POC accepted 5/29/09 Janelle Cox, OTR/L

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

PRINTED: 05/07/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
RECEIVED Wyoming Dept of Health JUN 04 2009	RECEIVED Wyoming Dept of Health 535042	A. BUILDING _____ B. WING _____	04/23/2009

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE
Office of Healthcare Licensing and Surveys SHEPHERD OF THE VALLEY	MAY 18 2009 Office of Healthcare Licensing and Surveys	60 MAGNOLIA CASPER, WY 82604

(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 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, medical record review, and resident and staff interviews, the facility failed to ensure dignity was maintained for 2 (#84, #164) of 23 sample residents. The findings were: 1. Observation on 4/20/09 at 5:53 PM revealed resident #84 was seated in the dining room for the evening meal. At 6:35 PM, observation showed the resident laid his/her head onto the table in the bowl of soup. The certified nurse aide (CNA) #5 assisting the resident asked if s/he was finished eating, and the resident gave an affirmative response. A second CNA #2 asked the resident if s/he wanted to watch TV (television) and the resident shook his/her head and stated s/he was too tired and would like to go to bed. Observation showed CNA #2 did, however, place the resident in front of the TV at that time. Periodic observations from 6:40 PM until 8:33 PM revealed the resident remained seated in the wheelchair slumped over with his/her head on his/her lap. Observation at 8:33 PM revealed CNA #3 assisted the resident into a recliner. Observations also showed the resident asked staff, visitors, and other residents to please take him/her to bed because s/he was so tired at 8:57 PM, 8:59 PM, 9 PM, 9:07 PM, and at 9:12 PM. At that time (9:12 PM), CNA #3 transferred the resident into a wheelchair and took him/her into his/her room. During an interview with the	F 241	F241 The facility will 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 will be accomplished by: 1. • Resident #84 will be assisted to bed when requested per CNA staff. • Resident #84 disposable brief will be checked in a private area and in a dignified manner by CNA staff. • Resident #164 call light will be answered in a timely manner by staff. 2. All residents will receive care as requested in a manner that maintains or enhances their dignity and respect. Staff will answer residents call lights in a timely manner to ensure care is received as required for the resident's comfort. 3. Nursing staff will be in-serviced to the deficiency. 4. Nursing management team or designee will perform five random audits monthly to monitor this process with immediate in servicing to follow as needed for three months.	6/4/2009 6/4/2009 6/4/2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jill Elliott CEO/Adm | TITLE | (X6) DATE: 5-15-09

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. POC accepted. Changes per Karen James, DON on 5/29/09 @ 1:35 PM.

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F 241	Continued From page 1 resident at 9:24 PM, s/he stated s/he was "really tired" and wanted to go to bed. Continued observation revealed the resident remained in the wheelchair, slumped over with his/her head on his/her lap until 10 PM when the surveyor asked CNA #3 when she planned to assist the resident to bed. The CNA responded there were two other residents she planned to assist to bed before she laid this resident down. The CNA then stated she would go ahead and assist this resident to bed first. When the CNA entered the room to assist the resident to bed, the resident refused stating, "Don't touch me, I'm too tired," and "Leave me alone." Observation revealed at 10:10 PM the CNA left the room and the resident remained slumped over in his/her wheelchair after having requested numerous times to go to bed since 6:35 PM (3 hours and 35 minutes). Observation on 4/20/09 at 8:35 PM revealed CNA #4 checked the resident's disposable brief by pulling the waist band of the resident's slacks out approximately nine inches. The CNA then pulled the incontinence brief out and placed her hand in to see if the resident was incontinent. This observation took place while the resident was seated in a recliner in the living room where guest musicians and eleven other residents were present. 2. Review of the medical record for resident #164 revealed the resident required extensive assistance with transfers and the resident had difficulty sitting for long periods due to psoriatic skin lesions. Observation of the resident on 4/20/09 at 7:20 PM revealed the resident sat in the wheelchair in his/her room and turned on the call light. Continued observation revealed four staff walked past the resident and his/her activated call light, but did not respond. At 7:40	F 241	5. The DON or designee will report audit results to the QA team no less than quarterly for six months.	6/4/2009

