7/3/13

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535022 | A. BUILDING _____ B. WING _____ | C 06/06/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PIONEER MANOR NURSING HOME | 900 W 8TH ST GILLETTE, WY 82716 |

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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations are used throughout this document:<br><br>MDS- Minimum Data Set<br>RN- Registered Nurse<br>MAR- Medication Administration Record<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>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.<br><br>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).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the | F 225 | F 225<br>Correction for cited resident(s):<br>Resident #22 - Validation of the care plan and interventions will address strategies for aggressive or threatening behavior, behavior/ environmental triggers, and need for diversion activities.<br>Resident #24 - Validation of the care plan and interventions will address aggressive or threatening behavior, behavior/ environmental triggers, and need for diversion activities. | 7-20-13<br>06-27-13<br>06-27-13 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 6/28/13

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



7/10/13 am
Jonny Belding, CEO notified by phone
date of completion = 7/20/13

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| F 225 | Continued From page 1<br>investigation is in progress.<br><br>The results of all investigations must be reported 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to investigate and report an incident of resident to resident abuse that occurred between 2 sample residents (#22, #24) in the Memory Support Unit. The findings were:<br><br>Review of nursing notes for resident #24 dated 3/19/13 and timed 6:02 PM revealed "Resident very agitated this evening, [spouse] arrived just before dinner and resident was agitated with [him/her], Resident spouse left, at this time resident then began pacing around dinning (sic) room [s/he] walked up to resident 1008 [#22] and slapped her in the face twice. [Two] 2 staff assisted resident away from resident 1008 [#22] and attempted redirections made, resident continued to remain agitated, cursing and attempting to hit at staff. Resident was given valium as schedule per MAR. Call placed to DPOA [family] member, [s/he] expressed understanding. Physician notified via fax form. Social Services notified via phone call..." | F 225 | F225 cont.<br>Identification of other residents will occur by: All residents have the potential to be affected by aggressive or abusive behavior.<br><br>Systemic Corrective Action:<br>• All alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property are reported in accordance with facility and state law.<br><br>07-20-13<br><br>• Staff Education on reporting abuse, injuries to be completed with current staff as well as upon new hire orientation and on an annual basis<br><br>06-13-13<br><br>Outcome:<br>➢ 100% of residents involved in altercations will be reported per state and federal guidelines.<br>DON or designee will collect data and evaluation will be reported quarterly to the QA Committee, with discrepancies investigated and resolved. | |

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| F 225 | Continued From page 2<br>Review of a prescriber fax notification form from the medical record of resident #22 dated 3/19/13 timed 5:45 PM revealed "Resident was slapped in the face by another resident. No injuries."<br><br>The following concerns were identified:<br>a. Review of the State agency records revealed no evidence the incident of resident to resident physical abuse was reported by the facility on 3/19/13.<br>b. Interview with the nursing manager on 6/6/12 at 12 PM verified the incident was not investigated and was not reported as required. | F 225 | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and resident and staff interview, the facility failed to ensure staff maintained the dignity of 2 of 21 sample residents (#66, #89). The findings were:<br><br>1. Observation on 6/3/13 from 5:45 PM through 9:15 PM showed RN #50 entered the room of resident #66 without knocking on two occasions, once at 7:22 PM and again at 8:25 PM. Interview with neighborhood 4 nurse manager on 6/6/13 at 11 AM revealed staff should always knock and wait for an answer prior to entering a resident's room. | F 241 | F 241<br>Correction for cited resident(s):<br>Resident #66 – Follow up with education of staff directly involved in patient care to endorse patient dignity actions required to ensure standard of care.<br><br>Resident #89 – Dining seating adjusted to seat resident in a manner to create an adult dining experience. Care plan updated to address dignity issues and options for dining accommodations as well as alternative options for resident choices<br><br>Identification of other residents will occur by: All residents have the right to have their personal dignity protected, supported and maintained.<br><br>Systemic Corrective Action:<br>• Include surveillance of staff in Leadership Rounding to evaluate patient dignity interventions.<br>• Visual reminders to be posted to remind staff & visitors to introduce themselves prior to resident contact<br>• Interdisciplinary evaluation of all resident physical environments to enhance eating experience and adaptations needed<br>• OT & PT evaluations will include evaluations of physical environment upon admission, quarterly, annually and upon significant change as applicable<br>• Staff education related to dignity recognition, interventions and reporting. | 07-20-13<br><br>06-13-13<br><br>06-13-13<br><br>07-20-13<br><br>07-20-13<br><br>07-20-13<br><br>07-20-13<br><br>06-13-13 |

