 - 8 days 4/25 - 5/22/09 - 27 days 5/27 - 5/31/09 - 4 days 6/1 - 6/7/09 - 6 days (noted to have three loose stools on 6/7). 2. Record review of resident #1's 4/15/09 quarterly and 1/15/09 significant change Minimum Data Set (MDS) assessments evidenced that the resident required extensive staff assistance with bed mobility, transfer, walking, locomotion, dressing, toileting, and personal hygiene and total assistance with bathing. On the 4/09 MDS assessment the resident was assessed to be frequently incontinent of urine and continent of bowel. a. Review of the resident's care plan included the following approaches/information related to bowel management and the side effects of the	F 309	Resident #1 bowel movement status will be Assessed daily. If no BM on day 2, the BM Monitoring program will be instituted with Treatment & results documented. She will Have a care plan problem with interventions of high risk for constipation d/t use of pain Meds, immobility, decrease fluid intake, Intermittent confusion.	

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F 309	Continued From page 3 resident's pain medication: BM at least every three days Prune juice every morning as needed Laxative per standing order. Fentanyl Side Effects - ... "Common Reactions: ...constipation..." Dilaudid: -..."Common Reactions: constipation..." There was no evidence that the use of pain medications with side effects of constipation had been care planned or assessed for this resident. b. Review of the resident's physician orders, including standing orders, revealed the following orders related to bowel management: 1/3/08 - Senokot-S every day as needed for constipation - 8.6 - 50 mg (milligrams), i or ii. ? (date) - Miralax or Docusate Sodium every PRN (as needed) Milk of Magnesia 30 cc (cubic centimeters), Dulcolax one suppository, or Fleets enema PRN Prune jam 2 oz (ounces) every day PRN with breakfast. c. Review of the resident's physician orders evidenced the following pain medications were ordered for pain management: 2/11/08 - Tylenol PM 1/2 at bedtime 12/30/08 - Dilaudid 4 mg as needed 12/30/08 - Tylenol 500 mg as needed 1/28/09 - Duragesic patch 100 mcg	F 309	Resident care plan has now been Updated that use of pain meds. with side effectsof constipation is noted.	July 22, 2009

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F 309	Continued From page 4 (micrograms). d. On 6/25/09 at 12:00 noon, in an interview with the DON, she verified that some of the time periods between documented BMs were long times. 3. Review of resident #7's 4/09 quarterly MDS assessment evidenced the resident required extensive assistance with toilet use, personal hygiene, and bathing. The resident was assessed to be frequently incontinent of urine and continent of bowel. a. Review of the resident's physician orders, including standing orders, revealed the following orders related to bowel management: 7/13/08 - Miralax or Docusate Sodium every PRN (as needed) Milk of Magnesia 30 cc (cubic centimeters), Dulcolax one suppository, or Fleets enema PRN Prune jam 2 oz (ounces) every day PRN with breakfast. b. Review of the resident's care plan revealed no approaches for bowel management. 4. Resident #10's record was closed. Review of the resident's 4/8/09 quarterly MDS assessment evidenced the resident was independent with all Activities of Daily Living, except bathing. a. Review of the resident's physician orders, including standing orders, revealed the following orders related to bowel management: 6/25/07 - Miralax or Docusate Sodium every PRN (as needed) Milk of Magnesia 30 cc (cubic centimeters),	F 309	Resident #7 bowel movement status will be Assessed daily. If no BM on day 2, the BM Monitoring program will be instituted with Treatment & results documented. She will Have a care plan problem with interventions of high risk for constipation d/t use of high Risk meds and immobility. Resident #10 is deceased. Bowel movement Status would have been assessed daily. Her Care plan should have included treatment with Results documented. The interventions for High risk of constipation should have been Noted.	

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F 309	Continued From page 5 Dulcolax one suppository, or Fleets enema PRN Prune jam 2 oz (ounces) every day PRN with breakfast. 1/5/09 - Imodium Advanced prn for diarrhea. 1/5/09 - Gas-Xlet prn for gas. 3/16/09 - Senna S 8.6-50 mg every day. b. Review of the resident's 4/9/09 Care Conference Summary revealed that "Freq (frequent) c/o (complaints of) constipation - Colace changed to Senna S ... Daughter will bring a small shaker for flax seed to keep @ bedside....." c. Review of the resident's care plan for the problem of "alteration in elimination r/t (related to) intermittent constipation or loose stools" revealed the following approaches: "Ask _____(resident's name) re: bowel movements - amounts, consistency. ____ (resident's name) is independent with toileting. Will need to ask ____(him/her) to be sure ___(he/she) is having stools at least every (?) days." "Encourage prune jam or prune juice every AM Prn. ____(He/She) will usually ask if ___(he/she) needs it or not. Encourage fluids." "Medication: Senna S, Miralax PRN, may also have laxatives prn per standing orders..." "Encourage fluid intake - at least 1500 ml (milliliters) per day...." "Ask ___(resident's name) daily re: BMs and	F 309		