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F 241	Continued From page 2 PM, the resident self propelled to the hallway and called out, "Hello, hello?" At 7:48 PM. (28 minutes after the call light was first activated) two CNA's transferred the resident to bed and provided incontinence care. Interview on 4/20/09 at 8:15 PM with the resident revealed the staff's delayed response to the request for assistance made the resident feel "crappy" because the resident was tired, and sitting for the long period of time was painful.	F 241		
F 253 SS=E	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 ensure 8 of 8 floor fans were kept clean and free of dust. In addition, 2 of 3 window sills in the special care unit (SCU) dining room were dirty, as was the floor beneath an ice machine. The facility further failed to repair 17 of 55 resident room doors with gouges and scratches, revealing bare wood. The findings were: Multiple observations of the facility on 4/20/09 through 4/23/09 revealed the following deficiencies: 1. Eighth floor fans on central, east, and west resident hallways were found to be covered with dust on the back of the fan housing. 2. Two windows sills in the back dining room of the SCU revealed dried food material on the	F 253	F253 It is the practice of the facility to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior in a timely manner. This will be accomplished by: 1. • Floor fans on central, east and west stations will be cleaned by housekeeping staff to include the fan housing on the back. • The dining room window seals on SCU will be cleaned to remove dried food, spilled pepper, dirt, dust and cobwebs. • Floor under ice machine on east nursing station will be replaced. • Resident room doors will be inspected for scratches and gouges and will be repaired. 2. Housekeeping staff will clean all floor fans weekly to include housing on back of fans. 3. Housekeeping staff will clean dining room window seals weekly.	6/4/2009 6/4/2009 6/4/2009

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F 253	Continued From page 3 wooden surfaces. Further, a glass pepper shaker was turned over in the window sill, with its contents spilled. Dust, dirt, and cobwebs were also observed in both window sills. 3. The floor under an ice machine behind the east nursing station was initially observed on 4/21/09 to be dirty and contain white, chalky mineral deposits. The floor had not been cleaned when repeated observations were made on 4/22/09 and 4/23/09. 4. Doors to resident rooms were observed multiple times during survey to be deeply gouged and scratched. A facility tour revealed 5 of 16 rooms on the SCU/west hallway, 2 of 22 rooms on east hallway, and 8 of 21 rooms on the central hallway had heavily marred and gouged doors. Interview with the chief of housekeeping on 4/22/09 at 4:20 PM revealed her plan was to clean floor fans once each week. She confirmed the dust on the fan housing was excessive and should be cleaned. She further confirmed the dirty condition of the SCU dining room window sills. Interview with the maintenance supervisor on 4/23/09 at 8:20 AM confirmed resident room doors were badly scratch and gouged; he stated there was an ongoing plan to repair and refinish the doors, but was uncertain when he would complete the project.	F 253	4. Housekeeping staff will in in-serviced to the deficiency. 5. Maintenance staff will be in-serviced to the deficiency. 6. The maintenance supervisor and housekeeping supervisor will perform bi-monthly audits of the facility to identify any maintenance or housekeeping concerns. Any identified concerns will be correcoted. 7. The DON or designee will report audit results and concerns with corrections to the QA team no less than quarterly for six months.	6/4/2009 6/4/2009 6/4/2009 6/4/2009
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.	F 272		

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F 272	Continued From page 4 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 assure comprehensive assessments were completed in a variety of areas related to the Minimum Data Set (MDS) assessments for 7 (#75, #84, #89, #112, #128, #141, #170) of 26 sample residents. The findings were: 1. Review of the 1/29/09 annual MDS assessment for resident #75 revealed falls triggered, which required a comprehensive	F 272	F272 The Facility will make a comprehensive assessment of resident needs, using the RAI specified by the State. This will be accomplished by: 1. • Resident #75, #84, #89, #112, #128 and 141 will have a comprehensive fall risk assessment done per MDS coordinators. • Resident #112 will have a psychotropic medication assessment done per MDS coordinator. 2. The Restorative Director or designee will complete post fall risk assessment after each resident fall to determine appropriate interventions for immediate implementation or upon readmission if hospitalized. 3. The Restorative Director and MDS team will perform comprehensive fall risk assessments on all residents' upon admission, significant change in condition and annually using the RAI. 4. Nursing staff and MDS team will be in-serviced to the deficiency. 5. The Nursing Management team will perform random audits on five charts monthly to monitor this process with immediate in servicing to follow as needed for three months.	6/4/2009 6/4/2009 6/4/2009 6/4/2009 6/4/2009

