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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING Office of Healthcare Licensing and Surveys B. WING	C 12/3/09 10/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

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F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure residents enjoyed a dignified dining experience. During 2 of 3 meals, 2 non-sample residents (#14, #15) had to wait an extended period of time to be served their meals. The findings were: 1. Observation during the lunch meal on 10/20/09 revealed resident #15 entered the dining room at 11:10 AM. The resident's meal order was taken at that time by staff, and the resident was then seated at a table. The resident's meal was delivered a half hour later at 11:40 AM. During this observation several other residents entered the dining room; their orders were taken, and they were seated. Three of these residents were served their meals before resident #15. During an interview on 10/23/09 at 10:30 AM, resident #15 stated, "I don't particularly like it, but I've learned I have to wait my turn." 2. Observation during the evening meal on 10/21/09 revealed resident #14 entered the dining room in a wheelchair at 4:40 PM. The resident's order was taken and then the resident was seated at a table. Over the course of the next 35 minutes, observation revealed the resident's meal was not served. The resident became restless and wheeled him/her self away from the table on four separate occasions in the attempt to leave	F 241	**Poplar 2009 Plan of Correction** Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. **F241** **Corrective Action: Resident #14 & #15 were assisted immediately upon learning of the situation** **Identification of Others: Dining Management program instituted and no other residents affected** **Systems/Measures:** 1. **CQI team instituted to develop and evaluate plan for prompt meal delivery** 2. **Dining room managers to observe and insure that residents do not wait for service** 3. **Rotating card systems in place to assure first come first serve service**	12/6/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis Toffaro | TITLE: Administrator | (X8) DATE: 11/13/09

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.

This POC accepted on 12/3/09 @ 1600 & additions & corrections specified per phone conversation w Dennis Toffaro, Adm, and Betty Nelson RN, State Health Surveyor

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F 241	Continued From page 1 the dining room. In each case, staff went after the resident and returned the resident to the table. When the meal was finally served, the resident remained at the table and ate. 3. Interview with the kitchen manager on 10/22/09 at 3 PM revealed there were several bottlenecks in the food delivery system that resulted in residents having to wait for their meals. Refer to F362 for details.	F 241	**Monitoring:** **Data obtained by way of audits/observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.**	
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, the facility failed to maintain a clean and safe environment in 1 of 6 resident bathing facilities. The findings were: Observation on 10/21/09 at 3:18 PM revealed the following concerns regarding the resident bathing room in hallway 6: a. The water discharge drain in the bathtub was covered in hair. b. One of the plastic non-slip attachments in the bathtub had partially come way from the tub floor, posing a potential slip hazard. c. The plastic cover on the ceiling light contained approximately 4 dead miller moths and approximately 10 dead flies. The ceiling light fixture was in full view of the bathtub and toilet. Interview with the director of nursing (DON) at the time of the observation confirmed the room needed to be cleaned, and the non slip	F 253	**Corrective Date:** **12/6/09** **F253** **Corrective Action:** **1. Bathtub/drain were cleaned on 10/21.** **2. Bathtub non-skid strips were replaced on 10/21.** **3. Ceiling light was cleaned on 10/21.** **Identification of Others:** **All showers were observed. No other issues identified.** **Systems/Measures:** **Maintenance to complete preventative maintenance program as written.** **Housekeeping to complete daily rounds of showers for cleanliness.** **Ambassador rounds done daily by IDT to observe any environmental concerns/hazards.** **Monitoring:** **Data obtained by way of rounds/preventative maintenance will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and**	

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F 253	Continued From page 2 attachment should be removed.	F 253	implement additional interventions as needed to ensure continued compliance monthly X3.	
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide	F 272	Corrective Date: 12/6/09 F272 Corrective Action: 1. Resident #12has been reviewed ~~for need for new comprehensive assessment completion by conducting a significant change of condition audit. Any significant change identified will be scheduled for a Significant Change Assessment (comprehensive) with thorough RAP completion.~~ and all identified areas will be assessed through the RAP process 2. Resident #5 has had a comprehensive assessment completed for bowel, mood, behavior, and bladder on or before 12/6. 2. Resident #7 has had a comprehensive assessment completed for ADLs on or before 12/6. 3. Resident #17 has had a comprehensive assessment completed for psychotropics on or before 12/6. 4. Resident #20 has had a comprehensive assessment completed for psychotropics on or before 12/6. 5. Resident # 6 has had a comprehensive assessment completed for psychotropics and bowel management on or before 12/6. 6. Resident #10 has had a comprehensive assessment completed for behaviors and bowel management on or before 12/6. 7. Resident #3 has had a comprehensive assessment completed for ~~psychotropics completed~~ bowel incontinence on or before 12/6. 8. Resident #11 has had a comprehensive assessment completed for bowel and bladder on or before 12/6. 9. Resident #1 has had a comprehensive assessment completed for bowel management on or before 12/6.	12/6/09

