	933015	B. WING	02/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 152 SS=D	483.10(a)(3)&(4) EXERCISE OF RIGHTS In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to ensure 1 (#25) of 10 sample residents was allowed the right to make an informed decision. The findings were: Review of the 10/13/08 initial and the 1/7/09 quarterly Minimum Data Set (MDS) assessment for resident #25 revealed s/he was able to make his/her own decisions. According to the 12/25/08 nursing notes, timed at 9:10 AM, the resident complained of chest pain manifested by pressure and tightness. The resident was transported to the hospital for assessment. On 12/26/08 at 9:30 AM the resident was re-admitted to the nursing home with a physician's order for a cardiac evaluation. Review of the nursing note written on 12/26/08 at 6:40 PM revealed a late entry noting the durable power of attorney (DPOA) was contacted at 5:15 PM regarding the cardiac consult and the DPOA declined the evaluation on behalf of the resident. While review of the medical record revealed the resident had designated a	F 152	F152: This facility will ensure each resident is allowed the right to make an informed decision. 1. Social Service will visit with resident #25 to discuss her rights and the facilities responsibility to her rights, especially as it relates to allowing her to make her own informed decisions. 2. Activity department will review resident rights at resident council meeting to ensure all residents understand their rights. Special attention will be given to their right to make an informed decision. Social Service will visit with any competent resident not attending Resident Council meeting to ensure they understand their rights, especially as it relates to their right to make an informed decision. 3. All staff will be inserviced on Resident Rights by Social Service. Special attention will be paid to a resident's right to make their own informed decision when they are capable of doing so. 4. Monitored by Quality Improvement Committee through quarterly reporting by Social Service of documentation review and resident interview.	5/6/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3-12-09

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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Wyoming Dept of Health
MAR 13 2009
Office of Healthcare Licensing and Surveys

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F 152	Continued From page 1 family member as his/her DPOA for times when the resident was unable to make his/her own decisions, there was no evidence the resident was unable to make his or her own decisions at that time. Interview with the resident on 2/20/09 at 9:40 AM revealed s/he was interested in having a cardiac evaluation. Interview with registered nurse (RN) #1 on 2/20/09 at 10:12 AM revealed she should have documented in the medical record the resident was "tired" upon his/her return to the facility and did not desire to make a decision at that time.	F 152		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	F157: This facility will ensure the physician and family are notified of a change in condition. 1. All Licensed Nurse staff will review resident #34's medical record to ensure understanding of need to notify physician and family for symptoms related to resident #34's health from 12/21/08 - 12/30/08. Resident #34 and her family will be notified of the symptoms exhibited by resident #34 and our need to notify both family and physician. Family and resident will be informed of our efforts to ensure family and physician notification of illness. 2. DON's will review all resident records to identify any illness or injury which do not have documentation regarding family and physician notification. All LN's will review any record identifying resident illness or injury without documentation regarding physician and family notification to ensure understanding of the need for notification.	5/6/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	02/20/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

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F 157	Continued From page 2 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the physician and family were notified of a change in condition for 1 (#34) of 10 sample residents. The findings were: Review of the 12/21/08 nursing note timed at 11 PM revealed resident #34 had vomited three times during the evening. Review of the 12/22/08 nursing note timed at 1:30 PM revealed the resident again complained of nausea and vomiting. Review of the 12/23/08 nursing note timed at 1:20 PM revealed the resident reported nausea that morning. Review of the 12/26/08 nursing note timed at 6:30 PM revealed the resident complained of nausea most of the day. Review of the 12/27/08 nursing note timed at 4:30 PM revealed the resident was "clammy." Review of the 12/30/08 nursing note timed at 3:30 PM revealed the resident complained of nausea, vomiting, and diarrhea, and stated s/he felt "like hell." Although the resident reported nausea, vomiting, and/or diarrhea on six days within a 10 day period, there was no evidence the facility ever notified the physician or the family. Interview with RN #1 on 2/20/09 at 10:20 AM revealed she thought staff had notified the physician, but could not remember for sure. She further stated the physician should have been contacted for these symptoms and the notifications should have been	F 157	3. All licensed nursing staff will be inserviced by DON regarding the need to notify physician and family and document the notification. Licensed Nurses will be reminded that residents right to make their own informed decision should be first consideration and should be documented. 4. Monitored by Quality Improvement Committee through quarterly reporting of documentation by DON's.	