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F 272	Continued From page 5 assessment. According to section V, the assessment for falls was the fall risk assessment. However, review of the 1/24/09 fall risk assessment revealed it was a data collection tool to determine risk for falls, but was not a comprehensive assessment. 2. Review of the 12/30/08 admission MDS for resident #170 revealed a comprehensive assessment for falls was required. The location of the falls assessment was identified as "see fall risk assessment." Review of the 12/22/08 fall risk assessment revealed it was a data collection tool to determine the fall risk, but was not a comprehensive assessment. 3. According to the 1/22/09 significant change MDS assessment, resident #89 required a comprehensive assessment related to his/her risk for falls. Further review of that MDS showed the information for the comprehensive assessment was the fall risk assessment dated 1/20/09. Review of that data showed the facility had not conducted an analysis to determine how a total score of 14 related to the resident's functional capacity and health status. Interview with MDS coordinator #3 on 4/22/09 at 2:50 PM confirmed a comprehensive fall assessment had not been completed. 4. Review of the 10/23/08 annual MDS assessment showed resident #112 triggered for falls and use of psychotropic medications and required comprehensive assessments in those areas. However, review of the information listed for those assessments revealed neither was comprehensive. The fall assessment listed a score of 14 with no analysis to show how it related to the resident, and, according to the	F 272	6. The DON or designee will report audit results to the QA team no less than quarterly for six months.	6/4/2009

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F 272	Continued From page 6 psychotropic medication assessment, the resident received psychotropic medications "per MD orders." On 4/22/09 at 2:50 PM, MDS coordinator #3 confirmed comprehensive fall and psychotropic medication assessments were lacking. 5. Observation on 4/20/09 at 5:53 PM revealed resident #84 had a bruise covering the right side of his/her face. Interview with a certified nurse aide (CNA) #1 at the time revealed the resident had experienced a recent fall which required the resident to be hospitalized and that was how s/he got the bruise. Review of the 3/12/09 quarterly MDS assessment revealed the resident had experienced a fall in the past 31 to 180 days. Review of the 12/18/08 quarterly MDS assessment revealed the resident also experienced a fall in the past 30 days. Review of the medical record revealed the resident had experienced a fall on 4/14/09 and was hospitalized until 4/16/09 when s/he was readmitted to the facility. Review of the entire medical record revealed there was no post fall assessment to determine the cause and contributing factors which caused the fall. Interview with the director of nursing (DON) on 4/22/09 at 4 PM revealed an assessment was not completed because the resident was transferred to the emergency room. However, the DON also stated the resident was expected to be readmitted to the facility so should have had a post fall assessment completed to determine appropriate interventions for implementation upon the resident's return. 6. Review of the 3/11/09 admission MDS assessment for resident #128 revealed falls	F 272		