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F 272	Continued From page 3 comprehensive assessments in various areas for 11 of 18 sample residents (#1, #3, #5, #6, #7, #10, #11, #12, #17, #19, #20). The findings were: According to the revised Long-Term Care Facility RAI User's Manual Version 2.0, page 4-11, "... the resident assessment protocol (RAP) documentation requires information from the resident's assessment and staff's decision-making about care... Decision-making is a written account of the team's clinical thought processes about the resident assessment findings." Page 4-10 of the RAI Manual list key issues the documentation should focus on. They include: Why will you address or not address specific conditions in the care plan? What is it about the condition that may affect the resident's daily functioning? Why did you decide the resident is at risk, or that improvement is possible, or that decline can be minimized? How could the resident benefit from consultation with an expert in a particular area? Or for triggered conditions that do not warrant care planning: Why did you determine that the triggered condition is not a problem for the resident? The following concerns with lack of comprehensive assessments were identified: a. Review of the 1/8/09 annual Minimum Data Set (MDS) assessment showed resident #12 required comprehensive assessments related to cognitive loss, mood state, behavioral symptoms, activities of daily living (ADLs), urinary incontinence, bowel incontinence, and psychotropic drug use. Furthermore, according to the 8/28/09 quarterly MDS assessment, the	F 272	10. Resident #18 has had a comprehensive assessment completed for psychotropics on or before 12/6. Identification of Others: Resident care management Director will complete monthly audit annual, admission, and significant changes to ensure completeness of assessments and RAPS per ~~RAI chapter 4 specifically pages 4-10 and 4-11 for the RAI. (I would delete this part) and just state any assessment without clearly documenting the care planning decisions, identifying causes, contributing condition, risk factors and actual or potential impact on residents health will be re-written prior to transmission~~ Any discrepancy will corrected and re-education completed for nursing as needed. Systems/Measures: 1. Regional Clinical Director/Designee will complete an in-service for MDS nurses and management nurses on proper way to complete a comprehensive assessment for all residents with RAP process utilizing examples and chapter 4 of the RAI manual RAI systems on or before 12/6. 2. DON/designee will complete random audits monthly on reviewing assessment for completeness. Monitoring: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly X3. Corrective Date: 12/6/09	12/6/09

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F 272	Continued From page 4 resident had an indwelling urinary catheter. Review of Section V for the annual MDS assessment showed the location of all information except bowel incontinence was in the Resident Assessment Protocol (RAP) summaries. Additional information was listed as located in the social service (SS) assessments, the caretracker records, and the medication administration records (MARs). Review of the RAPs attached to Section V showed a collection of data with yes/no answers for each required area. Additionally, even though several questions were pertinent, they were answered "N/A" (non applicable). Review of the summaries for each section showed a repeat of the information provided by the MDS assessments. Review of the SS documentation, MARs, and caretracker records revealed that information failed to provide comprehensive assessments. A clear and complete evaluation of causes, contributing conditions, risk factors, and the impact on the resident's health were lacking. Finally, the bowel assessment provided by the facility was incomplete; the information was not analyzed and there was no evidence that the cause of the resident's bowel incontinence was determined. Observation on 10/19/09 at 3:35 PM showed the resident had an indwelling urinary catheter. Interview with registered nurse (RN) #4 on 10/23/09 at 8:10 AM revealed the resident returned to the facility with a catheter in August 2009. However, a comprehensive assessment identifying the rationale for the catheter could not be located. At 8:30 AM on 10/23/09 the DON confirmed an assessment for the catheter had not been done. b. According to the 8/14/09 significant change MDS assessment, resident #5 triggered for comprehensive assessments in the areas of	F 272		

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F 272	Continued From page 5	F 272		

mood state, behavioral symptoms, and bladder incontinence. This information was listed in Section V as located in the RAP summaries, SS notes, and caretracker record. Review of the indicated information showed a collection of data with yes/no or "N/A" answers for each required area. The summaries repeated the information already documented in the MDS assessments; a critical analysis of the data was lacking. The 8/14/09 assessment also documented the resident required a comprehensive assessment for bowel incontinence. Review of that assessment showed it was incomplete. An evaluation of causative factors, contributing conditions, risk factors, and the impact on the resident's health, were lacking.

c. Review of the 5/19/09 annual MDS assessment showed resident #7 required a comprehensive assessment of ADL status. This information was listed in Section V of that MDS as located in the attached RAP. Review of the information revealed a comprehensive assessment was not completed as the assessment consisted of a collection of data with yes/no or "N/A" answers, and the summary reiterated the information already present in the MDS assessment.

d. Information reviewed in the 12/23/08 annual MDS assessment indicated resident #17 required a comprehensive assessment for psychotropic drug use. Review of the attached RAP information (identified by the facility as the comprehensive assessment) revealed the information in the MDS assessment was repeated. A critical analysis identifying the causes, contributing conditions, risk factors, and the actual or potential the impact on the resident's health. were lacking.

e. The annual assessment completed on

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F 272	Continued From page 6 1/26/09 documented that resident #20 required a comprehensive assessment for psychotropic drug use. The comprehensive assessment information was identified as being located in the attached RAP. However, review of this information showed the assessment was not comprehensive as it failed to identify the causes, contributing conditions, strengths and risk factors and the impact of the psychotropic medications on the resident's health. f. Review of the significant change MDS assessment dated 3/13/09 showed resident #6 triggered for comprehensive assessments in the areas of psychotropic medications and bowel incontinence. Review of the information provided for those assessments showed they failed to determine the cause and contributing factors, the impact on the resident's health, and the thought processes of the team. g. Review of the 8/3/09 annual MDS assessment for resident #10 showed comprehensive assessments were required for behavioral symptoms and bowel incontinence. Review of the information provided by the facility showed the RAP for behaviors was a series of questions with yes/no answers. The RAP simply repeated the information in the MDS. A comprehensive assessment identifying causative and contributing factors and the impact on the resident's health, was not completed. In addition, a review of the "Bowel Retraining Review" revealed it was incomplete. h. According to the 9/15/09 significant change MDS assessment, resident #3 was totally incontinent of bowel and required a comprehensive assessment of his/her bowel status. Review of the "Bowel Retraining Review" revealed it was incomplete. i. Review of the 5/11/09 annual MDS	F 272		