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F 157	Continued From page 3 documented in the medical record. Review of the physician's orders and progress notes revealed there was no evidence the physician was aware of the resident's complaints of nausea, vomiting, and/or diarrhea.	F 157		
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a self administration of medication evaluation was performed by the interdisciplinary team for 1 (#25) of 1 sample resident who had medications at the bedside. The findings were: Observation on 2/20/09 at 9:40 AM revealed resident #25 had TUMS and Glucose tablets at the bedside. Review of the October 2008 physician's orders revealed an order to self administer TUMS and Glucose tablets and to leave the medications at the resident's bedside. Interview of the resident by RN #1 on 2/20/09 at 10 AM confirmed the resident took TUMS as needed, but had not required the Glucose tablets. Review of the self- evaluation of medication administration form, dated 10/10/08, revealed a notation the resident wished to keep the TUMS and glucose tablets at the bedside to use as needed. However, review of the 10/10/08 form revealed the assessment criteria was marked out with an "X" and was not completed. Interview with RN #1 and licensed practical nurse (LPN) #1 on	F 176	F176: This facility will ensure a self-administration of medication evaluation is performed by the interdisciplinary team. 1. Resident #25 will have a complete self-administration of medication evaluation done by DON. 2. All residents will have self-administration of medication evaluation reviewed by DON's. Any resident identified to have incomplete nursing evaluation will have evaluation completed by DON's. 3. All Licensed Nurses and interdisciplinary staff will be inserviced by DON regarding need to have self-administration of medication evaluation completed prior to allowing meds at bedside for any resident. 4. Monitored by Quality Improvement Committee through quarterly reporting of documentation review by DON.	5/6/09

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F 176	Continued From page 4 2/20/09 at 9:55 AM confirmed the assessment criteria should have been completed and the resident evaluated for appropriateness of medication self-administration.	F 176		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT 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 accurately	F 278	F278: This facility will ensure assessments are accurately documented. 1. DON's will review resident #36 closed record. Review will include all bowel documentation, medication administration records, nurses notes, dietary notes and histories. DON's will use record to ensure understanding of accurate assessment reporting from documentation. 2. DON's will review all resident's bowel documentation records, medication administration reports, nurses notes, dietary notes and histories. This review will include review of MDS and Care Plan accuracy based on documentation. Any resident identified as not having accurate reporting of documentation to assessment will have immediate evaluation done and MDS and Care Plan will be updated to address issues accurately. 3. DON's will use closed record #36 and MDS guideline book as an inservice tool to identify accurate reporting of documentation. 4. Monitored by Quality Improvement Committee through quarterly reporting by Interdisciplinary Team of documentation and assessment review.	5/6/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	535013	B. WING _____	02/20/2009

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F 278	Continued From page 5 document assessments of bowel patterns and incontinence for 1 (#36) of 10 sample residents. The findings were: Review of the 2008 medication administration record (MAR) for resident #36 revealed the following: In October, the resident received laxatives nine different occasions; in November the resident received laxatives six times; and in December the resident received laxatives four times. Review of the 9/3/08 and 12/10/08 registered dietitian (RD) nutritional risk reviews for the resident revealed constipation was a problem. Interview on 2/20/09 at 9 AM with certified nurse aides (CNA) #1 and #2 revealed the resident began to decline during the first part of December, required more assistance with activities of daily living, became increasingly confused and had frequent episodes of bowel incontinence. Review of the 12/08/08 quarterly MDS documented that the resident did not have bowel incontinence or any problems with his/her bowel patterns. Interview on 2/20/09 at 10 AM with the director of nursing (DON) #1, however, revealed the 12/08/08 quarterly MDS assessment regarding bowel incontinence and bowel patterns was inaccurate for this resident and should have correctly identified constipation and incontinence as a problem.	F 278		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure professional	F 281	F281: This facility will ensure professional standards of quality are met. 1. A. Resident #2 will have blood pressure reading done and documented weekly by nursing staff. B. Resident #25 will have heart rate checked and documented daily for two weeks by nursing staff.	5/6/09