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F 272	Continued From page 7 triggered, which required a comprehensive assessment. According to section V, the assessment for falls was the fall risk assessment. However, review of the 3/20/09 fall risk assessment revealed it was a data collection tool to determine risk for falls, but was not a comprehensive assessment. 7. Review of the 3/11/09 significant change MDS assessment for resident #141 revealed falls triggered, which required a comprehensive assessment. According to section V, the assessment for falls was the fall risk assessment. However, review of the 3/31/09 fall risk assessment revealed it was a data collection tool to determine risk for falls, but was not a comprehensive assessment. 8. On 4/22/09 at 3:20 PM, the DON stated there were no comprehensive fall assessments for initial, significant change, or annual MDS assessments. She further stated not all post-fall assessments were completed for those residents who had sustained falls.	F 272		
F 281 SS=E	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 professional standards were followed for 4 (#42, #61, #75, #112) of 23 sample residents related to nutritional assessments and medication administration. In addition, 6 medication containers were not properly dated. The findings	F 281	F281 The Facility will provide services that meet professional standards of quality. This will be accomplished by: 1. • Residents #42, #61, #75 and #112 will have a nutritional status RAP reviewed and signed by the registered dietitian. • Resident #2 will receive insulin in a syringe prepared using aseptic technique during preparation and administration per nursing staff.	6/4/2009

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F 281	Continued From page 8 were: 1. During an interview on 4/21/09 at 3:50 PM, the registered dietitian (RD) stated the assessment for nutritional status was the RAP (Resident Assessment Protocol). She stated the certified dietary manager (CDM) did complete the RAPs for non-Medicare residents, and annual and quarterly assessments. She stated RAPs were done by herself for significant changes, Medicare residents, residents with feeding tubes, or residents at high risk. The RD stated she did not have enough hours in the facility to complete all the assessments, therefore she assessed the high risk residents, and the dietary manager assessed the others. Medical record review revealed the following nutritional status RAPs were completed by the CDM, and not the RD: a. The RAP for the 1/29/09 annual Minimum Data Set (MDS) assessment for resident #75. b. The RAP for the 10/23/08 annual MDS assessment for resident #112. c. The RAP for the 12/30/08 annual MDS assessment for resident #42. d. The RAP for the 1/27/09 annual MDS assessment for resident #61. According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining,	F 281	• Resident #40 will receive medications as ordered and MAR will be signed by initials per nursing staff when administered. • Resident #88 Reneacidin irrigation solution was discarded due to no date, time or initial when opened • Multi-use vial and container of vinegar and heparin on east station were discarded due to no date, time or initial when opened. • Multi-use vials of insulin's on west station were discarded due to no date, time or initial when opened • Multi-use vial of Vitamin B-12 on south station were discarded due to no date, time or initial when opened 2. Registered dietitian will use review and sign nutrition status RAP's on all residents with significant change of condition and annual MDS's. and admission. jc 3. Residents will receive inject able medications in a syringe prepared using aseptic technique during preparation and administration per nursing staff. 4. Residents will receive medications as ordered and MAR will be signed by initials per nursing staff when administered. 5. Resident specific multi-use vials and containers will be dated, timed and initialed when opened by nursing staff.	~~4/23/2009~~ ~~4/23/2009~~ ~~4/23/2009~~ ~~4/23/2009~~ 6/4/2009 6/4/2009 6/4/2009 6/4/2009 6/4/2009

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F 281	Continued From page 9 verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals ...for nutrition risk factors. ..It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients." 2. Observation on 4/20/09 at 5:52 PM showed registered nurse (RN) #4 prepared and administered an injection of insulin to resident #2. However, the RN had her fingers around the plunger of the syringe while withdrawing the insulin from the vial. When she saw bubbles in the insulin inside the syringe, she moved the plunger back and forth to remove them, thus contaminating the insulin in the syringe prior to administering it to the resident. On 4/23/09 at 8:50 AM the director of nursing confirmed staff should hold the phalange at the end of the plunger, not the plunger itself. According to "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, 4th Edition, 2007, when preparing injections, one should "use strict aseptic technique during preparation and administration to minimize the risk of infection" and "avoid touching" the plunger of a syringe. 3. During observation of a medication pass for resident #40 on 4/20/09 at 5:37 PM, RN #5 stated Neurontin would not be given as it was not available. She stated the pharmacy would deliver medications around 6:30 PM, and she would have the oncoming nurse give it then. Review of	F 281	6. Resident multi-use vials and containers will be dated, timed and initialed when opened by nursing staff.	6/4/2009
			7. Nursing staff will be in-serviced to the deficiency.	6/4/2009
			8. ▪ The Nursing Management team will perform random audits on five charts monthly to monitor nutritional status RAP process with immediate in servicing to follow as needed for three months. ▪ The Nursing Management team will perform random audits on five injections monthly to monitor aseptic technique during preparation and administration with immediate in servicing to follow as needed for six months. ▪ The Nursing Management team or designee will perform twenty-five random MAR audits monthly to monitor medication administration with nursing initials with immediate in servicing to follow as needed for three months.	6/4/2009