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F 309	Continued From page 6 record. Notify nurse if having loose or incontinent stools or if no BM in 3 days." d. On 6/25/09 at 7:32 AM, during an interview with the DON, she described resident #10 as non-compliant with his/her diabetic regimen, refusing care for elevated blood sugar levels. She indicated that the resident was independent with ambulation, was alert and oriented, had visual impairment, and frequently experienced nausea, vomiting, and diarrhea. 5. Resident #2's medical record review revealed the resident was admitted to the facility on 5/1/09 with diagnoses which included: Bipolar disorder with agitation and anxiety, dementia with behavioral problems, osteoarthritis multiple joints, diabetes, squamous cell skin cancer, and chronic constipation. a. Review of the "Progress Notes" on 5/2/09 identified the resident as having chronic problem with constipation. The family reported "manual removal of BM" about every month. b. Review of the "Monthly Summary" sheet, dated 5/4/09, identified a problem of chronic constipation and enemas one time per month. c. Review of resident #2's "Care Conference Summary" sheet dated 5/19/09 identified the resident as needing extensive assist with use of a Sara lift to the bedside commode or bathroom for toileting. The resident's cognitive status was described as modified independence with short and long term memory problems. The area of "pain" identified the resident as having, "arthritis pain both knees (physician name) injected right knee 5/15/09 and plans to inject left knee 5/22/09. Neuropathy pain especially lower legs with any	F 309	Resident #2 bowel movement status will be Assessed daily. If no BM on day 2, the BM Monitoring program will be instituted with Treatment & results documented. She will Have a care plan problem with interventions of high risk for constipation d/t use of pain Meds, immobility, decrease fluid intake, Intermittent confusion.	

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F 309	Continued From page 7 touch". It also identified the resident as having ongoing complaints of dizziness and reduction of Seroquel due to ongoing complaints of dizziness. d. Review of resident #2's "Medication Record" for May and June 2009 revealed multiple medications with anticholinergic effects. ["Anticholinergic side effect" is an effect of a medication that opposes or inhibits the activity of the parasympathetic (cholinergic) nervous system to the point of causing symptoms such as dry mouth, blurred vision, tachycardia, urinary retention, constipation, confusion, delirium, or hallucinations.] The resident's medications included: Seroquel 300 mg orally BID (twice a day) which was reduced to 200 mg in the AM and 300 mg in the PM on 5/12/09, and 200 mg PO BID on 6/4/09, Zoloft 100 mg 1 tablet PO (orally) QD (every day), Namenda 10 mg 1 tablet PO BID, Celebrex 200 mg 1 cap PO QD, Ativan 0.5 mg 1/2 tablet PO PRN agitation and Ativan 0.5 mg 1 tablet PO PRN agitation, Lasix 10 mg PO QD, (TWO Laxatives) Senna Herbal 8.6 mg 2 tablets Q AM and Metamucil Fiber one tablet PO QD,	F 309		

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F 309	Continued From page 8 e. Review of the facility's BM List revealed the following information resident #2 dates with no BM charted: 5/7 - 5/11/09 - 4 days, 5/16 - 5/20/09 - 4 days and 6/13 - 6/17/09 - 4 days. The issue with no follow up for four days places this resident with a history of chronic constipation and current medications at high risk for constipation and associated complications, including bowel obstruction. 6. On 6/23/09 at 2:10 PM, in an interview with the Director of Nursing (DON), she revealed that the facility utilized standing orders which were the same for all of the residents. The DON commented that these orders were signed by the physicians when the residents were admitted to the facility. These orders included: "Miralax or Docusate Sodium every PRN (as needed) Milk of Magnesia 30 cc (cubic centimeters), Dulcolax one suppository, or Fleets enema PRN Prune jam 2 oz (ounces) every day PRN with breakfast." 7. On 6/24/09 at 3:43 PM, during an interview with the Administrator and the DON, the surveyor requested a copy of the facility's bowel management program. On 6/25/09, the DON verified that the facility did not have a specific policy/protocol for BM management. 8. On 6/25/09 at 12:05 PM, in an interview with the DON, she confirmed that BM (bowel management) List should be utilized by the nursing staff and that nursing staff should be asking residents about whether or not they have had BMs.	F 309		