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F 272	Continued From page 7 assessment for resident #11 showed comprehensive assessments were required for bowel and bladder incontinence. Review of the RAP assessment for urinary incontinence revealed it was not comprehensive, and both the "Bladder Incontinence Evaluation" and "Bowel Retraining Review" were noted to be incomplete. j. According to the 4/6/09 admission MDS assessment, resident #1 required a comprehensive assessment for bowel incontinence. Review of the "Bowel Retraining Review" revealed it was incomplete. k. According to the 8/21/09 significant change MDS assessment, resident #18 triggered for a comprehensive assessment for psychotropic drug use. That information was identified as located in the RAP attached to Section V. Review of the information revealed it was not comprehensive. During an interview on 10/23/09 at 10:45 AM, the DON confirmed the lack of comprehensive assessments in the aforementioned cases.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		

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F 280	Continued From page 8 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to update the care plans for 2 of 18 sample residents (#3, #12) to reflect their current conditions. The findings were: 1. On 10/19/09 at 4 PM RN #7 stated resident #12 was on bedrest. The RN also stated the current care plan was in the resident's medical record. Observation from 10/19/09 through 10/23/09 showed the resident remained in bed. Review of the physician's orders showed the resident was placed on comfort care on 10/9/09, and most medications and treatments were discontinued. Review of the care plan in the medical record revealed comfort care was added on 10/12/09, but the plans for activities of daily living (ADLs), wandering, psychotropic medications, fluctuating blood glucose levels, potential for bleeding related to medications, hydration, activities, elopement and potential for injuries were not revised to reflect the change in the resident's status. 2. Medical record review showed resident #3 fell on 8/29/09 and was identified with a fractured femur on 9/9/09. The resident was on bedrest from 9/9/09 until 9/16/09. Review of the care plan showed it had not been revised to reflect the resident's changed status in the areas of	F 280	**F280** **Corrective Action:** **Resident #3 care plans were updated to reflect current status of resident on 11/11.** **Resident #12 care plans were updated to reflect current status of resident on 11/11.** **Identification of Others:** All resident care plans will be reviewed by 12/6/09 ~~**Resident requiring significant changes to change in status will be reviewed.**~~ **Any care plans not correct will be corrected at that time.** **Systems/Measures:** **RCMC/Designee to complete re-education for MDS nurses on updating care plans as changes occur on 12/6/09.** **DON/designee to review residents ~~with change of condition~~ to ensure care plans reflect current status of resident.** **Monitoring:** **Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	

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F 280	Continued From page 9 hydration, elopement, pressure ulcers, potential for injury, and ADLs. On 10/19/09 at 4 PM RN #7 confirmed the current care plans were in the medical record.	F 280	**F281** **Corrective Action:** **Nurses #5 & #6were re-educated on proper way to dispense medications per physician orders by SDC/designee on 11/6.** **Nurse #3 was re-educated on storing medications appropriately in a locked medication cart.** **Identification of Others:** **Medication carts were observed by DON/designee for any medications left on cart on 11/9,** **SDC to review medication pass on 4 nurses by 12/6.** **Audit of physician orders will be completed by 12/6/09 for complete orders including dosage by licensed nurses.** **Systems/Measures:** **Licensed nurses will be re-educated on dispensing medication orders as written, if there is a discrepancy in the order, the nurse will contact the physician for clarification.** **Telephone orders and new admission orders will be reviewed during morning IDT meeting to ensure dosage is written for all medications.** **The SDC will observe licensed nurse medication passes Weekly x4, then monthly X3 for dispensing medication as ordered.** **DON/Designee will complete random weekly audits of medication, ~~audits~~ charts to ensure medications are locked appropriately** **Monitoring:** **The DON or designee will track and trend the licensed nurse medication pass observations/audits of medications left on cart/medication orders and report**	
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 observation, medical record review, and staff interview, the facility failed to ensure staff adhered to professional standards of practice related to medication administration for 2 of 10 residents (#24, #25) and medication storage on 1 of 3 medication carts. The findings were: 1. According to the 2004 Sixth Edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, "If a written order is illegible or questionable for any reason, the physician must be notified for clarification." Failure to follow this standard of practice was identified as follows: a. Observation on 10/19/09 at 4:18 PM showed registered nurse (RN) #5 prepared and administered glucosamine and chondroitin 500 milligrams (mg) to resident #24. Reconciliation of the medication pass with the physician's orders revealed only glucosamine 500 mg was ordered. This order was originally written on 12/30/08 and had not been clarified or revised. On 10/22/09 at 4:32 PM, the DON stated the order should have been clarified. b. Observation on 10/22/09 at 10:45 AM showed RN #6 prepared and administered calcium carbonate 600 mg to resident #25. Reconciliation of the medications showed the	F 281		

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F 281	Continued From page 10 physician ordered calcium carbonate 650 mg on 9/22/09. Review of the October 2009 medication administration record (MAR) showed the medication was entered as ordered, but 650 mg had been crossed out and 600 mg written above it. Review of the MAR with RN #3 confirmed the dosage had been altered. Review of the facility's reference book, "Nursing 2008 Drug Handbook" revealed the medication did come in a 650 mg dosage. On 10/22/09 at 1:10 PM the DON confirmed the order was not clarified with the physician, and the MAR should not have been altered. 2. Observation on 10/22/09 at 10 AM showed 4 packages containing individual doses of inhaled medications and a bottle of Alphagan ophthalmic drops were left on the top of the medication cart used in halls 1 and 2. RN #3 was in a resident's room and during that time did not have the medication in sight. This practice left the medication open to theft. When questioned after the observation, the RN stated she was unaware the medications should be secured. According to the 4th Edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, medications should be removed from a drawer of a secured medication cart.	F 281	**findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.** **Corrective Date:** **12/6/09**	12/6/09
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282	**F282** **Corrective Action:** **CNAs on secured unit were re-educated on need to toilet residents before and after meals and as needed by SDC/designee on 11/6.** **Identification of Others:** **Rounds will be made by Ambassadors for odors and incontinence. Any findings will be corrected and 1:1 education will be completed by SDC/designee with staff at that time.** **Systems/Measures:** **1. Nursing staff will be in-serviced by SDC on toileting residents before and after meals, with ADL care, etc. on 12/6** **2. Ambassadors will make rounds/observations daily to monitor for toileting, odors, concerns, etc.** **3. Charge nurses will supervise C.N.A.s to ensure residents are being toileted as needed.** **4. Toileting needs will be placed on Cardex and updated upon admit, quarterly, annually, and with significant change.**	12/6/09