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F 281	Continued From page 6 standards were followed in regard to following physician's orders for 2 (#2, #25) of 10 sample residents. The findings were: 1. Review of the October 2008 physician's order recapitulation for resident #2 revealed s/he had diagnoses that included hypertension. Further review of physician's orders revealed an order for blood pressure readings every week. Review of the nursing notes and vital sign flow sheet for August 2008 through February 18, 2009 revealed blood pressures were not taken during the weeks of 9/14/08, 10/12/08,11/30/08, 12/14/08, and 1/11/09. Review of the resident's blood pressure readings that were taken revealed they fluctuated between 90 (systolic) over 40 (diastolic) and 199 over 26. Interview with RN #1 on 2/20/09 at 10:15 AM confirmed physician orders should be followed. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nurses must function under the direction of a licensed physician. 2. Review of the October 2008 physician's order recapitulation for resident #25 revealed s/he had diagnoses that included hypertension and coronary artery disease. According to the 12/25/08 nursing notes timed at 9:10 AM, the resident complained of chest pain, which s/he described as pressure and tightness. The resident was transported to the hospital for assessment and was re-admitted the following day (12/26/08) with a physician's order for a cardiac evaluation and an order for documenting blood pressure readings and heart rate daily for two weeks. Review of the vital sign flow sheet and nursing notes for December 26, 2008 through January 7, 2009 (14 days) revealed these vital	F 281	2. DON's will review all resident's physician orders and will review all nursing documentation to ensure all physician orders are being followed. Any order noted to not have appropriate documentation of orders will have immediate implementation or orders by nursing staff. 3. DON's will inservice nursing staff regarding the need to comply with all physician orders. 4. Monitored by Quality Improvement Committee through quarterly reporting by DON of documented compliance with physician orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530019	02/20/2009

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F 281	Continued From page 7 signs were not taken on 12/30/08, 12/31/08, and 1/1/09 as ordered. Interview with RN #1 on 2/20/09 at 10:15 AM confirmed physician orders should be followed. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nurses must function under the direction of a licensed physician.	F 281		
F 309 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on the medical record review, staff interview and review of the facility's policies and procedure, the facility failed to ensure 2 (#36, #34) of 10 residents received ongoing assessments and monitoring as needed for declining health conditions. The findings were: 1. Review of the 9/1/08 CNA assessment form for resident #36 revealed the resident had bowel incontinence and "tends to be constipated." Review of the 9/6/08 initial Minimum Data Set (MDS) assessment for the resident revealed s/he was usually continent of bowel and had bowel movements at least every three days. Review of the 2008 medication administration record (MAR) for the resident revealed the following: In October, the resident received laxatives nine times; in November the resident received laxatives six	F 309	F309: This facility will ensure each resident receives ongoing assessment and monitoring as needed for declining health conditions. 1. A. Resident #36 closed record will be reviewed by DON's to identify appropriate reporting of documented bowel condition to include appropriate MDS reporting and Care Plan interventions. B. Resident #34 will have nausea and vomiting (12/21/08 - 12/30/08) documentation review done by DON's. 2. All residents will have one year of documentation review done by DON's to identify inappropriate reporting, evaluation and care planning of any resident medical condition. All identified documentation will result in follow-up review of MDS accuracy and Care Plan implemention. 3. All Licensed Nursing staff will be inserviced by DON's regarding facility "Acute Charting Guidelines," and appropriate follow through for all acute care needs.	5/6/09