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F 281	Continued From page 10 the medication administration record (MAR) on 4/21/09 at 9:25 AM showed the medication was not signed off as given; instead there was a "-" in the space. However, a count of the medications sent from the pharmacy with RN #6 on 4/21/09 at 9:25 AM showed the dose was given. On 4/23/09 at 8:50 AM, the director of nursing stated staff were to initial the MARs for the correct date and time a medication was administered. If not given, they were to initial the space, circle their initial, and document the reason the medication was not administered on the back of the MAR. According to "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, 4th Edition, 2007, one should record administration of medications on the MAR "as soon as you give it." 4. Observation on the East nursing unit on 4/22/09 at 10:30 AM showed an opened 500 milliliter (ml) container of Renacidin Irrigation Solution for resident #88. Further observation revealed a 500 ml container of vinegar and a 30 ml vial of Heparin. A transfer spike had been inserted into the caps of each container but the dates the containers were opened was not indicated. During the observations registered nurse (RN) #7 stated Renacidin and vinegar were currently used for catheter irrigations, and the Heparin was a stock vial for intermittent intravenous use. The RN also stated she had no idea when the containers were opened. According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, page 552, "If multiple-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials." 5. Observation of medication storage on 4/22/09	F 281	▪ The Nursing management team or designee will perform weekly audits for date, time and initials on all resident specific multi-use vials/containers and resident multi-use vials/containers to monitor this process with immediate in servicing to follow as needed for three months. 9. The DON or designee will report audit results to the QA team no less than quarterly for six months.	6/4/2009

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	535042	A. BUILDING _____ B. WING _____	04/23/2009

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SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(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 281	Continued From page 11 at 2:15 PM in the secure unit showed an open vial of Lantus insulin and an open vial of Humalog insulin with no date showing when each vial was opened. Interview with RN #2 at that time revealed her expectation was for all medication vials to be dated when first opened. Observation of medication storage on 4/22/09 at 2:45 PM on the south unit showed an open vial of cyanocobalamin (Vitamin B-12) with no date as to when the vial was opened. Interview with RN #1 revealed her expectation was for all medication vials to be dated when they are first used. According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, page 552, "If multiple-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials."	F 281		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff provided care needed to prevent urinary tract infections for one (#112) of six residents with indwelling urinary catheters.	F 315	F315 The facility will ensure 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 will be accomplished by: 1. Resident #112 will receive proper catheter care during perineal care and at bedtime. 2. All residents with indwelling catheters will receive proper catheter care during perineal care and at bedtime.	6/4/2009 6/4/2009

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F 315	Continued From page 12 The findings were: During an observation on 4/20/09 at 7:53 PM, certified nurse aide (CNA) #2 assisted resident #112 to the bathroom. The resident had a smear of feces on the incontinence brief (confirmed by the CNA)and had a bowel movement while on the toilet. The observation also showed the resident had an indwelling urinary catheter connected to a leg bag. Before completing perineal care, the CNA connected the resident's leg bag to the night drainage bag but did not provide catheter care, either then or after assisting the resident to bed. When questioned at 8:25 PM, the CNA stated they (the CNAs) were taught to perform catheter care any time perineal care was provided and at bedtime. She further stated she just "spaced" providing the care.	F 315	3. All resident's who are incontinent of bladder will receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 4. Nursing staff will be in-serviced to the deficiency. 5. The Nursing management team will perform three random audits monthly to monitor this process with immediate in servicing to follow as needed for three months. 6. The DON or designee will report audit results to the QA team no less than quarterly for six months.	6/4/2009 6/4/2009 6/4/2009 6/4/2009
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 transfers were done safely for 1 (#136) of 10 sample residents who utilized a mechanical lift. In addition, the facility failed to ensure one of two isolation carts was maintained in good repair to prevent potential injury. The findings were:	F 323	F323 The facility will ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accents. This will be accomplished by: 1. • Resident #136 will be transferred with a mechanical lift with the safety seat belt unfastened. • Isolation cart outside room 42 bottom drawer was removed, isolation items that had fallen behind the back of the drawer were removed allowing bottom drawer to close tightly and properly.	6/4/2009 ~~4/24/2009~~