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F 282	Continued From page 11 Based on observation, medical record review, and staff interview, the facility failed to ensure staff followed the care plan for 2 of 18 sample residents (#5, #10). The findings were: 1. Observation on 10/20/09 at 7:58 AM showed resident #3 returned to the dining area after receiving a shower. The resident remained in that area until 12:55 PM, an elapsed time of 4 hours and 57 minutes. Although the resident's disposable brief was changed at that time, certified nursing assistant (CNA) #1 stated the resident would also have been changed during the morning, but required 2 staff for transfers. She further stated someone currently working would have assisted the other CNA who left ill. By 1:52 PM, all staff who were in the secured unit that day denied having provided assistance with transfers or perineal care for this resident. Review of the resident's incontinence care plan, last updated on 10/10/09, showed the resident was to be checked and changed before and after meals, at bedtime, and as needed. 2. Observation on 10/20/09 at 7:31 AM showed resident #10 was in the dining room eating breakfast. The resident remained in the dining room until 11:10 AM, when s/he ambulated independently to his/her room and lay down on the bed. Observations ceased at 11:45 AM, but at no time during this 4 hour and 14 minute period was the resident reminded to use the toilet or taken to the bathroom. By 1:52 PM that day, all staff who were in the secure unit that morning denied having assisted or reminded the resident regarding toileting. According to the resident's incontinence care plan, last updated on 10/7/09, the resident required "prompted voiding" before and after meals, at bedtime, and as needed.	F 282	**Monitoring:** **Data obtained by way of audits and observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	12/6/09

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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 observation, medical record review, and resident, family, and staff interview, the facility failed to monitor, assess, and consistently implement preventive treatment and care to control pain for 1 of 4 sample residents (#12) identified by the facility as having pain. The findings were: Review of the 10/12/09 care plan for comfort care showed staff were to "monitor" resident #12 for "complaints of pain or discomfort and do interventions as ordered." Review of the resident's specific care plan for pain showed "medicate...for pain prior to treatments and therapy, if indicated." Observation on 10/20/09 at 8:05 AM showed the resident was in bed prior to morning care being completed. When questioned by the CNA's prior to care being initiated, the resident denied pain. At 8:15 AM the wound team entered the room to provide treatment for the pressure ulcer on the resident's sacral area. Each time the resident was turned or moved during the procedure, s/he complained of pain, particularly in the legs, stating "My legs have hurt since I came here." The resident yelled and cursed about pain throughout the procedure. When questioned immediately after the procedure, RN #10 stated	F 309	**F309** **Corrective Action:** **Resident #12 received new orders for routine pain medications on 10/20.** **Identification of Others:** **Residents were assessed for pain control. Any resident that pain is not controlled will be reported to MD for further orders.** **Systems/Measures:** **1. Upon admission, residents will be assessed for pain by using the nursing admission/assessment form.** **2. Residents will be assessed for pain by using the quarterly pain assessment quarterly, annually and with any significant change.** **3. Additionally, any resident report of inadequate pain control or identified with a new onset of pain, displays new signs or symptoms of pain, or identified through the RAI process or otherwise will have a full evaluation of the pain conducted using the quarterly pain assessment form.** **4. Following the pain evaluation notify the physician of the findings and document on the change of condition-nurse to physician communication form. Implement new orders as received.** **5. Each resident identified for pain will have a management care plan. The care plan will have individualized interventions related to that resident's individual control of pain management. The care plan should include both pharmacological and no-pharmacological pain management interventions.**	12/6/09

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F 309	Continued From page 13 the resident was on routine pain medications given every three hours and was, therefore, not premedicated prior to the dressing change. At 8:40 AM RN #10 reported the resident's medications were changed the previous week and the routine pain medication had been discontinued. The RN stated the resident now received pain medication as needed (prn) every 4 hours, and it had been administered at 4 AM that morning. The following concerns related to lack of consistent, effective pain management were identified: a. Review of the physician's orders confirmed the resident no longer received routine pain medications but s/he did have an order for morphine 4 mg every 2 to 4 hours as needed for pain. b. Staff failed to determine if the resident was medicated prior to the dressing change. c. During the procedure, no one suggested immediately medicating the resident and delaying the dressing change until s/he was comfortable d. Review of the narcotic record showed the resident's last dose of morphine prior to the dressing change on 10/20/09 was that morning at 5 AM. Review of the facility's reference book, "Nursing 2008 Drug Handbook" showed the duration of morphine is 3 to 7 hours. e. On 10/20/09 at 1:10 PM a family member stated the resident frequently complained of leg/knee pain, especially with movement. f. During an interview on 10/22/09 at 5:40 PM, RN #4 stated the resident was "much better" since routine use of a narcotic was re-started after the dressing change on 10/20/09.	F 309	**6. The licensed nurse will implement a pain management flow sheet in the MAR for documentation of pain, interventions and outcomes. Guidelines for the pain management flow sheet are explained below.** **7. The licensed nurse will communicate any new onset of resident pain or change in resident pain through the 24-hour report process.** **8. The IDT will discuss the new onset of pain at the daily stand-up meeting and the IDT team conference.** **9. The pain management care plan with interventions will be updated as indicated and discussed at the IDT stand up meetings, as needed.** **10. The staff will implement the care plan, monitor the resident and administer therapeutic interventions for pain, if ordered.** **11. The licensed nurse/medication aide, when administering pain medications, will record the drug administration on the MAR and the pain management flow sheet.** **12. The pain management flow sheet guidelines are:** • **Record the pain scale using the Wong-Baker Faces Rating Scale with and without movement.** • **Record the location of the pain** • **Record the pharmacological interventions attempted.** • **Record the non-pharmacological interventions attempted.** • **Record the follow-up observations one-hour post intervention. If resident is asleep or resting, document it as an observation.**	12/6/09
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		