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| F 241 | Continued From page 3<br>2. Observations on 6/3/13 at 5:45 PM (evening meal) and then again on 6/4/13 at 12 PM (lunch meal) revealed resident #89 was seated and eating at a dining room table in the 500 hall. Further observation revealed the resident was sitting in a wheelchair that was low to the floor. As a result, the standard dining table height was approximately level with the resident's chin. Interview with physical therapist #1 on 6/5/13 at 1:48 PM revealed the resident had a low to the ground wheelchair because the resident had short legs and was able to self-propel while sitting in the wheelchair. She also stated that neither she nor anyone from occupational therapy had assessed the resident height while seated at the table. Interview of the resident on 6/5/13 at 2:48 PM revealed "the dining room table is too high. I'd like it lowered." | F 241 cont. | Outcome:<br>➢ 90% or greater of staff observations during Leadership rounding will reflect dignity issues are being addressed<br>➢ 90% or greater of interdisciplinary evaluations are completed when indicated (chart audit)<br>DON or designee will collect data and evaluation will be reported quarterly to the QA Committee w/ discrepancies investigated and resolved. | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided | F 279 | F 279<br>Correction for cited resident(s)-altered sleep pattern:<br>Resident # 62: Care plans updated to reflect individualization regarding interventions to assure healthy sleep patterns, effective use of sleep medications and preferred bedtime.<br><br>Resident # 70: Care plans updated to reflect individualization regarding interventions to assure healthy sleep patterns, effective use of sleep medications and bedtime schedule routines.<br><br>Resident #2: Care plans updated to reflect individualization regarding interventions to assure healthy sleep patterns, effective use of sleep medications and bedtime schedule routines. | 07-20-13<br><br>06-27-13<br><br>06-27-13 |

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| F 279 | Continued From page 4<br>due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and medical record review, the facility failed to ensure an individualized care plan was developed in a variety of areas for 4 of 21 sample residents (#2, #24, #62, #70). The findings were:<br><br>In regard to altered sleep pattern:<br><br>1. Review of the 12/3/12 annual MDS assessment for resident #62 showed s/he was admitted with diagnoses including atrial fibrillation, coronary artery disease, hypertension, gastroesophageal reflux disease, renal insufficiency, and rheumatoid arthritis. Review of the 5/20/13 care plan showed the resident had difficulty falling asleep and staying asleep at night and frequently dozed off during the day. Further review of the care plan showed interventions included: limit care activity with sleep. When asked what this meant, neighborhood 4 nurse manager stated on 6/6/13 at 11 AM, she was unsure. Also included as an intervention was non-medication sleep aids but no specific or individualized sleep aids were identified or suggested. Finally, an intervention included having a regular bedtime schedule but did not specify what that schedule was. Interview with CNA #2 on 6/3/13 at 6:20 PM revealed the resident liked to go to bed early but was unable to state a specific or approximate time. | F 279 | F279 Conf.<br><br>Correction for cited resident(s)-altered coping mechanisms:<br>Resident # 62: Care plans updated to reflect Individualization regarding interventions to assure identification of specific support systems for effectual coping and pain control.<br><br>Resident # 70: Care plans updated to reflect individualization regarding identification of specific support systems for effectual coping related to body integrity, body changes, and feelings of hopelessness.<br><br>Correction for cited resident(s)-knowledge deficits:<br>Resident # 62: Care plans updated to reflect Individualization regarding interventions for knowledge deficits related to altered thought processes.<br><br>Correction for cited resident(s)-behaviors:<br>Resident #24: Care plans updated to reflect individualization regarding wandering and food seeking behavior, and the reduction of risk behaviors that expose resident to infection during mealtimes. | 06-27-13<br><br>06-27-13<br><br>06-27-13<br><br>06-27-13 |

