PRINTED: 08/27/2013
FORM APPROVED
OMB NO. 0938-0391

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
	53A050	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	110 HOSPITAL LANE AFTON, WY 83110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to immediately notify the resident's physician and the resident's legal representative	F 157	The facility will immediately notify the resident's physician and the resident's legal representative/interested family member when there is a significant change in the resident's condition. This will be accomplished by:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Johnson RN BSN | TITLE: NHA | (X6) DATE: 9-6-13

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

Revised 9-26-13

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F 157	Continued From page 1 or interested family member when there was a significant change in the resident's condition which had the potential for requiring physician intervention. This was identified for 3 of 10 sampled residents (#4, #10 and #3) who had documented changes in their condition which included: 1) rectal bleeding, 2) changes in blood pressure and 3) staff holding resident medications. Findings include: 1. Resident #4 was admitted to the facility on 11/20/09 with diagnosis which included: Parkinson's, hypertension, depression, anxiety and seizures. The resident was also identified as having a supra pubic catheter for a neurogenic bladder and history of constipation. a. Review of resident #4's medical record revealed changes in the resident's condition documented in the nursing "Progress Notes" which included: 1/12/13- "S/P (supra public) catheter leaking, blood in the urine noted. S/P catheter #18 removed using sterile technique. 20 cc H2O w/d (withdrawn) from balloon. S/P catheter #18 replaced, sterile technique maintained. Balloon inflated with 10 cc H2O. Pinkish/yellow urine return in tubing. Foul odor noted in urine. Resident tolerated procedure well." (Note: There was documentation of follow up to the physician with the resident having blood and foul smelling urine. The CNA "pocket care plan" noted the resident as having a history of MRSA (Methicillin Resistant Staphylococcus) infection in the urine.)	F 157	A. Resident #4 and #3 have been assessed and will continue to be assessed for concerns and/or significant changes which require notification of their physician or legal representative/interested family member. Resident # 10 has been discharged from facility. B. All resident charts will be reviewed to ensure that proper notification of their physicians or legal representative/interested family member is in place for any concerns or significant changes.	09/20/13 09/20/13

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F 157	Continued From page 2 The next entry was (five days later) on 1/17/13-1645 (4:45 PM) "Rectal bleeding-resident noted to have bright red rectal bleeding, large amount, dripping out of rectum. Resident denies pain or discomfort associated with this. Call made to Dr. (name) office, left message on (name) answering machine with report of rectal bleeding." (signed by RN) There was no further documentation of vital signs or assessments of this resident by the nurse. 1/17/13 6P-6A "Continues to have small amount of bright red bleeding from rectum. Denies pain or discomfort will continue to monitor et attempt to contact MD again in morning." (There was no documentation of vital signs or further assessment of this resident by the nurse.) 1/18/13 "No rectal bleeding today (Resident name) out to meals and activities. Bright and alert no problems noted." 1/19/13 6A-6P "No further rectal bleeding noted or reported." (No documentation the resident's physician was contacted and notified of blood and foul smelling urine or large amount of blood from the rectum.) The next entry was not until 2/12/13 (23 days later). 2/12/13 The resident was noted to be having issues with nausea and vomiting. 2/13/13 The resident started vomiting undigested food and was sent to the emergency room at the hospital for evaluation and treatment. b. Review of the outpatient record dated 2/13/13 showed the resident had an IV infusion of lactated ringers, started on IV antibiotics, given IV	F 157	C. 1) The Change of Condition Policy will be reviewed and revised to include the following components: * The CNA is responsible to report any concern or changes in a resident's condition to the nurse immediately. * The nurse is responsible to perform an appropriate assessment of the resident's condition (including vital signs). * Significant changes or concerns, as well as questions involving change in medications where the medication may be held prior to response from MD, will be reported to the MD by the nurse via either phone call or in person. If no immediate response, the physician will be called by each following shift until a response is obtained. * Change in condition charting will take place each shift following the change,including vital signs and assessment of the resident, until a response is received from the physician.	