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F 315	Continued From page 14 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff provided necessary care and services to maintain dryness for 1 of 10 sample residents (#3) identified with incontinence. The findings were: According to the 10/10/09 incontinence care plan, resident #3 was to be checked and changed before and after meals, at bedtime, and as needed. Observation on 10/20/09 at 7:58 AM showed the resident was brought into the dining area for breakfast. The resident remained in that area until 12:55 PM: 4 hours and 57 minutes. When the resident's disposable brief was removed at 12:55 PM, observation showed the resident had been incontinent of urine and his/her buttocks were bright pink. During the observation, CNA #1 stated the resident should have been checked and changed earlier that morning. Refer to F282 for details related to failure to follow this resident's incontinence care plan.	F 315	**Monitoring:** **Data obtained by way of audits and observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09** **F315** **Corrective Action:** **Nursing staff on secured unit were re-educated on Resident #3 toilet plan on 10/26. Cardex was reviewed and updated with toileting schedule on 11/11** **Identification of Others:** **Cardexes were updated with current toileting schedule of residents on 11/21** **Systems/Measures:** **1. By 12/6 the SDC re-educated nursing staff on urinary management to include following the residents toileting, changing schedules as well as providing the assistance as needed per the care plan.** **2. Daily Ambassador rounds will be completed to monitor for toileting of residents.** **3. IDT will review residents who are incontinent or in the need for assistance and update their care plans as needed.** **4. IDT will review residents toileting needs on admission, quarterly, annually, and with change of condition through the care plan process and care plans will be updated at that time.**	12/6/09
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	F 329		

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F 329	Continued From page 15 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimens for 3 of 18 sample residents (#6, #10, #18) were free of unnecessary medications. The findings were: 1. Review of physician's orders showed resident #10 had been on the antipsychotic, Zyprexa, 2.5 mg per day since 8/26/08, and the antidepressant, Zoloft, 100 mg daily since 4/1/04. Review of the medication administration records (MARs) confirmed the medications had been administered as ordered. Review of the pharmacist's notes showed he had requested	F 329	**Monitoring:** **Data obtained by way of observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09** **F329** **Corrective Action:** **Resident #10 risk benefit statement was received for zyprexa and Zoloft on or before 12/6.** **Resident #18 risk benefit statement was received for use of Zoloft on or before 12/6.** **Resident #6 risk benefit statement was received for Zoloft and Remeron on or before 12/6.** **Identification of Others:** **All residents on psychotropics have the potential to be affected.** **Systems/Measures:** **The consultant pharmacist will review residents receiving psychotropic medications monthly and recommend gradual dose reductions per regulation and as appropriate. These recommendations will be reported to the attending physician and the facility DON and/or NHA.**	12/6/09

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F 329	Continued From page 16 either a dose reduction of Zyprexa or a medical rationale for continued use at the same dose. These requests were made on 10/23/08, 12/24/08, and 9/28/09. Each time the physician failed to respond or wrote "Do not change. "No request for a dose reduction was found for Zoloft. Interview with the DON on 10/21/09 at 1:45 PM revealed she was unable to locate a medical rationale for using either medication outside the recommended guidelines. On 10/29/09 at 1:40 PM the pharmacist verified the lack of a medical rationale. 2. According to the physician's orders and the MARs, resident #18 had received Zoloft 75 mg daily since 2/26/07. Review of the medical record showed a gradual dose reduction (GDR) had not been attempted, nor was there any response from the physician to the request for a GDR or supporting documentation from the physician that a dose reduction was clinically contraindicated. On 10/29/09 at 1:40 PM the pharmacist and DON verified the lack of a medical rationale for this medication. 3. Review of physician's orders and the MARs showed resident #6 had received the antidepressant, Remeron, 15 mg daily since 6/30/08 and Zoloft, 50 mg every day, since 2/2/09. Review of the medical record showed no evidence a GDR had been attempted or that a GDR was clinically contraindicated. On 10/29/09 at 1:40 PM the pharmacist and DON verified the lack of a medical rationale for continued use of these medications without a GDR.	F 329	**The pharmacist will provide inservice education to the IDT regarding the policy and regulation as it relates to psychotropic medication monitoring and gradual dose reductions.** **The IDT, led by the Social Worker, will complete quarterly chemical restraint reviews for residents receiving psychotropic medications. Reviews will ensure physician assessments have been completed, behaviors are tracked, adverse reactions are monitored and gradual dose reduction attempts per regulation or documentation of risk/benefit statements are completed.** **The Social Worker will complete monthly audits for 3 months and then quarterly of residents receiving psychotropic medications to ensure these residents have been assessed by their physician, behaviors are tracked, adverse reactions are monitored and they have either had an attempted gradual dose reduction ~~in the past 12 months~~ or a risk/benefit statement is documented in the medical record.** **Monitoring:** **Data obtained by way of psychtropic meetings and pharmacy recommendations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	12/6/09
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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F 332	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, medical review, and staff interview, the facility failed to maintain an error rate under 5 percent (%). Three errors occurred out of 40 opportunities for error, resulting in an error rate of 7.5%. The findings were: 1. Observation on 10/19/09 at 4:18 PM showed RN #5 prepared and administered glucosamine and chondroitin 500 mg to resident #24. Reconciliation of the medication pass with the physician's orders revealed only glucosamine 500 mg was ordered. On 10/22/09 at 4:32 PM the DON stated the facility did not have a standing order or physician's approval to substitute the medication, glucosamine and chondroitin, for glucosamine. She confirmed the medication error. 2. On 10/20/09 RN #9 prepared and administered medications, including prednisone, 1 mg, to resident #26 at 9:10 AM. Reconciliation of the medications showed the physician ordered prednisone, 4 mg on 9/28/09. Review of the medication administration record (MAR) showed 4 mg was clearly indicated as the correct dose. Review of the unit dose packaging showed 4 tablets was circled in red. Review of the MAR and the unit dose package with RN #3 confirmed an error occurred. Information received from the physician on 10/23/09 showed the error was not significant. 3. Observation on 10/22/09 at 10:45 AM showed RN #6 prepared and administered calcium carbonate 600 mg to resident #25. Reconciliation	F 332	**F332** **Corrective Action:** **Resident #24 has been receiving the proper medications per the physician order.** **Resident #26 has been receiving the proper medications per the physician order.** **Resident #25 has been receiving the proper medications per the physician order.** **Identification of Others:** **All residents have the potential to be affected by this alleged deficient practice.** **Systems/Measures:** **The SDC/designee will provide inservice education to licensed nurses including but not limited to: accuracy in medication pass including the "Five Rights of Medication Administration", Aseptic technique, hand washing, receiving, discontinuing and transcribing medications. Newly hired nurses will receive this education during orientation to the facility.** **The SDC will observe licensed nurse medication passes weekly for accuracy and appropriate technique.** **Monitoring:** **Data obtained by way of medication pass observation will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	