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F 309	Continued From page 9 9. On 6/25/09 at 2:45 PM, in an interview with nurse (A), she explained that the information from the "BM List" is transferred to the "BM Monitoring" form (used by the nurse for tracking BMs and the need for interventions) and the "BM Weekly" form (used by the Certified Nurse Aides) (CNAs). She verified that the most accurate BM information is found on the BM List. 10. Review of the BM Monitoring forms dated 3/24/09, 3/28/09, 4/1/09, 4/12/09, 4/14/09, 4/23/09, 4/25/09, 5/4/09, 5/5/09, and 6/18/09 revealed the following: (Note: These were the only sheets on the clipboard and the nurse indicated that she did not know where any other ones were kept.) a. The columns were entitled date, resident name, last BM, Day 2, Day 3, Day 4, treatment, results, and follow-up. b. The following protocol was noted at the bottom of the sheet: Day 2 6-2 prune juice, prunes or prune jam Day 3 6-2 prune juice, prunes or prune jam 2 -10 If no BM by 3 pm - give MOM Day 4 6-2 Give MOM 2-10 - If no BM by 3 pm - give enema or suppos (suppository). c. Much of the documentation for each resident was incomplete, lacking information about BMs, treatment, results, and/or follow-up. Review of these forms failed to show how the nurses provided interventions as specified in the protocol as noted on the forms.	F 309	The documentation on each Resident will be complete, w/ Treatments, results, &/or Follow-up. Nurses will provide Interventions as specified in The protocol.Inservices on BM& constipation, filling Out forms, will be added to The facility QI plan & reported To the QI committee. The DON Will monitor this.	Aug. 14, 2009

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F 309	Continued From page 10 The facility failed to monitor and/or provide interventions for residents who were at risk for complications of constipation and fecal impaction. Reference for BOWEL MANAGEMENT 1. The Merck Manual of Geriatrics, Chapter 110 "Constipation, Diarrhea, and Fecal Incontinence," some medications, low dietary fiber, inadequate hydration, and reduced caloric intake are common causes of constipation. Functional impairment from immobility, muscular weakness, some neuromuscular disorders, altered mental status or depression may also contribute to constipation. Dietary approaches begin with adequate hydration, a cornerstone to treating constipation. 2. A presentation, entitled Management of Diarrhea and Constipation (2005), given by David R.P. Guay, Pharm.D., F.C.P, F.C.C.P, F.A.S.C.P listed "Complications of Constipation in the Elderly." This list included fecal impaction and sigmoid volvulus. 3. Medical Update November, 2001 [Update 01-11], Office of the Ombudsman for Mental Health & Mental Retardation, Minnesota, Bowel Obstruction Alert indicated the following: "Factors that may contribute to constipation: Dietary factors - low residue (low fiber) diet, not drinking enough liquids Inactivity and immobility.... Environmental factors... Structural abnormalities... Smooth muscle or connective tissue disorders... Depression	F 309	The facility will monitor/provide interventions for residents who Were at risk for complications of Constipation & fecal impaction. This will be added to the QI plan & Reported to the committee. The DON will monitor this.	August 14, 2009

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F 309	Continued From page 11 Neurological disorders... Metabolic/endocrine disorders... Medications "This list is intended to give common examples and cannot include all current or future medications that can cause constipation. Opioid analgesics... Nonsteroidal antiinflammatory drugs... Antacids... Anticholinergic drugs... Antidepressants - particularly lithium and tricyclics (like Elavil, Anafranil, desipramine, Pamelor, Tofranil/imipramine) Antipsychotics... Antihypertensives... Inderal... Antiarrhythmics... Diuretics... Anticonvulsants... Dilantin... Antihistamines - Benadryl Anti-ulcer medications... Antilipidemics... Monitoring bowel function: It is important for every facility and home health care program to have an established procedure for monitoring bowel function and responding to changes. Clients should be asked on a daily basis whether they have had a bowel movement. The information needs to be documented in order to learn what the individual's normal routine is and to monitor for the development of problems." COUMADIN Record review for resident #6 revealed that the	F 309		

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F 309	Continued From page 12 resident had a history of pruritis, which was treated with various medications. The resident had physician orders for Benadryl Cream, Eucerin Cream, zinc oxide, Lidex Cream, and oral Benadryl. a. Review of the resident's physician interim orders revealed the following: 2/24/09 - "____(resident's name) has had increased pruritis since resuming Coumadin. ___(He/she) is receiving the generic brand - pharmacist feels an inactive ingredient might contribute to this - Would you want to order the brand name Coumadin to see if pruritis improves?" The physician ordered "Brand Coumadin please." This order was noted on 3/5/09. 4/24/09 - "Resident has a lot of C/O itching. ... Notified pharmacy to send Coumadin not warfarin. ? Causing itching." b. Review of the resident's 3/09, 4/09, and 5/09 Medication Administration Records evidenced that "Coumadin (Warfarin sodium)" was listed to be given. On 5/14/09 the dose of Coumadin was changed and a hand-written, undated note indicated "Do not give generic". c. Review of the resident's 6/09 Medication Administration Record evidenced that "Coumadin (Warfarin sodium)" with an order date of 4/6/2009 was listed. A hand-written note, dated 5/12/09, noted "don't give Warfarin". d. Review of the resident's care plan for the problem of "Alteration in skin integrity R/T(related to) ... chronic pruritis with rash..." included the following approaches:	F 309		