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F 309	Continued From page 8 times; and in December the resident received laxatives four times. Review of the 9/3/08 and 12/10/08 registered dietitian nutritional risk reviews for the resident revealed constipation was a problem. Interview on 2/20/09 at 9 AM with CNA #1 and CNA #2 revealed the resident began to decline during the first part of December, required more assistance with activities of daily living, became increasingly confused and had frequent episodes of bowel incontinence. Review of the facility's policy for monitoring acute medical conditions: "Acute Charting Guidelines," revealed charting was to be done every shift until the resident was stable and daily charting was to be continued until the condition resolved. Review of the 12/16/08 physician's visit note revealed the physician documented his awareness of the resident's poor nutritional intake and confusion. Review of the 1/01/09 and 1/4/09 physician's documentation revealed the resident was admitted to the hospital from the facility on 1/1/09 for treatment of a developing bowel obstruction. The resident was noted to have had diarrhea four to five days prior to admission to the hospital, with increasing abdominal distention. The following concerns were identified: a. Review of the 12/08/08 quarterly MDS documented the resident did not have episodes of bowel incontinence and had no problems with his/her bowel patterns. Review of the resident's are plan revealed no interventions for constipation or bowel incontinence had been established for this resident. b. Review of the December 2008 licensed nurse assessments and nurses' notes revealed no documentation of the resident's condition from 12/23/08 until 1/1/09 (eight days prior to admission to the hospital). Review of the resident's medical record revealed staff did not	F 309	4. Monitored by Quality Improvement Committee through quarterly reporting by Interdisciplinary Team of acute care documentation and follow through.	

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F 309	Continued From page 9 monitor the resident's bowel movements, abdominal distention, nausea and vomiting, and did not check the resident for a possible fecal impaction from 12/23/08 to 1/1/09. c. Interview on 2/20/09 at 10 AM with the director of nursing (DON) #1 revealed the 12/08/08 quarterly MDS assessment for bowel incontinence and bowel patterns was inaccurate and should have correctly identified constipation and incontinence as a problem for the resident. She said the care plan for the resident should have included interventions for bowel incontinence and constipation. She said the facility's system for monitoring bowel movements consisted of a monthly log and the monthly log was discarded at the end of every month which limited information regarding bowel patterns to the current month. She confirmed that the "Acute Charting Guidelines" was the current facility policy. She also said staff could more promptly identify and implement changes in nursing care interventions when ongoing assessments were performed according to the policy, but staff did not follow the policy. 2. Review of the 12/21/08 nurses note timed at 11 PM revealed resident #34 had vomited three times earlier in the evening. Review of the 12/22/08 nurses note timed at 1:30 PM revealed the resident again complained of nausea and vomiting. Review of the 12/23/08 nurses note timed at 1:20 PM revealed the resident reported nausea that morning. Review of the 12/26/08 nurses note timed at 6:30 PM revealed the resident complained of nausea most of the day. Review of the 12/27/08 nurses note timed at 4:30 PM revealed the resident was "clammy." Review of the 12/30/08 nurses notes timed at 3:30 PM revealed the resident complained of nausea,	F 309		

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F 309	Continued From page 10 vomiting, and diarrhea and stated s/he felt "like hell." The following concerns were identified: a. Review of the physician's orders revealed there was no order for an "as needed" medication for nausea, vomiting or diarrhea and the resident received no medications or treatment for his/her complaints. b. Although the resident reported nausea, vomiting, and/or diarrhea on six days within a ten day period, there was no evidence the facility notified the physician. Interview with RN #1 on 2/20/09 at 10:20 AM revealed she thought staff had notified the physician, but could not remember for sure. She further stated the physician should have been contacted for these symptoms so as needed orders could be obtained to address the resident's discomfort. Review of the physician's orders revealed no evidence the physician had been made aware of the resident's complaints of nausea, vomiting, and/or diarrhea.	F 309		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment for residents in three locations in the facility. The findings were:	F 323	F323: This facility will ensure a safe environment for residents. 1. A. Entry door to facility's main bathing room will be secured and wall cabinet containing sharps will have lock secured by maintenance. B. Electric range in small preparation kitchen will have knobs removed from front of stove by maintenance. C. 4" piece of copper plating projected from behind electric wall unit in laundry alcove will be removed by maintenance.	5/6/09