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| F 279 | Continued From page 5<br>2. Review of the 3/16/13 hospital discharge summary for resident #70 showed s/he had diagnoses including past cerebral vascular accident (stroke) with left-sided deficits, chronic headache, depression, anxiety, pain status post-left leg fracture, gastroesophageal reflux disease, and chronic obstructive pulmonary disease. Review of the 4/2/13 care plan showed the resident had difficulty falling asleep and staying asleep at night and frequently dozed off during the day. Further review of the care plan showed interventions included: limit care activity with sleep. When asked what this meant, neighborhood 4 nurse manager stated on 6/6/13 at 11 AM, she was unsure. Also included as an intervention was non-medication sleep aids but no specific or individualized sleep aids were identified or suggested. Finally, an intervention included having a regular bedtime schedule but the care plan did not specify what that schedule was.<br><br>3. Review of the 6/27/13 care plan for resident #2 showed s/he had difficulty falling asleep and staying asleep at night and frequently dozed off during the day. Further review of the care plan showed interventions included: limit care activity with sleep. When asked what this meant, neighborhood 4 nurse manager stated on 6/6/13 at 11 AM, she was unsure. Also included as an intervention was non-medication sleep aids but no specific or individualized sleep aids were identified or suggested. Finally, an intervention included having a regular bedtime schedule but the care plan did not specify what that schedule was.<br><br>In regard to coping mechanisms: | F 279 | F279 Cont.<br>Identification of other residents will occur by: All residents have the right to have individualized plans of care to meet their unique needs.<br><br>Systemic Corrective Action:<br>• Implement a performance improvement team to implement enhancements to the electronic care plan that make a more individualized document possible for easy recognition, updated in timely manner and address each resident's special needs.<br><br>• Staff education on individualized care planning, infection prevention techniques and sleep patterns.<br><br>• Revision of psychiatric progress note<br><br>Outcome:<br>➢ 95% of direct care givers interviewed will verbalize their plan of care is consistent with the documented individualized care plan.<br>DON or designee will collect data and evaluation will be reported quarterly to the QA Committee with discrepancies investigated and resolved. | 07-20-13<br>07-20-13<br>06-07-13 |

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| F 279 | Continued From page 6<br><br>1. Review of the 12/3/12 annual MDS assessment for resident #62 showed s/he had a score of 10 on the PHQ-9 (mood) screening which indicated moderate depression. Review of this same MDS assessment showed the resident had diagnoses including rheumatoid arthritis which contributed to the resident's pain. The pain was noted to be 8 out of 10 on a pain scale of 0 to 10 with 10 being the worst. In addition, review of this MDS assessment showed the pain made it hard for the resident to sleep at night and limited his/her day-to-day activities. Review of the 5/20/13 care plan showed the resident had difficulty coping with life style changes and his/her current illness/pain. Further review of this care plan showed interventions included "identify support systems," however, review of the document showed no specific or individualized support systems for the resident.<br><br>2. Review of the 3/16/13 hospital discharge summary for resident #70 showed s/he had diagnoses including depression and anxiety. Review of the 4/15/13 care plan showed the resident had difficulty coping with changes in his/her body integrity, life style changes, and had feelings of hopelessness. Further review of this care plan showed interventions included "identify support systems". However, no specific or individualized support systems for the resident were noted in the care plan.<br><br>In regard to knowledge deficits:<br><br>Review of the 5/20/13 care plan for resident #62 showed knowledge deficit related to altered thought process and inability to retain information | F 279 | | |