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F 323	Continued From page 13 1. Observation on 4/20/09 at 8:30 PM revealed certified nurse aide (CNA) #6 and CNA #7 used a mechanical lift to transfer resident #136 from the wheelchair to the bed. Observation revealed the resident was positioned in the wheelchair with a fastened safety seat belt. When the mechanical lift moved the resident upward it also caused the resident to pull the wheelchair upward. Further observation revealed the CNAs released the seat belt prior to completing the transfer, but not before the resident received red indentations on his/her abdomen from supporting the weight of the wheelchair with the unreleased seat belt. Interview on 4/20/09 at 9:20 PM with CNA #7 revealed the CNAs failed to release the seat belt prior to the transfer because they did not know the resident had it. 2. During the initial tour of the facility on 4/20/09 at 2:30 PM, a metal isolation cart was observed in the hallway outside resident room 42 in the special care unit (SCU). The lower drawer on the cart was dented in the middle, causing both ends of the drawer to protrude an inch from the forward edge of the cart, at a position 14 inches above the floor. The exposed drawer edges where rough and presented a potential hazard to residents walking along the hallway. The cart remained in the SCU for the duration of the survey, 4/20/09 through 4/23/09. The maintenance supervisor stated in interview on 4/23/09 at 9:45 AM he was unaware of the bent drawer and exposed edges.	F 323	2. All residents transferred with mechanical lift will be have safety belt unfastened it they require a safety belt. 3. Nursing staff to be in-serviced to deficiency. 4. Maintenance staff to be in-serviced to deficiency. 5. The Nursing management team will monitor this process with immediate in servicing to follow as needed. 6. The maintenance supervisor will perform bi-monthly audits of the facility to identify any maintenance or housekeeping concerns. Any identified concerns will be corrected. 7. The DON or designee will report audit results and concerns with corrections to the QA team no less than quarterly	6/4/2009 6/4/2009 6/4/2009 6/4/2009 6/4/2009 6/4/2009
F 425 SS=D	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	F 425		

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F 425	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure medications were available for administration as ordered for one (#40) of seven residents observed during medication passes. In addition, the facility failed to ensure expired medications were not available for resident use in two of four nursing units. The findings were: 1. During observation of a medication pass for resident #40 on 4/20/09 at 5:37 PM, registered nurse (RN) #5 stated Neurontin would not be given as it was not available. She stated it was not given that morning and displayed the circled nurse's initials on the medication administration record (MAR) for that morning's dose. Further review of the MAR showed the reason the nurse's initials were circled was the Neurontin was "not given, ordered from Pharmacy." The RN stated	F 425	F425 The facility will 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. This will be accomplished by: 1. • Resident #40 will receive medications from the pharmacy in a timely manner to ensure resident receiving all medication doses as per physician order. • Resident #101 expired Vicodin 5/500 was removed from medication cart and placed in narcotic destruction drawer in DON office • Resident #42 expired Imodium 2mg was removed from medication cart and placed in expired medications holding area. • Resident #23 expired Vistaril 50mg was removed from medication cart and placed in expired medications holding area. 2. All residents will receive medications from pharmacy in a timely manner to ensure resident receiving all medication doses as per physician order. 3. Nursing staff to check all residents' medications for expiration date prior to administration to ensure resident receives no expired medications.	6/4/2009 ~~4/23/2009~~ ~~4/22/2009~~ ~~4/22/2009~~ 6/4/2009 6/4/2009