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

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F 332	Continued From page 18 of the medications showed the physician ordered Calcium Carbonate 650 mg on 9/22/09. Review of the facility's reference book, "Nursing 2008 Drug Handbook" revealed the medication was available in a 650 mg dose. On 10/22/09 at 1:10 PM the DON confirmed the dose should not have been altered.	F 332		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that --	F 334	**F334** **Corrective Action:** **Resident #4 has received the flu vaccine on 10/12 and was documented in the medical record.** **Resident #5 has received the flu vaccine on 11/13 and was documented in the medical record.** **Identification of Others:** **An audit was completed on pneumococcal and flu vaccines to ensure they were offered, administered, and documented in the medical record.** **Systems/Measures:** **By 12/6 the SDC/Designee will provide inservice education to licensed nurses regarding offering the influenza and pneumococcal vaccine to residents upon admission to the facility and providing them and/or their legal representatives with education regarding the benefits and potential side effects of the vaccines.** **The Medical Records Director/Designee will audit admission charts within 72 hrs of admission to ensure the vaccines have been offered, education regarding benefits and potential side effects has been provided and the appropriate documentation is contained in the medical record.**	12/6/09

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F 334	Continued From page 19 (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to maintain documentation in the medical	F 334	**Monitoring:** **Data obtained by way of vaccine audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	12/6/09

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 20 record that 2 of 5 sample residents (#4, #5) did or did not receive the influenza and/or pneumococcal immunizations. The findings were: According to the facility's undated policies and procedures, "Immunizations: Influenza (Flu) Vaccination of Residents, Staff, and Volunteers" and "Immunizations: Pneumococcal Vaccination (PPV) of Residents," staff were to document the administration of either vaccine, including the injection site, in the medical record. During an interview on 10/20/09 at 11:30 AM, the DON stated immunizations for all residents were recorded in a log book instead of in the medical record. She further stated the documentation might be in the individual resident's nursing notes or in the medication administration record if the nurse administering the vaccine documented the information there. However, staff were only required to enter the immunizations in the log. Review of the medical records for residents #4 and #5 failed to reveal evidence influenza immunization status and pneumococcal immunization status were documented as required prior to the survey.	F 334		
F 356 SS=B	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).	F 356		

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	535024	A. BUILDING _____ B. WING _____	C 10/23/2009

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F 356	Continued From page 21 - 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 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 the required nurse staffing data in the required format. The findings were: Observation on 10/22/09 at 4:13 PM showed the nurse staffing data posted for public review listed halls 1, 2, 3, and 4; halls 5 and 6 were not shown. Additionally, the data only provided the date and the numbers of staff working in each hall that day. Missing information included the facility name, the actual hours worked per shift per category of staff, and the daily resident census. In addition, the data for the entire 24-hour period was posted at the same time instead of at the beginning of each shift. Interview with the DON at the time of the observation revealed this was the only data the facility posted. The DON stated she was	F 356	**F356** **Corrective Action:** **Nurse staffing was posted on daily basis with facility name, current date, actual hours worked for RN/LPN/C.NA/ The form is updated on a daily basis by staffing coordinator** and the resident census **Identification of Others:** **Only one area for this posting. No other areas identified with the alleged deficient practice.** **Systems/Measures:** **NHA/Designee to re-educate the staffing coordinator and Human resource coordinator on proper way to post nursing hours by 12/6.** **NHA/Designee to observe posting for completeness/accuracy daily.** **Monitoring:** **Data obtained by way of audits of observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by NHA/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	12/6/09