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| F 279 | Continued From page 7<br>was identified as a problem for this resident. Further review of the care plan showed no interventions for this problem.<br><br>In regard to behaviors:<br><br>Observation on 6/3/13 at 6:10 PM revealed resident #24 was wandering about the memory support unit dining room. The resident's meal was served at 5:42 PM, and s/he was observed at 6:10 PM wandering around the dining room, eating off other residents' plates, sometimes using other residents' already used flatware. Interview with LPN #1 at 6:28 PM revealed that eating other residents' food is "normal" behavior for him/her, but that staff "try to catch [him/her] before [s/he] uses other people's silverware."<br>Review of the resident's care plan on 6/6/13 revealed that the resident had a care plan for "Altered Intake." However, the care plan did not include any planned, individualized interventions intended to protect the resident from the risks associated with eating off of other residents' plates, with already used flatware. Further, the resident had a care plan for "Behavior." The behavior care plan also failed to include planned, individualized interventions to manage the resident's tendency to wander about the dining room and eat off of abandoned plates. | F 279 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by: | F 281 | F 281<br>Correction for cited resident(s):<br>Resident #2: Psychiatric evaluation occurred on 5-14-2013. The delay in completion was investigated, discussed with ordering provider and resolved.<br>06-13-13 | 07-20-13 |

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| F 281 | Continued From page 8<br>Based on staff interview and medical record review, the facility failed to ensure staff followed physician's orders in a variety of areas for 1 of 21 sample residents (#2). The findings were:<br><br>Review of the medical record for resident #2 showed a physician's order dated 1/4/13 at 9 AM for a psychiatric evaluation. According to this order the indication for the evaluation was to develop a behavioral management plan for the resident's dementia with behaviors diagnosis. Review of the 3/5/13 physician's orders showed the following: "was psych [psychiatric] consult ever completed?" Further review showed on 5/9/13 at 8:30 AM the physician wrote "Please have psych (psychiatry) notified and completed as asked on 3/5/13."<br><br>Interview with neighborhood 4 nurse manager on 6/6/13 at 11 AM revealed she was unsure why there was a delay in following the physician's orders; she said maybe the resident refused but was unable to produce any evidence of such. The psychiatric evaluation was completed on 5/14/13.<br><br>According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. | F 281 | F281 cont:<br>Identification of other residents will occur by: All residents have the potential to be affected by delayed or uncompleted medical orders/consultations.<br><br>Systemic Corrective Action:<br>• Complete physician education regarding delineation of the type of consultation requested (psychologist or psychiatry)<br><br>• Implement process to confirm the scheduling and completion of physician orders for in-house consultations to ensure timely service is obtained<br><br>Outcome:<br>➢ 95% of charts audited with psychiatric consultations will be completed within 14 days.<br>DON or designee will collect data and evaluation will be reported quarterly to the QA Committee with discrepancies investigated and resolved. | 06-20-13<br><br>07-20-13 |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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 | F 309<br>Correction for cited resident(s):<br>Resident #2: Psychiatric evaluation occurred on 5-14-2013. The delay in completion was investigated, discussed with ordering provider and resolved. | 07-20-13<br><br>06-13-13 |

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| F 309 | Continued From page 9 and plan of care. | F 309 | F309 Cont | |

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review and staff interview, the facility failed to ensure 2 of 21 sample residents (#2, #70) were provided the necessary care and services in regard to comfort and behaviors. The findings were:

1. Review of the 4/2/13 sleep assessment for resident #70 showed s/he "....is not always comfortable in [his/her] bed and asked to be repositioned multiple times before able to relax enough to sleep." Review of a "prescriber fax notification form" dated 4/18/13 showed a request to the physician to order a low air loss mattress for the resident because the air overlay mattress currently on his/her bed caused his/her left hip to be painful. Review of the medical record and observation of the resident's bed showed no evidence the air overlay mattress was replaced. Interview with the nurse manager and MDS staff from neighborhood 4 on 6/6/13 at 11 AM revealed the physician had never responded to the request. Further interview revealed nursing had not followed up to re-request the order since 4/18/13 (49 days).

2. Review of the medical record for resident #2 showed a physician's order dated 1/4/13 at 9 AM for a psychiatric evaluation. According to this order the indication for the evaluation was to develop a behavioral management plan for the resident's dementia with behaviors diagnosis. Review of the 3/5/13 physician's orders showed

06-13-13

Resident # 70: Re-assessment of sleep and pain completed. Resident stated current mattress meets comfort and sleep needs. Care plan updated to reflect assessment findings.