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F 425	Continued From page 15 the medication would not be available until that evening as medications ordered from the pharmacy were usually delivered around 6:30 PM. 2. On 4/22/09 at 10:30 AM observation of medication storage areas on the east nursing station showed Vicodin 5/500 milligrams (mg) for resident #101 had expired on 3/25/09. RN #7 confirmed the expiration date and stated the medication was available for resident use. 3. Observation of the medications available for administration on 4/22/09 at 2:45 PM in the two south unit medication carts revealed the following outdated medications: a. Imodium 2 milligrams (mg)-fourteen capsules with an outdate of 3/30/09 for resident #42. b. Vistaril 50 mg- ten capsules with an outdate of 4/11/09 for resident #23. After the observation, RN #1 then took both medications and placed them in the expired medication holding area.	F 425	4. Nursing staff to remove any expired medications from medication cart to ensure resident receives no expired medications. 5. The Nursing management team or designee to perform random weekly audits on twenty-five residents to monitor process with immediate removal of expired medications and in-servicing to follow as needed for three months. 6. The DON or designee will report audit results and concerns with corrections to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009
F 431 SS=E	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	F 431		

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F 431	Continued From page 16 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications were stored and labeled appropriately in 1 of 4 nursing units. In addition, the facility failed to store and reconcile controlled substances at all nursing units. The findings were: 1. Observation on 4/22/09 at 10:30 AM showed the thermometer in the refrigerator used for medication storage on the east unit read 50 degrees Fahrenheit (F). Rechecking the temperature 10 minutes later with the surveyor's thermometer showed it was still 50 degrees F. At that time registered nurse (RN) #7 confirmed the temperature was too high. A temperature log was	F 431	F431 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The facility will 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 will be accomplished by: 1. • Medication refrigeration on east station was changed to ensure proper temperature. Medications moved to another unit's medication refrigerator for 12 hours. • Stock bottles of Mag-tab SR 84 and MAPAP 325mg were discarded for lack of expiration date. • Schedule I medications will be reconciled at shift change. 2. Medication refrigerator temperature checks will be logged daily by nursing staff.	~~4/22/2009~~ ~~4/23/2009~~ 6/4/2009 6/4/2009

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F 431	Continued From page 17 not available to determine how long the temperature had been above the recommended level. At 2:15 PM that day, the head nurse for the East unit, RN #8, stated the nurses did not routinely check the refrigerator temperatures. She further stated she had no idea how long the refrigerator had been at 50 degrees F. The refrigerator contained multiple vials of insulin, Phenergan, Tylenol, inhalation solutions, and various kinds of suppositories. According to pharmacist #2 on 4/28/09 at 2:50 PM, medications were to be stored between 36 and 46 degrees F. 2. Observation of the East nursing unit on 4/22/09 at 10:30 AM showed the following medications lacked expiration dates: a. A stock bottle of Mag-tab SR 84 milligrams (mg). b. A stock bottle of MAPAP 325 mg. During the observation, RN #7 verified the lack of expiration dates. 3. Observation on 4/23/09 at 8 AM showed Klonopin 1 mg in the non-controlled medication section of the medication cart. At that time, licensed practical nurse (LPN) #9 stated they did not reconcile Klonopin or Darvocet N on the east unit. Review of the facility's 2009 "Nursing Drug Reference" showed the medications were classified as controlled drugs at the Schedule 1 level. Interview with the DON on 4/23/09 at 10:15 AM revealed the facility did not reconcile Schedule 1 medications at all.	F 431	3. Nursing staff to be in-serviced to deficiency. 4. Nursing staff to check all stock medications for expiration date prior to administration to ensure resident receives no expired medications. 5. Nursing staff to remove any medication without expiration date from medication cart to ensure resident receives no expired medications. 6. The Nursing management team or designee to perform random weekly audits on stock medications to monitor process with immediate removal of medications without expiration dates and in-servicing to follow as needed for 3 months. 7. The DON or designee will report audit results and concerns with corrections to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009 6/4/2009
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	F 441		