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	53A050	A. BUILDING _____ B. WING _____	06/25/2009

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F 309	Continued From page 13 "....has problems with chronic skin rash and pruritis with occ. (occasional) cellulitis. Encourage not to scratch at areas. Benedryl cream prn...." "Generic Coumadin was changed to brand name Coumadin per pharmacist recommendations to see if pruritis improves and this has decreased severity of problem." e. On 6/25/09 at 1:43 PM, at the surveyor's request, nurse (E) contacted the pharmacy that supplied Coumadin for resident #6 and asked for a printout of all of the Coumadin/Warfarin supplied by the pharmacy from 3/09 to the current date. f. Review of the pharmacy's Patient Profile form evidenced the following doses of Coumadin and Warfarin were sent to the facility for this resident: 2/3/09 - Warfarin Sodium 2.5 mg - 30 2/26/09 - Warfarin Sodium 2.5 mg - 30 3/5/09 - Warfarin Sodium 2.5 mg - 30 3/5/09 - Coumadin 2.5 mg - 30 3/26/09 - Coumadin 2.5 mg - 30 4/9/09 - Warfarin 5 mg - 14 4/24/09 - Coumadin 5 mg - 30 5/26/09 - Coumadin 2.5 mg - 30 5/28/09 - Coumadin 5 mg - 30. g. On 6/24/09 and 6/25/09, in interviews with nurse (A), she indicated that the resident's skin condition and itching was still present but it had gotten better when the brand name Coumadin was used, instead of the warfarin. h. On 6/24/09 at 4:38 PM, in an interview with the Director of Nursing (DON), she stated that the Warfarin was in the cupboard (in 4/09 with the	F 309		

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F 309	Continued From page 14 dosage change) and the nurse used it, instead of the ordered Coumadin. The surveyor requested to see the medication error report (for the incorrect medication being given). i. On 6/25/09 at 11:25 AM, in an interview with the DON, she indicated that she had gotten clarification and there had been no medication error made. She stated that on 4/6/09 there was a change of dosage to Coumadin 5 mg, the pharmacy sent the name brand Coumadin, and the warfarin was not used. j. Review of the resident's pharmacist reports failed to show that the Coumadin/warfarin concern was addressed by the pharmacist. However, during the 6/25/09 interview with the DON, she verified that the idea to stop the warfarin and start the brand name Coumadin was the pharmacist's idea. She confirmed that this information was not documented in the resident's monthly pharmacist reviews. There was no evidence to show that the resident's physician orders were followed in relation to the use of brand name Coumadin. ASSESSMENT of ACUTE ILLNESS Closed record review for resident #10 evidenced the resident experienced nausea, vomiting, and diarrhea, starting on 6/6/09. a. Review of the resident's Progress Notes revealed the following: 6/6/09 6P - 6A - "Resident with N/V (nausea and vomiting) tonight X 3 Sm. (small) amt (amount). Phenergan 25 mg supp given X 2 tonight.	F 309	When a resident is to receive name brand Medication only, the nurse will notify the Pharmacy of choice of the physicians order. "Brand Name Only" will be written in red ink On the medication administration record to Alert the nurse administering the medication & to prevent a medication error. The Pharmacist will address the use of name brand Only medications in the monthly pharmacy Review. This will be added to the facility QI plan. The D.O.N. & pharmacist will monitor. August 14, 2009 #6 The pharmacy has been notified & their Computer system has been updated to send Name brand Coumadin only. The medication Administration record currently has & will Have "Brand Name Only" written in red ink By the Coumadin order to alert nursing staff To not administer Warfarin. The DON & Pharmacist will monitor. July 31, 2009 The" brand name only "information was presented to the P&T committee. This information Will be added to the medication Administration policy. Aug.14, 2009	