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F 356	Continued From page 22 unaware of the specific regulatory requirement. On 10/28/09 at 9:50 AM the administrator stated the posted information had not been maintained for at least 18 months.	F 356		
F 362 SS=E	483.35(b) DIETARY SERVICES - SUFFICIENT STAFF The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the availability of a sufficient number of dietary staff to serve resident meals in a timely manner during 3 of 3 dining observations. The findings were: Observation during the lunch meal on 10/20/09 revealed residents #14 and #15 waited a half hour or longer before being served a meal (refer to F241 for details). Interview with the facility cook on 10/20/09 at 12:30 PM revealed meal orders/cards were taken for all residents and then meals (individual resident room and dining room trays) were prepared. Meal cards for dining room (DR) residents were prepared by DR staff as each resident came to the service window. The cards were then given to the cook for meal preparation. Resident room meal orders were taken over the phone by the cook. Cards and then meals were prepared as orders were received. Interview with the kitchen manager on 10/21/09 3:48 PM revealed there were some problems with the	F 362	F362 **Corrective Action:** **The facility will provide staff in sufficient numbers to meet the needs of the residents. The facility will evaluate the current level of dietary staffing to ensure that the resident's needs are met.** **Identification of Others:** **Residents currently residing at the facility have the potential to be affected by the alleged deficient practice.** **Systems/Measures:** **NHA/Dietary Manager/Designee will evaluate the staffing to ensure that there is sufficient staff to meet the resident's needs.** **Dietary will be educated by Dietary Manager on procedure for the tray line by 12/6.** **Monitoring:** **Data obtained by way of monitoring dietary staffing patterns will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by Dietary Manager/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	12/6/09

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F 362	Continued From page 23 current system. a. Meal cards were supposed to be given to the cook and trays prepared on a first come first serve basis. However, there was no mechanism in place to ensure cards were received or meals prepared in sequential order (Refer to F241 for details). b. The service window could only hold four trays at a time. Resident room trays and DR trays were prepared and placed in the service window at the same time, where they remained until picked up and delivered. Room trays sat in the window until hallway staff came to the dining room and retrieved them. DR trays sat in the window until DR staff were able to take them to the seated residents. Multiple observations (10/19/09 evening meal, 10/20/09 breakfast meal, and 10/21/09 lunch meal) revealed DR staff were not always able or available to deliver meal trays in a timely manner. Room trays might be sitting in the window waiting to be picked up, preventing DR trays from being prepared. Or DR staff might be unavailable to deliver trays because they were involved in other activities; e.g. bussing dishes, cleaning tables, setting up new table service settings, taking meal orders, seating residents, retrieving residents (Refer to F241 for details), passing water, coffee, tea, etc. Interview with the kitchen manager and dietary manager on 10/22/09 at 2:20 PM confirmed the meal tray delivery system needed to be evaluated and changes needed to be made in order to reduce resident waiting time for meals.	F 362		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must -	F 371		

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F 371	Continued From page 24 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to prevent possible food contamination. The findings were: 1. Observation on 10/19/09 at 5:48 PM revealed five frying pans of varying sizes sitting on a clean shelf in the kitchen. The pans' interior cooking surfaces were encrusted in a quarter inch thick, hard, black, rough baked-on covering. Also, there were multiple scratches on the interior of the pans. In addition, the rubber coated pan handles were cracked and easily broken off. Interview with the kitchen manager at the time of the observation confirmed the pans should no longer be used. According to Food Code 2005, U.S. Public Health Service, 4-101.11, "Materials that are used for food-contact surfaces shall be: (D) Finished to a smooth, easily cleanable surface." 2. Observation on 10/19/09 at 5:32 PM revealed several stand alone wire shelves in the kitchen where clean kitchen equipment was being stored. However, cobwebs and dust had accumulated on the shelving. Interview with the kitchen manager at the time of the observation confirmed the presence of the dirt and cobwebs. The manager	F 371	**F371** **Corrective Action:** 1. **Frying pans were discarded and new pans ordered on 10/19.** 2. **Wire shelves in kitchen were cleaned on 10/19.** 3. **C.NA is no longer employed at facility** **Identification of Others:** **Residents currently residing at the facility have the potential to be affected by the alleged deficient practice.** **Systems/Measures:** **Dietary Manager will re-educate dietary staff on the cleaning schedule on 12/6/09. Monthly sanitation rounds will be completed by NHA/Designee. Dietary manager will monitor cleaning schedule to ensure staff are completing items as listed on a daily basis.** **Monitoring:** **Data obtained by way of monitoring dietary sanitation will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by Dietary Manager/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09** Staff were educated on not eating at the counter on 12/1/09 BW	

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F 371	Continued From page 25 stated the kitchen staff was supposed to keep the shelves clean. 3. Observation on 10/21/09 at 11:48 AM during the noon meal revealed a CNA standing at the food service window eating from a bowl of macaroni and cheese. This window was where resident's food trays were passed to CNAs for service to residents. Interview with the kitchen manager at that time revealed staff were not supposed to eat while serving resident food trays. According to Food Code 2005, U.S. Public Health Service, 2-401.11, "Employees shall eat or drink in designated areas where the contamination of exposed food, clean equipment, utensils and linens, unwrapped single-service and single-use articles or other items needing protection can not result."	F 371		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**F425** **Corrective Action:** **Benadryl was removed from the cart and discarded on 10/23.** **Maalox was removed from the cart and discarded on 10/22.** **Liquifilm was removed from the cart and discarded on 10/23.** **Identification of Others:** **All medication carts were audited by unit managers on 10/23 for expired meds. Any expired medications will be discarded.** **Systems/Measures:** **1. Weekly audits of med carts/rooms for expired meds are being conducted by licensed nurses.** **2. Audits of med carts/rooms for expired meds are being conducted by nurse managers.** **3. Re-education has been completed by the SDC for licensed nurses on removing expired medications by 12/6/09.** **Monitoring:** **Data obtained by way of medication cart audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	12/6/09