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F 157	Continued From page 3 medication for nausea and UA (urinalysis) collected. c. Interview with the DON (Director of Nursing) on 8/15/13 confirmed that the nursing progress notes did not show the resident's physician and family were immediately informed of the resident having changes in her condition. The DON then provided a "Nurse/physician communication" form which showed a sheet was sent to the physician on 1/17/13 which stated, "Resident noted to have bright red rectal bleeding, large amount. Denies pain associated with this." The physician signed and dated this form on 1/23/13 (six days after it was sent.) The facility failed to promptly notify the resident's physician and family member of this resident's changes in condition. 2. Closed record review for resident #10 revealed the resident was admitted to the facility on 5/17/12 with diagnoses that included coronary artery disease (CAD), congestive heart disease (CHF), hypertension (HTN), stroke (CVA), depression, agitation, joint pain, and ulceration of the intestine. Further review of the resident's medical record evidenced that the resident was transferred to the hospital on 5/29/13 (per the nurse's late entry progress note). a. Review of the resident's physician orders evidenced the following orders for his diagnosis of HTN: 7/14/12 Lisinopril 10 mg (milligrams) 1 tab PO (oral) QD (daily)	F 157	C. 2) Education will be provided to Nurses and CNAs regarding the Change of Condition Policy. Focusing on the following elements: * The CNA is responsible to report any concern or changes in a resident's condition to the nurse immediately. * The nurse is responsible to perform an appropriate assessment of the resident's condition (including vital signs). * Significant changes or concerns, as well as questions involving change in medications where the medication may be held prior to response from MD, will be reported to the MD by the nurse via either phone call or in person. If no immediate response, the physician will be called by each following shift until a response is obtained. * Change in condition charting will take place each shift following the change, including vital signs and assessment of the resident, until a response is received from the physician.	09/20/13

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F 157	Continued From page 4 7/14/12 Atenolol tablet 25 mg 1 PO QD. No blood pressure (BP) parameters were noted in the above orders to indicate when to hold the medications and/or when to notify the physician of abnormal values. Additionally, a review of the "Star Valley Care Center Routine Orders" revealed no blood pressure parameters were included. b. Review of the resident's May, 2013 Medication Administration Record (MAR) revealed the resident's Lisinopril and Atenolol were circled (to indicate the medications were held) on the following dates with the blood pressure readings: 5/19/13 8:00 AM with BP of 114/56 5/24/13 8:00 AM with BP of 90/50 5/25/13 8:00 AM with BP of 88/50 5/26/13 8:00 AM with BP of 90/50. There was no explanation on the MAR to note why the medications were held or that the physician was notified. Additionally, no BPs were documented with the medications until 5/19/13. On the following dates, when the medications were not held, the BPs were noted to be: 5/27/13 8:00 AM with BP 109/61 5/28/13 8:00 AM with BP 90/50. c. Review of the resident's nurses' Progress Notes evidenced the following: On 5/15/13 for 6 P - 6 A - "Resident has no	F 157	C. 3) The Star Valley Care Center Routine Orders will be revised to include an area for the resident's physician to specify blood pressure parameters. C. 4) Any medication held will have an explanation documented on the MAR. The nursing staff will be trained regarding this documentation standard.	09/20/13 09/20/13

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F 157	Continued From page 5 observable SE (side effects) from decrease in Seroquel. He denied any pain & was cooperative with HS (bedtime) cares. Increase in Norco 10/325 mg to TID (three times a day) appears to be working on pain during HS shift." The next nursing note was written as a late entry dated 5/29/13 after the transfer to ER (emergency room). "At approx 2330 (11:30 PM) on 5/29/13 this RN (Registered Nurse) found resident laying supine.....unresponsive to any stimuli with the exception of ....Irregular HR (heart rate) + rhythm 104 bpm (beats per minute), 82/52, T (temperature) 94, Respirations 20/minute..." [Note: Review of the resident's hospital laboratory reports revealed that the resident was admitted to the Emergency Department of the hospital on 5/28/2013 and the resident's blood was drawn on 5/29/13 at 0031 (12:31 AM). The resident was actually transferred before midnight on 5/28/13. The date and time of the "Late Entry" was inaccurate.] d. Review of the resident's "Nurse/Physician Communication" forms from 5/9/13 to 5/28/13 revealed the following communications with the physician's response and the date of response: 5/9/13 at 2:00 PM - communication about antipsychotic and pain medication - signed by the doctor on 5/10/13. 5/14/13 no time specified - communication about measurement of contractures - signed by the doctor on 5/16/13. 5/16/13 no time specified - "88/47. Resident has been hypotensive, may we request a BP protocol	F 157	C. 5) The nursing staff will have an inservice regarding the correct way to document late entries in the Medical Record.	09/20/13