06-26-13

Identification of other residents will occur by: All residents have the potential to be affected by inadequate physical or psychological care provisions.

Systemic Corrective Action:

- Implement a performance improvement team to evaluate and streamline process for validation, confirmation and completion of physician orders.

07-20-13

Outcome:

- 95% of chart reviews will demonstrate orders were verified and completed.

DON or designee will collect data and evaluation will be reported quarterly to the QA Committee with discrepancies investigated and resolved.

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| F 309 | Continued From page 10<br>the following: "was psych (psychiatric) consult ever completed?" Further review showed on 5/9/13 at 8:30 AM the physician wrote "Please have psych (psychiatry) notified and completed as asked on 3/6/13".<br><br>Interview with neighborhood 4 nurse manager on 6/6/13 at 11 AM revealed she was unsure why there was a delay in completing this evaluation, she said maybe the resident refused but was unable to produce any evidence of such. The psychiatric evaluation was completed on 5/14/13. | F 309 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions | F 441 | F 441<br>Correction for cited resident(s):<br>Resident #24: Care plan adjusted to alter eating environment and timing of meal delivery to accommodate individualized eating habits thus reducing food search activity. Additionally, updated to outline options for access to finger foods and snacks PRN<br><br>Identification of other residents will occur by: All residents have the potential to be affected by the lack of infection measures and inadequate nutritional intake.<br>Systemic Corrective Action:<br>• Alteration in mealtimes will be made to adjust meals to meet each resident's nutritional needs. | 7-20-13<br><br>06-27-13<br><br>07-20-13 |

8/21/13

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| F 441 | Continued From page 11<br>from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review and staff interview, the facility failed to monitor and redirect the behavior of 1 of 6 sample residents (#24) residing in the memory support unit who habitually ate from leftover plates with flatware used by other residents. The findings were:<br><br>On 6/3/13 at 6:10 PM, resident #24 was observed to wander about the dining room of the memory support unit, eating off the plates of residents who had finished their meals and left the table, occasionally picking up used flatware and using it to consume other residents' leftover food.<br><br>Interview with LPN #1 on 6/3/13 at 6:28 PM confirmed this is normal behavior for this resident although they "try to catch [the resident] before [s/he] uses other people's silverware."<br><br>Review of the resident's care plan revealed no planned interventions for this behavior. Interview | F 441 | Fault Corrt<br>• Staffing are to ensure appropriate clearing of dining areas after meals.<br><br>• Hand hygiene supported by staff in Leadership rounding and during direct observation<br><br>• Staff education on individualized care planning, infection prevention techniques.<br><br>Outcome:<br>➢ 100 % direct observations will demonstrate correct nutritional meal hygiene practices.<br>DON or designee will collect data and evaluation will be reported quarterly to the QA Committee with discrepancies investigated and resolved. | 07-20-13<br><br>07-20-13<br><br>07-20-13 |

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| F 441 | Continued From page 12<br>with the Infection Preventionist on 6/6/13 at 9:50 AM revealed the facility expectation is that staff would intervene with this resident to prevent him/her from eating food off of other residents' plates and using other residents' flatware, and the facility "should have a plan." | F 441 | | |
| F 465 SS=E | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to provide a safe environment for facility staff in 1 of 5 clean laundry rooms. The findings were:<br><br>Multiple observations at various times from 6/3/13 at 4:48 PM through 6/6/13 at 9:48 AM revealed a wall mounted cupboard in the "clean linen room" in the 500 hall, by resident room #620. One of two hinges on the 2 ft by 4 ft door to the cupboard was not attached to the frame. When opened, the door was loose and unstable.<br><br>Interview with RN #1 on 6/6/13 at 9:48 AM revealed she was unaware of the loose door. She also stated if the one remaining hinge came away from the frame, the door would fall onto someone who could be seriously hurt. | F 465 | **F 465**<br>Correction for cited deficiency: Work order placed and faulty cabinet door removed to prevent staff injury<br><br>All residents and staff are potentially affected by the lack of preventative maintenance of their physical environment.<br><br>Systemic Corrective Action:<br>• Preventative maintenance rounding to be included in Leadership daily rounds with work orders completed for variances<br><br>• Monthly safety rounding by safety coach staff with the completion of work orders for variances.<br><br>Outcome:<br>➢ 90% of environmental issues will have a documented work order completed at the time of discovery.<br>Plant Operations staff or designee will collect data and evaluation will be reported quarterly to the QA Committee with discrepancies investigated and resolved | 07-20-13<br><br>06-07-13<br><br>07-20-13<br><br>07-20-13 |
| F 614 SS=D | 483.75(l)(1) RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE | F 614 | | |