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F 323	Continued From page 11 Observations on 2/17/09 at 5:10 PM, on 2/18/09 at 11:48 AM and then again on 2/19/09 at 1:48 PM revealed the following concerns: 1. The entry door to the facility's main bathing room and doors to the wall cabinet located in the bathing room were unlocked. The doors to the wall cabinet had a padlock attached to the doors, but on the above stated times, the cabinet doors were unlocked. Inside the cabinet were several sharp scissors and approximately eleven hand razors. 2. The electric range in the small preparation kitchen did not have a secure master switch on the wall to control electric current to the range. This kitchen was accessible from both the main hallway and the dining room. The range had four electric elements. All four elements could be turned on by their respective control knobs. 3. A 1/4 inch by 4 inch piece of copper plating projected from behind an electric wall outlet in the laundry alcove off the main hallway. An electronic scale was plugged into the outlet. Interview with the facility maintenance manager during a tour of the facility on 2/19/09 between 11:30 AM and 2:30 PM confirmed the above findings.	F 323	2. A. Safety Officer will check that all hazardous area rooms and cupboards are secured. Any door or cupboard identified as not secure will be immediately secured by Safety Officer. B. All facility electrical appliances will be check by Safety Officer for resident access and safety. Any appliance identified as unsafe or not secure will immediately be secured by Safety Officer. C. All facility electrical outlets will be observed by Safety Officer to ensure no inappropriate placement of objects. Any inappropriate item will be immediately removed by Safety Officer. 3. All nursing and maintenance staff will be inserviced by Safety Officer regarding facility safety hazards and the need to secure all hazardous areas. Electrical master switch placement will be reviewed for fire safety requirements and cost by Safety Officer for appropriate consideration. 4. Monitored by Quality Improvement Committee through quarterly reporting of safety hazards by Safety Officer.	
F 329 SS=D	483.25(l) 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.	F 329	F329: This facility will ensure residents do not receive unnecessary medications. 1. A. Resident #32 will have sleep assessment initiated and summarized by DON. Assessment will include nonpharmacological interventions tried and results of each. Resident #32 will have hypnotic use determined by evaluation of completed assessment and evaluation by physician.	5/6/09

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F 329	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to for 2 (#32, #34) of 10 sample residents and 1 (#30) non sample resident did not receive unnecessary medications. The findings were: 1. Review of the October 2008 recapitulation of physician orders for resident #32 revealed a 12/19/08 order for Ambien (hypnotic) at bedtime for sleep as needed. Review of the 1/6/09 physician's order revealed the Ambien had never been changed from as needed to every evening at bedtime. Review of the medical record revealed no evidence there had been a formal assessment of the causes and contributing factors for this resident's insomnia. A sleep log was partially completed (one entire shift was not assessed), but there was no assessment of the data. In addition, there was no evidence that any non-pharmacological interventions had been	F 329	B. Resident #34 will have physician and pharmacist review of anti-depressant and consideration for reduction or holiday. C. Resident #30 will have sleep assessment initiated and summarized by DON. Assessment will include causes and contributing factors as well as nonpharmacological interventions. Resident #30 will have hypnotic use determined by evaluation of completed assessment and evaluation by physician. 2. A. All residents will have hypnotic use review done by DON's. Any resident identified as using a hypnotic will have documentation reviewed for appropriate sleep assessment which includes nonpharmacological interventions. Any resident identified to not have complete sleep assessment, including nonpharmacological interventions, will have sleep assessment initiated and summarized by DON. Each resident's hypnotic need will be determined by evaluation of completed sleep assessment and evaluation by physician. B. All residents will have review of psychoactive medications done by Interdisciplinary Team. Any resident identified as having adverse reactions, excessive duration, excessive dose, or without adequate indication for use will have psychotropic evaluation by and presented to physician for holiday or dose reduction consideration by physician.	