Amended page — acceptable B- Per Dolly on 8/7/09

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F 309	Continued From page 15 Resident with diarrhea. Mylanta 30 cc po (orally) given per request. ..." 6/7/09 1453 (2:53 PM) - "Res (resident) cont (continued) with n/v et has now started with diarrhea. Mylanta et phenergan given with sm amt relief. Res has worsened throughout day et Res is requesting ER (emergency room) assessment. T (temperature) - 94.4. P (pulse) - 147 BP (blood pressure) - 147/100 O2 (oxygen) 95% RA (room air). _____notified. Res taken to ER." 6/7/09 1740 (5:40 PM) - "Res returned from ER. Res seen by Dr _____(name). Res with UTI (urinary tract infection). He gave Res Rocephin IM (intramuscular), drew labs, ordered to repeat liver function test in one week....Notified _____...Keep res comfortable." 6/7/09 6P - 6A - "T 96.2, P 92, R 20, B/P 147/89 O2 93%. Continues to c/o nausea, emesis X 1, diarrhea X 1...Continue to feel ill..." 6/8/09 0630 (6:30 AM) - "C/O nausea. no emesis ... T 95 P 115, R 24 BP 146/95..." 6/8/09 0815 (8:15 AM) - "... State Phenergan made ___(him/her) sleepy, but still nauseous. no emesis ..." 6/8/09 1115 (11:15 AM) - "Call to _____(physician's name)'s office et report given to office staff..." 6/8/09 1315 (1:15 PM) - "Call to ___(physician's name) ... Phenergan supp repeated..." 6/8/09 1835 (6:35 PM) - "Phenergan supp given PR (per rectum) for C/O nausea..."	F 309	Assessment of Acute Illness When a resident is acutely ill the nurse will Ensure that all residents are evaluated by a Physician in a timely manner. The physician Will be contacted and/or the resident will be Sent to the ER if 1) symptoms persist for longer Than 24 hrs. 2) there are 3 consecutive Abnormal vital signs. 3) physician notified earlier t/or sent to ER based on severity of symptoms. 07/30/09 1:15pm M. Olsen RN Vital signs are to be done every 4 hrs. or sooner & documented on the vital sign flow sheet. The Vital sign flow sheet has been revised to Document abnormal findings. Nurses will be given training on proper Documentation for an acutely ill resident . This will be added to the facility QI plan and Reported to the committee. The DON will Monitor. August 14, 2009 #10 resident is deceased. Vital signs would Have been taken every 4 hrs from the onset of Her nausea, vomiting & diarrhea then Documented on the flow sheet. Her physician Would have been contacted after 24 hrs. or After 3rd abnormal vital sign for her to be seen Or taken to the ER. After the resident was sent To the ER, her nurse should have been informed Of her vital signs & condition daily until she was Admitted to the hospital. August 14, 2009	

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F 309	Continued From page 16 6/8/09 2100 (9:00 PM) - "Res cont C/O N/V - had emesis X 1...T 96.0 P 132 R 24 BP 167/103...states Phenergan not working. phenergan 25 mg given po per Res request..." 6/8/09 2350 (11:50 PM) - "Res incontinent Lg (large) loose stool in bed... " 6/9/09 0530 (5:30 AM) - "Res cont to have N/V thru noc. No further diarrhea reported..." 6/9/09 0800 (8:00 AM) - Physician note - "Pt demanded to see provider this AM....'I'm so sick'.. Will admit to hospital for IV (intravenous) hydration ... will need to get ____(another physician's name) to admit." 6/9/09 1005 (10:05 AM) - "T 96.1 P 144 R 22 BP 123/81 ...Res cont with n/v et diarrhea,...reported it is getting worse...Hospital called to notify that they will have room ....probably after 1300 (1:00 PM)..." 6/9/09 1250 (12:50 PM) - "Received order from ____(physician's name) that organism growth in urine is resistant to Macrobid. Macrobid D/C'd (discontinued), will not order another ATB (antibiotic) because Rocephin given last Sunday should cover it. Orders carried out." (Note: the resident's transfer or status at the time of transfer was not documented in this note.) The next note was written 6/10/09 at 1400 (2:00 PM) - "Res passed away... at hospital..." b. Review of the resident's vital sign flow sheet revealed no additional documentation of vital signs in 6/09. However, review of the resident's vital sign documentation (dated 2008 and 2009)	F 309		

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F 309	Continued From page 17 indicated the resident's baselines were T 97 to 98.6 degrees Farenheit and P 90 - 105. c. Review of the resident's laboratory reports evidenced the following: 6/7/09 blood drawn at 3:57 PM - WBC (White Blood Count) 10.6 K/uL (Normal 4 -10) 6/9/09 blood drawn at 6:59 AM - WBC 15.8. Reference: Merck Manual Second Edition Sepsis is a serious bodywide response to bacteremia or another infection. Septic shock is life-threatening low blood pressure (shock) due to sepsis · Usually, sepsis results from certain bacterial infections, often acquired in a hospital. · Having certain conditions, such as a weakened immune system, certain chronic disorders, an artificial joint or heart valve, and certain heart valve abnormalities, increases the risk. · At first, people have a high (or sometimes low) body temperature, sometimes with shaking chills and weakness. · As sepsis worsens, the heart beats rapidly, breathing becomes rapid, people become confused, and blood pressure drops. · Doctors suspect the diagnosis based on symptoms and confirm it by detecting bacteria in a sample of blood, urine, or other tissue. · Antibiotics are given immediately, and people with septic shock are given oxygen and fluids and sometimes drugs to increase blood pressure. Usually, the body's response to infection is limited to the specific area infected. But in sepsis, the response to infection occurs throughout the body-called a systemic response. This response	F 309		