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F 441	Continued From page 18 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, and review of medical records and infection control surveillance data, the facility failed to maintain complete and accurate surveillance information for 19 of 21 residents with infections or receiving antibiotic therapy. Further, the facility failed to ensure 4 of 14 hand sanitizer dispensers in resident hallways and common use areas were refilled when empty. The findings were: 1. The facility's infection control surveillance data for January 2009 and March 2009 were reviewed on 4/22/09 at 2:10 PM; the DON and assistant ADON performed infection control surveillance and were present for the review. These data revealed the following deficiencies: a. In January 2009, thirteen residents were identified as having specimens submitted to the laboratory for microbiological culture. The surveillance logsheets failed to include culture findings for twelve of these residents. Further, one additional culture status was entered as "unknown" with no further information to show a follow-up into the culture status of the resident. b. Of the 12 residents lacking culture results on the January 2009 surveillance logsheets, three residents (#40, # 103, and #155) were found to	F 441	F441 The facility will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. 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. 1. • Residents #40, #103, #155 infections were resolved in January 2009, surveillance log sheets updated to include culture results. • Resident #117 sputum culture results obtained and placed in medical record. • Residents on surveillance log sheet for March and April 2009 were updated to include culture results if applicable. • April 2009 surveillance log sheet have been updated to include final resolution. • Residents with MDRO have been placed on a permanent chronological listing.	6/4/2009

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F 441	Continued From page 19 have positive culture findings in their medical records that were not reported by the surveillance program. Resident #155's medical record revealed s/he had a history of cultured-confirmed methicillin-resistant Staphylococcus aureus (MRSA). A fourth resident (#117) listed on the January 2009 surveillance logsheet as having a sputum culture had no record of a sputum culture request or any sputum culture results in his/her medical record. c. In March 2009, eight residents were identified on the infection control surveillance logsheet as having specimens submitted for culture, but seven of these entries lacked a culture result. One additional resident (#30) was listed as having no cultures performed in March 2009; however, review of his/her medical record found a urine culture was reported positive for Escherichia coli on 3/16/09. The culture report further showed the bacterial isolate was positive for extended-spectrum beta lactamases (ESBL), suggesting multidrug resistance that was not recognized by the facility's infection control team. d. The January and March 2009 surveillance logsheets failed to show the final clinical resolution for any of the twenty-one residents documented as receiving antibiotic therapy for an infection. e. The facility did not maintain a chronologic line listing of MDRO infections among residents. 2. Multiple observations on 4/20/09 through 4/22/09 revealed four hand sanitizer dispensers in two resident hallways (central and east) and outside the physical therapy room were empty. The chief of housekeeping stated on 4/22/09 at 7:45 AM she was responsible for refilling the dispenser, but was out of refills earlier in the month. The dispensers were refilled on the	F 441	2. Resident Infection Control Coordinator will place residents admitted with or acquire an infection while in facility on the surveillance log sheet to include culture results if applicable and track to final resolution of infection. 3. Resident Infection Control Coordinator will place any resident identified with MDRO on the permanent MDRO chronological listing. 4. Hand sanitizers will be checked weekly by housekeeping to ensure refilled in a timely manner. 5. Nursing staff will be in-serviced to the deficiency. 6. Housekeeping staff will be in-serviced to the deficiency. 7. Resident Infection Control Coordinator or designee to perform random monthly audits on infection surveillance log sheets to monitor process with immediate correction of log sheet as needed for three months. 8. Housekeeping supervisor to perform random monthly audits on 5 hand sanitizers to monitor hand sanitizer refills with in-servicing to follow as needed for 3 months. 9. The DON or designee will report audit results to QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009 6/4/2009 6/4/2009 6/4/2009

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F 441	Continued From page 20 afternoon of 4/22/09. 3. The DON stated in interview on 4/22/09 at 4:20 PM she was aware the infection control surveillance data was incomplete with regard to culture results as well as tracking resident infections to resolution. She also stated hand sanitizer dispensers should be refilled promptly as these devices were part of the facility's program for improving hand hygiene compliance among staff.	F 441		