	535018	5. WING	(X3) DATE SURVEY COMPLETED 02/20/2009

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F 329	Continued From page 13 attempted. Interview with RN #1 on 2/20/09 at 10:30 AM confirmed the sleep log was incomplete and there had been no assessment of the data collected. 2. Review of the October 2008 recapitulation of physician orders for resident #34 revealed an order dated 3/25/05 for Effexor XR (antidepressant) to be administered daily. Review of the quarterly psychoactive medication reviews revealed there had been no attempted gradual dose reductions in December 2007 or in all of 2008. Record review also revealed that on 9/3/08 a request for a gradual dose reduction was made by the interdisciplinary treatment team. However, the physician made the decision not to reduce the dosage, although he did not provide any rationale. In addition to the length of time the resident had received the medication (at least 13 months), nursing staff informed the physician by a facsimile that the resident was experiencing the following side effects of the medication: constipation, anorexia, weight loss, headache, dizziness, and nausea. The interdisciplinary team requested a trial of a different antidepressant based on the resident's experiencing so many of the side effects. Interview with RN #1 on 2/20/09 at 10:30 AM, revealed she was unsure why the physician continued the same antidepressant at the same dose. 3. Review of the October 2008 recapitulation of physician's orders for resident #30 revealed a 10/21/08 order for Ambien (hypnotic) at bedtime for sleep "as needed." Further review revealed the order for Ambien was changed on 2/5/08 from "as needed" to every night. Review of the medical record revealed no evidence an assessment of the causes and contributing factors for the resident's insomnia was	F 329	C. All resident will have hypnotic use review done by DON's. Any resident identified as using a hypnotic will have documentation reviewed for appropriate sleep assessment which includes causes and contributing factors and nonpharmacological interventions tried. Any resident identified to not have a complete sleep assessment including causes and contributing factors and nonpharmacological interventions, will have sleep assessment initiated and summarized by DON. Each resident's hypnotic need will be determined by evaluation of completed sleep assessment and evaluation by physician. 3. DON's will inservice licensed nursing staff regarding the need to do complete sleep log and follow trial of nonpharmacological sleep interventions. Medical Director will inservice DON's about possible causes and contributing factors of insomnia and will inservice MD's about need to consider psychoactive medication holidays and reductions, and the need to provide rationale for declining psychoactive medication changes. 4. Monitored by Quality Improvement Committee through quarterly review of psychoactive medication review by Interdisciplinary Team.	

535018	B. WING	02/20/2009

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F 329	Continued From page 14 performed. Interview on 2/20/09 at 10 AM with DON #1 confirmed the lack of a sleep assessment.	F 329		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff did not administer a medication to which one sample resident was allergic. The findings were: Review of the admission records and the medication administration records (MARs) for resident #2 revealed s/he was allergic to Macrobid (antibiotic). Review of the 8/19/08 un-timed nursing notes revealed the resident had a urinary tract infection (UTI). Review of a faxed order signed by the physician on 8/20/08 revealed an order for Macrobid to treat the UTI. Review of the 8/23/08 timed at 4 AM nursing notes revealed the resident was started on Macrobid for the UTI on 8/22/08. Review of the August 2008 MAR revealed the Macrobid was administered to the resident twice on 8/22/08. Review of the 8/23/08 timed at 1:30 PM nursing notes revealed the resident was not eating and was pale in color. Continued review of the nursing note revealed the nurse noticed the resident was allergic to Macrobid. The physician was notified and then discontinued the Macrobid. The physician ordered a different antibiotic to treat the UTI. Interview with RN #1 on 2/20/09 at 10:22 AM confirmed the nurse who administered the Macrobid on the first day should have checked the MAR because any	F 333	F333: This facility will ensure residents are free of medication errors. 1. Resident #2 will have new and prominent display of "Allergies" placed on resident chart and Medication Administration Record. 2. All resident's Medication Administration Records and physician orders and list of allergies will be reviewed by DON/designee and allergies identified. All residents charts will have new, clearly marked, ALLERGY stickers placed and all Medication Administration Records will have allergies highlighted and clearly identified. 3. DON's will inservice nursing staff regarding need to carefully review resident chart for allergies prior to initiating any medication. 4. Monitored by Quality Improvement Committee through quarterly reporting by DON of allergy documentation review.	5/6/09