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F 309	Continued From page 18 includes an abnormally high temperature (fever) or low temperature (hypothermia) plus one or more of the following: - Rapid heart rate - Rapid breathing rate - An abnormally high or low number of white blood cells As sepsis worsens, organs begin to malfunction and blood pressure may decrease. Sepsis is considered severe if organs malfunction. Septic shock is diagnosed when blood pressure remains low despite intensive treatment. In the United States, about 90,000 people, usually those who are hospitalized, die of septic shock each year.	F 309		
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356	F356 The current nurse staffing data sheet will Be posted upright at all times at the nurses Station. The signage will alert the public of Its availability. A person in a wheel chair can Readily see the report now. This will be added to The facility QI plan. The DON will monitor.	July 17,2009

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F 356	Continued From page 19 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This Requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to post their nurse staffing information in a place which was easily visible/available for the public. The findings included: On 6/24/09 at 11:25 AM, the paper with the nurse staff posting was lying on the counter at the nurses' station. At this time, nurse (A) confirmed that the posting was normally lying on the counter. She indicated that there was a book on the wall by the nurses' station where the page had previously been kept. On 6/24/09 at 3:43 PM, in an interview with the Administrator and the Director of Nursing (DON), the need for the nurse posting to be readily accessible/visible to the public was discussed. On the morning of 6/25/2009, the posting was again observed lying on the counter at the nurses' station.	F 356		
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363	F 363 Menus must meet the nutritional needs of Residents in accordance with the recommended Dietary allowances of the food and nutrition Board of the National Research Council, Ntl. Academy of Sciences.	

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F 363	Continued From page 20 This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to serve the items which were planned on the written menus. The findings included: 1. Review of the menu for the evening meal on 6/23/09 reviewed that the following foods were menued: REGULAR Four cheese pizza 2 ounce/1 slice Caesar salad w/Caesar dressing 1 cup Breadstick (dough) 1 each Italian ice 4 ounce Cookie (dough) 1 each Milk 1/2 cup PUREED Pureed four cheese pizza Vegetable juice 1/2 cup Breadstick pureed Italian ice Cookie pureed Milk RCS (restricted concentrated sweets) Same as regular HI-PROTEIN Same as regular, except 1.5 slices of pizza and 1 cup milk 2. The "Week at a Glance" Menu summary breadstick was crossed off.	F 363	#2 the dietary director and dietitian made Decision to cross off breadstick prior to day Served d/t assessing too many carbs. In the Future the dietary director and dietitian will Initial and date each change. The Dietary Dir. Will monitor. July 28, 2009	

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F 363	Continued From page 21 3. Observation revealed that there were cups of sherbet , cups of fresh fruit, and vanilla wafers sitting on the counter. The staff member who passed the desserts offered the residents fruit cups and vanilla wafers. 4. Review of the "Care Center Diet Card Summary" which listed the diets for 22 residents evidenced that seven residents were to receive additional or large portions of protein. 5. On 6/24/09 in staff interviews with dietary staff, they revealed that residents who were to receive increased protein were given larger serving amounts of meat (or the protein food). 6. Observation of the evening meal on 6/23/09 from 5:20 PM to 6:15 PM revealed the following: a. Review of resident #11's diet as listed on the "Care Center Diet Card Summary" evidenced that the resident was to receive a regular diet with large protein portion, no concentrated sweets. The resident was served one slice of pizza. The staff member who was passing out the desserts offered the resident ice cream, which the resident indicated that he/she wanted. The resident was observed to receive a Magic Cup. A Magic cup contains 290 calories with high sugar content. b. Review of resident #12's diet as listed on the "Care Center Diet Card Summary" evidenced that the resident was to receive a regular diet with large protein portion, small carbohydrates. The resident received one slice of pizza. The staff member who was passing out the desserts offered the resident ice cream, which the resident indicated that he/she wanted. The resident was given berries and ice cream.	F 363	#3 The dietary staff members will ensure proper Menu items will be served from now forward. Cook will oversee this and report to the Dir. Of Dietary. July 28, 2009 #6Menus will be followed. Changes must be Documented. Special diet requests made by Resident, dietician or physicians will be followed. Staff will receive training on the importance of Special diets from the contract dietitian during Monthly department meetings. The cook will give extra protein when serving Following the diet card summary. The menu Substitution policy has been revised. Training & Education will be conducted by July 28, 2009 Dir.Of dietary will add this to the QI plan & Report to the committee. Dir. Of dietary will Monitor this. August 14, 2009 There will be random checks by the Dietary Director and dietitian. Performance counseling May be necessary. July 28, 2009	