7/3/13

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| F 514 | Continued From page 13<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to assure the MAR for 2 of 21 sample residents (#56, #64) was accurate. The findings were:<br><br>1. Review of the medical record showed resident #56 had diagnoses including diabetes mellitus. Review of the May 2013 physician's recapitulation of orders showed an order dated 3/27/13 for Levemir (insulin) 20 units subcutaneously twice daily for management of his/her diagnosis of diabetes. In addition, there was an order dated 12/5/12 for Novolog 2 units subcutaneous with each meal. The following concerns with medication management of this resident's diabetes were identified:<br>a. Review of the May 2013 MAR showed the Levemir insulin was not documented as being administered on 5/20/13 at 8 AM, on 5/22/13 at 5 PM, on 5/26/13 at 5 PM and on 5/28/13 at 5 PM.<br>b. Review of the May 2013 MAR showed the | F 514 | F 514<br>**Correction for cited resident(s):**<br>Resident #56: Staff involved in the delivery of medication administration counseled in correct documentation and use of the Medication Administration Record.<br><br>Resident #64: Staff involved in the delivery of medication administration counseled in correct documentation and use of the Medication Administration Record.<br><br>All residents and staff are potentially affected by the medication administration practices and documentation.<br><br>Systemic Corrective Action:<br>• Staff education on documentation and completeness of medical record to ensure medication administration process documentation is recorded according to policy.<br><br>• Conduct ISO audit of medication administration practices and document control – results to be evaluated by leadership team for improvement strategies. | 07-20-13<br><br>06-07-13<br><br>06-07-13<br><br>07-20-13<br><br>07-20-13 |

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| F 514 | Continued From page 14<br>Novolog insulin was not documented as being administered at the noon meal on 5/28/13 and at the evening meal on 5/15/13, 5/16/13, 5/22/13, 5/23/13, 5/26/13, and on 5/28/13.<br><br>2. Review of the medical record showed resident #64 had diagnoses including diabetes mellitus. Review of the May and June 2013 physician's recapitulation of orders showed an order dated 2/12/13 for Levemir insulin 14 units subcutaneously daily. The following concerns were identified with medication management:<br>a. Review of the May 2013 MAR showed no evidence the resident received the insulin on 5/8/13, 5/26/13, 5/26/13, 5/28/13 and 5/29/13.<br>b. Review of the June 2013 MAR showed no evidence the resident was administered the insulin on 6/4/13 as ordered.<br><br>3. Interview with neighborhood 4 nurse manager on 6/6/13 at 11 AM revealed she believed the omissions on the MAR were not actual omissions of the medication but were documentation errors. She further said there was no evidence of any negative outcome on those dates and times for either resident. | F 514 | F514 cont.<br>• Conduct medication pass audits and One-on-one education of medication documentation. 07-20-13<br>• Contract pharmacy services to address medication administration methodology and reduce risk issues. 07-20-13<br>• Educate staff in hand-off communication and reporting to assure effective medication administration. 07-20-13<br><br>All residents and staff are potentially affected by medication administration practices and documentation.<br><br>Outcome:<br>➢ 95% of medication administration episodes audited will be documented according to policy.<br>DON or designee will collect data and evaluation will be reported quarterly to the QA Committee with discrepancies investigated and resolved. | |