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F 425	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired medications on 2 of 3 medication carts were not available for resident use. The findings were: 1. Observation of the north station (halls 3 and 4) medication cart on 10/23/09 at 7:20 AM revealed a stock bottle of Benadryl and Maalox that had expired on 10/12/09. The bottle had been opened and contained 14 ounces of medication. RN #3 confirmed the medication was available for resident use. 2. At 9:42 AM on 10/23/09 observation of the medication cart in the secured unit (halls 5 and 6) revealed a bottle of Liquifilm Tears for resident #28 with an expiration date of 9/09. RN #4 confirmed the medication was available for use.	F 425		
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 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	F 431		

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F 431	Continued From page 27 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 and staff interview, the facility failed to ensure medications on 2 of 3 medication carts contained expiration dates. The findings were: 1. Observation on 10/23/09 at 7:30 AM showed the north station medication cart contained the following medications, which did not have expiration dates. a. A stock box of individually wrapped tablets of Omeprazole. The box was approximately 1/3 full, but originally contained 42 tablets. No expiration date was visible on the box or the individual tablets. b. A bottle of Propafenone 150 milligrams from a local pharmacy for resident #29. During the observation, RN #3 confirmed the lack	F 431	**F431** **Corrective Action:** **Omeprazole was discarded on 10/23.** **Propafenone was discarded on 10/23.** **Promethazine was discarded on 10/23.** **Identification of Others:** **All medication carts were audited by nurse managers on 10/23 for medications without expiration dates. Any found will be discarded.** **Systems/Measures:** **Weekly audits of med carts/rooms for medications without expiration dates are being conducted by licensed nurses.** **Audits of med carts/rooms for medications without expiration dates are being conducted by nurse managers.** **Re-education has been completed by the SDC for licensed nurses on ensuring all medications have expiration dates by 12/6/09.** **Monitoring:** **Data obtained by way of medication cart audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	12/6/09

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F 431	Continued From page 28 of expiration dates. 2. Observation on 10/23/09 at 9:42 AM revealed a syringe of Promethazine 25 milligrams/milliliter for resident #30 that did not contain an expiration date. During the observation, RN #3 confirmed the lack of an expiration date. She stated she had no idea how long the medication had been on the cart.	F 431	**F441** **Corrective Action:** **1. Infection Control Nurse and DON were educated on infection control system by RCD on 11/17.** **2. Ice machine was drained, cleaned, and a lock was placed on it to prevent it from contamination on 10/19.** **3. Infection control log was updated with changes for resident #12 and resident #13 on 10/20.** **4. The items on top of linen cart were removed on 10/21.** **Identification of Others:** **All residents have the potential to be affected by this alleged deficient practice. All linen carts were inspected for items left on top. Any items found will be removed.** **Systems/Measures:** **All staff were educated by SDC/designee on removing items from linen carts on 12/6/09.** **Ambassadors will completed daily to observe carts and remove items if found. RCD to complete review of infection control paperwork to ensure completeness and accuracy of monitoring for all departments.** **Monitoring:** **Data obtained by way of rounds/observations/IC paperwork reviews will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will evaluate effectiveness of the plan based on thrends identified and implement additional interventions as needed to ensure continued compliance monthly X3.** **Corrective Date:** **12/6/09**	12/6/09
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of the infection control log, the facility failed to develop and maintain an effective infection control program. The infection preventionist (IP) lacked education, surveillance of staff and residents related to infection control practices was lacking, infection baselines were not determined, and infections were not tracked to resolution over consecutive months. The findings were: 1. Interview with the IP and the DON on 10/21/09 at 8:55 AM revealed the following concerns:	F 441		

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F 441	Continued From page 29 a. The IP had been employed by the facility since 9/18/09 and the DON since July 2009. Both stated they had not received specific education related to an infection control program. b. The IP and DON both stated resident use of the ice machine was not monitored. See #2 below. c. Both denied surveillance of staff related to infection control practices such as handwashing, perineal care, etc. The DON stated this had been done in the past, but she was unable to locate documentation other than yearly competencies. In addition, both stated monitoring for infection control practices was not conducted for all departments. d. The IP stated the facility lacked a baseline determination of those residents with chronic or colonized infections. e. Residents whose infections and treatment carried over to another month (e.g., August to September to October) were not carried forward on the facility's log after the first month's entry. f. Both the IP and DON were unaware of changes in the antibiotics used for residents #12 and #13. 2. Observation on 10/19/09 at 4:48 PM revealed an ice machine in the dining room. On a table next to the ice machine was a large ice scooping spoon in a plastic bucket. At that time, an unidentified, non-sample resident walked over to the ice machine, opened the door and used the ice scoop to re-fill his/her plastic drinking cup. The cup did not contain all the ice placed in it, and the remaining ice cubes fell back into the ice machine. Additionally, some ice cubes formed a mound in the cup preventing the resident from placing a lid on the cup. The resident then used the ice scoop to level the mound of ice in his/her	F 441	Development & implementation of the infection control program containing areas of trending, tracking & surveillance has been implemented. DD	

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F 441	Continued From page 30 personal drinking cup, and in so doing, touched the top of the cup with the ice scoop. The resident then placed the ice scoop back in the plastic bucket next to the ice machine. 3. Review of the physicians' orders for residents #12 and #13 showed the antibiotic use was changed for both residents. The antibiotic for resident #12 was placed on 'hold' on 10/14/09, and the antibiotic for resident #13 was changed that same day. Review of the infection control log showed neither change was documented. 4. Observation on 10/21/09 at 2:48 PM revealed a clean linen cart in an alcove in hallway 4. On top of the cart were two bottles of water, a stethoscope, a blood pressure cuff, an extensor grabber, and an examination gown. Attached to the wall directly over the linen cart was a sign that read "Please do not put anything on top of linen cart!! Remember infection control." Interview with the director of housekeeping at the time of the observation revealed the items were not supposed to be there. She also stated she would need to talk to nursing service regarding not placing items on the clean linen cart.	F 441		