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F 363	Continued From page 22 c. Review of resident #1's diet as listed on the "Care Center Diet Card Summary" evidenced that the resident was to receive a regular diet with extra protein, extra fats and gravies, small portion. The resident was served one slice of pizza. d. Review of resident #13's diet as listed on the "Care Center Diet Card Summary" evidenced that the resident was to receive a regular diet with additional protein. The resident was served one slice of pizza. 7. On 6/25/09 at 8:12 AM, in an interview with the Dietary Manager (DM), he confirmed that the dessert was sherbet and the residents were to receive the fruit cups in addition to the sherbet and cookie. The sherbet was to be used in place of the Italian ice. He verified that two small vanilla wafers were not equal to the menued cookie.	F 363		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to store, prepare, and distribute food in a manner that minimized the potential for the spread of food-borne illness. The findings included: 1. On 6/23/09 at 9:00 AM, during the initial dietary tour of the kitchen and dining room, the following observations were made in the presence of the	F 371		

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	53A050	A. BUILDING _____ B. WING _____	06/25/2009

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F 371	Continued From page 23 Dietary Manager (DM): a. Kitchen A plastic container with flour in it had a scoop inside it. In the reach-in refrigerator, there was a container of milk which had been opened but not dated. The DM verified that opened items should be dated. b. Dining Room On top of the steam table, there was an open can of Beneprotein which was not dated with the open date. Beneprotein per manufacturer's instruction is to be dated when it is opened and it is good for six months after it is opened. This was discussed with the DM at the time of the observation. This undated can of Beneprotein was observed on the steam table on 6/24 and 6/25/09. There was an open cardboard box of spoons under the sink. The inside of the stove oven (used by activities per the DM) was dirty. There was an open can of whipped cream in the refrigerator; this had not been dated with an open date. 2. On 6/23/09 during the evening meal service, observation revealed that the cook (B) repeated served food items with his gloved hands, touched carts or other items, and then served food items, picking them up with his gloved hands. At 6:00 PM, the cook changed his gloves but did not wash his hands. He continued to pick up food	F 371	F371 Sanitary Conditions-food prep & service 1a. The scoop has been removed. Staff have Been trained and will continue to be trained On sanitary conditions . This was done June 25, 2009 July 28, 2009 Weekly compliance check sheet has been Implemented. July 28, 2009 This will be completed by AM & PM cook weekly. This will be monitored by Dietary Director & immediately corrected. Container labeling, lids fitting tightly, proper Storage is being monitored by weekly check sheet. The cooks will review. Dietary Director will Monitor. Date of inservice is July 28, 2009 1b.The Beneprotein is now labeled and was dated When opened. The box of spoons have been discarded and /or Stored elsewhere. Staff inservice August 14, 2009 Stove cleaning has been completed.There is a Communication process in place so the dietary Staff know the oven has been used. Dir. Of Dietary will monitor this. July 20, 2009 Container labeling and dating inservice has taken Place. July 28, 2009 Director of Dietary will monitor this. August 14, 2009	

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F 371	Continued From page 24 items with his gloved hands, touch other items, and serve more food with the same gloved hands. 3. On 6/24/09 during the breakfast meal service, observation revealed that the dietary staff member (C) repeated served food items with her gloved hands, touched carts or other items, and then served food items, picking them up with her gloved hands. She continued to pick up food items with her gloved hands, touch other items, and serve more food with the same gloved hands. 4. On 6/24/09 at 2:00 PM, observations of the kitchen revealed the following: In the dry storage area, there was a plastic container with noodles in it. The lid was not closed on the container. Staff (C and D) verified that the lid did not fit the container. There was a large open box of yellow cake mix with the inner plastic bag open. In the walk-in freezer, there was a bag of grilled chicken and a bag of chicken breast which had been opened but were not labelled or dated. Staff (C and D) confirmed that these bags should be labelled and dated. 5. On 6/25/09 at 8:12 AM, the observations of the evening meal and breakfast meal and of the food storage areas were discussed with the DM.	F 371	#3, 4. Handwashing All staff will receive additional training on proper Glove usage through in-service at monthly mtgs. First inservice was conducted June 25. Additional Trainings will occur July 28 and more as needed By August 14, 2009. Staff will be observed, a check List completed. Director of Dietary will monitor this. Cooks will also observe staff. Contract dietitian will Observe twice weekly when she is on-site. August 14, 2009 Container labeling and dating inservice has taken Place. July 28, 2009 Director of Dietary will monitor this. August 14, 2009 The above 1-4 items & plan of correction will be added to the QI plan& reported to the committee. The Dir. of dietary will monitor this. August 14, 2009	
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES 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	F 431	F431 pharmacy services The facility will use properly labeled medications For all residents.	