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F 333	Continued From page 15 allergies (including this particular residents's allergy to Macrobid) would be noted there.	F 333		
F 385 SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure supervision and care by a physician was provided for 1 (#2) of 10 sample residents. The findings were: Review of the 8/26/08 notification faxed to the physician of resident #2 revealed the resident had an old bruise that was very hard underneath and was fixed, not mobile. A request was made for the physician to "check it." Review of the entire medial record including physician's progress notes and orders revealed no evidence the physician evaluated the nodule. Interview with RN #1 on 2/20/09 at 10:40 AM revealed she was unsure whether or not the physician had ever assessed the nodule. She further stated since there was nothing written in the physician's progress notes and no specific treatment ordered, she "assumed" the physician had not performed an assessment as requested by nursing staff.	F 385	F385: This facility will ensure each resident receives supervision and care by a physician. 1. Resident #2 will have evaluation of old bruise area examined by physician to ensure condition has resolved. Resident #2 will have documentation review by DON to evaluate communication of resident condition and follow-through. 2. All residents will have review of nurses notes to identify any resident condition requiring follow-up by physician. Physician will be notified of any condition and appropriate follow-up will be done at the direction of Medical Director. 3. Medical Director will inservice DON's, licensed nurses, and physicians about the need to identify, follow through and examine any resident condition. Process will be set-up by administrator to ensure resident is included in physician daily patient scheduling. 4. Monitored by Quality Improvement Committee through quarterly reporting of documented resident conditions by DON's.	5/6/09
F 387	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN	F 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	533018	B. WING	02/20/2009

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F 387 SS=D	Continued From page 16 VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to assure 2 (#25, #15) of 10 sample residents were seen by a physician at least once every thirty days for the first ninety days after admission. The findings were: 1. Review of the admission face sheet for resident #15 revealed s/he was admitted to the facility on 7/17/08. Review of the physician progress notes revealed the resident was not seen by the physician from 8/12/08 to 10/23/08 (72 days). Interview with DON #1 on 2/20/09 at 10:45 AM confirmed there was no evidence the resident was seen by a physician between 8/12/08 and 10/23/08. 2. Review of the admission face sheet for resident #25 revealed s/he was admitted to the facility on 10/1/08. Review of the physician's progress notes revealed the resident was not seen by a physician from 10/23/08 until 12/9/08 (47 days). The physician did not see the resident once every thirty days as required for the first 90 days after admission. Interview with RN #1 on 2/20/09 at 10:02 AM confirmed there was no	F 387	F387: This facility will ensure a resident is seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. 1. A. Physician will review resident #15 record to recognize missed visit. B. Physician will review resident #25 record to recognize missed visit. 2. All resident records will be reviewed by Interdisciplinary Team for identification of timely physician visits. Any resident identified to not have timely physician visits will be reported to physician for record review. 3. Medical Director will inservice physicians regarding requirement to evaluate new admission residents a minimum of every 30 days for 90 days then every 60 days. Visits will be coordinated between DON and physician office to ensure resident inclusion into physician daily patient schedule. 4. Monitored by Quality Improvement Team through quarterly reporting of admission date and physician visits by Medical Records.	5/6/09

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
535019	B. WING _____	02/20/2009

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F 387	Continued From page 17 evidence the resident had been seen by a physician between 10/23/08 and 12/9/08.	F 387		