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F 431	Continued From page 25 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 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, record review, and staff interview, it was determined that the facility failed to use properly labelled medications for one of ten sample residents (#2). The findings included: Resident #2's medical record review revealed the resident was admitted to the facility on 5/1/09 with diagnoses which included: Bipolar disorder with agitation and anxiety, dementia with behavioral problems, osteoarthritis multiple joints, diabetes,	F 431	The medication administration policy has been Revised to include a procedure under dispensing. There is added language in the policy regarding The labeling. Policy is attached. The Policy will Be reviewed at the pharmacy/therapeutics Committee. July 22, 2009 This will be added to the QI plan & monitored by pharmacist & DON Aug.14, 2009	

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F 431	Continued From page 26 squamous cell skin cancer, and chronic constipation. a. Review of resident #2's "Medication Record" for May and June 2009 revealed the resident's medication regimen included: Seroquel 300 mg orally BID (twice a day) which was reduced due to complaints of dizziness to 200 mg in the AM and 300 mg in the PM on 5/12/09, and 200 mg PO BID on 6/4/09, Zoloft 100 mg 1 tablet PO (orally) QD (every day), Namenda 10 mg 1 tablet PO BID, Celebrex 200 mg 1 cap PO QD, Ativan 0.5 mg 1/2 tablet PO PRN agitation and Ativan 0.5 mg 1 tablet PO PRN agitation, (2 Laxatives) Senna Herbal 8.6 mg 2 tablets Q AM and Metamucil Fiber one tablet PO QD, Avandamet 4-500 one PO Q AM, Lantus Insulin 15 units SQ (subcutaneous) Q PM. b. Review of the "Progress Notes" dated 6/4/09 stated, " (___name) notified nursing today not to order Seroquel from (_____named pharmacy) et cost hundreds of dollars. Family has samples at home they will bring in for (__name resident #2). c. Interview with nurse A on 6/24/09 revealed that family had brought in samples of Seroquel and that they were administered to the resident. Staff confirmed that the medication had not been checked by the facility's pharmacist or labeled	F 431		

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F 431	Continued From page 27 prior to administration. Additionally there had been changes in the medication dose which had to be ordered from the pharmacist leaving two different doses available for use. The facility failed to coordinate with the licensed pharmacist to ensure a formal mechanism to safely handle these medications and maintain accurate medication records involving use of medication samples. [Medication labeling identifies, at a minimum, the medication's name, strength, expiration date when applicable, and lot number, and provides instructions as necessary for safe administration.] d. Interview with the Pharmacist on 6/25/09 revealed that he was not aware of a policy or a procedure to allow for the use of samples of prescription medication to be administered without being checked by a pharmacist. He also confirmed that the licensed pharmacist was responsible for proper labeling of medications and he was not aware of the current State requirement with using sampled medication in a long term care setting. Additionally, there was no documentation of review or follow-up with the family concerns with the cost of the resident's medications with the pharmacist and the physician. e. On 6/24/09 at 3:43 PM, in an interview with the Administrator and the Director of Nursing (DON), the facility's use of sample medications provided by the family for resident (#2) was discussed. They indicated that the medications had already been checked by the Pharmacist and these were re-labelled for use. The facility failed to ensure drugs and biologicals	F 431		

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F 431	Continued From page 28 used in the facility are labeled in accordance with applicable Federal and State requirements and currently accepted pharmaceutical principles and practices.	F 431	The labeling of the sample medication in Question was completed by June 29, 2009.	June 29, 2009
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS 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 upon observation and staff interview, it was determined that the facility failed to provide safety equipment to prevent back siphonage of contaminated water into the potable water system of the building. The findings included: During the initial tour of the dietary department on 6/23/09 at 9:00 AM in the presence of the Dietary Manager (DM), an unsecured blue cylinder identified by the DM as a CO2 (carbon dioxide) tank was observed standing inside the east door of the kitchen. This was observed again on 6/23/09 at 4:25 PM and on 6/24/09 at 2:00 PM. During the environmental tour on 6/25/09 at 12:10 PM, the Administrator was shown the unsecured carbon tank standing inside the east kitchen door. The Administrator directed the staff to secure the tank as it posed a safety risk to staff. On 6/25/09 at 2:50 PM, the maintenance department lead reported the he had been asked to take care of the tank prior to the survey but it had not been addressed. He then reported he would get the tank secured in the cabinet under the soda dispenser.	F 465	F465 Other environmental conditions The facility will provide housekeeping and Maintenance services necessary to maintain a Sanitary, orderly, and comfortable interior. The CO2 tank was secured June 25, 2009. Staff education for dietary & maintenance staff Was completed by directors of dietary & Maintenance. Each director will monitor usage & placement of CO2 tanks. July 28, 2009 This will be added to the QI plan & monitored By Directors of dietary & maintenance. Aug.14,2009	