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F 157	Continued From page 6 for Atenolol 25 mg QD and Lisinopril 10 mg QD." The physician response was "Please change BP treatment to Lisinopril 10 mg PO QD and Atenolol 25 mg PO QD." This was signed by the physician on 5/21/13 and it was noted by the nurse on 5/22/13. (Note: The orders for these two medications are the same as the resident was receiving since 7/14/12.) 5/22/13 at 11:20 AM - "Need parameters for hypotensive episodes. Currently taking Lisinopril 10 mg PO QD & Atenolol 25 mg PO QD." The physician response was "He should be treated if his BP numbers are greater than 160/90." The physician signed this communication form on 5/23/13 and it was noted by the nurse on 5/24/13. 5/24/13 no time specified - "_____(resident's name) has been hypotensive. What are parameters you would like his Lisinopril & Atenolol held?" The physician's response was "Pt is deceased". The physician signed this 6/10/13. 5/28/13 at 11:46 PM - "T 94 P 104 R 20 BP 82/52. Res transported to ER - was unresponsive. Cold. Clammy & had episode of N, V, &D. Dx with M.I. Family informed. The physician's response was "Pt is deceased". The physician signed this 6/10/13. From 5/18/13 to 5/28/13, there was a lack of evidence that the physician was notified and responded in a timely manner. When the physician did respond, the orders did not address the request and/or were not timely. The facility failed to ensure that the physician was notified of the resident's condition change so that the resident was assessed and treated.	F 157	D. 1) The DON will ensure that the Change of Condition Policy is revised. D. 2) The DON or designee will check for changes in condition, changes in medication, and/or any concerns via report sheets and communication with charge nurse for 5 days per week for 2 weeks, then weekly for 1 month, PRN change in condition following to ensure proper notification and assessments have taken place. The results of these observations will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	09/20/13 09/20/13

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F 157	Continued From page 7 e. On 8/15/13 in the afternoon, during interviews with the Director of Nursing (DON) and the MDS Coordinator (MDSC), the surveyor asked if they could locate any more evidence of nurse charting, vital sign records, or documentation to show that the resident's change in condition was addressed and the physician was notified in a timely manner. The DON and MDSC verified that no additional documentation was available to show physician notification. 3. Review of resident #3's "Nurse/Physician Communication" forms evidenced that on 7/29/13 the physician ordered a urine culture to be done on 7/30/13. On 7/30/13, the physician ordered: Augmentin 875 1 pill twice/day X 10 days Trimethoprim 200 mg po qHS after finished with Augmentin. a. Review of the resident's August, 2013 MAR evidenced that Trimethoprim was to be started on 8/10/13 at HS. The word Start was written next to the box indicating when the medication was to be started. Then the word Start was written in the box where the first dose was to be charted. On 8/11 and 8/12/13 the nurses' signatures were circled, signaling that the medication was omitted. The undated explanation on the MAR as to why the medication was not given was "Allergic to Sulfa & Trimethoprim is a Sulfa Drug. Hold until get clarification from MD". b. Review of the Progress Notes evidenced the following information related to the Trimethoprim being held: 8/11/13 6 a - 6 p - "Has completed Augmentin on	F 157	D. 3) The DON will perform 100% chart audit of all existing residents and any new admissions to assure that blood pressure parameters are ordered by the physician in cases where a medication has been ordered that affects blood pressure. The results of this audit will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program. D. 4) The DON or designee will perform periodic audits of the MAR to ensure reason documentation for any medication that is held. The results of this audit will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	09/20/13 09/20/13

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F 157	Continued From page 8 8-10-13 for UTI (urinary tract infection), has remained with adverse effects. orders are to start Trimethoprim 200 mg po q hs for UTI prophylaxis. Resident noted to have allergy to Sulfa. @1530 (3:30 PM) telephone call to Dr. _____(name)'s office. Left message regarding sulfa allergy & will wait further orders. Will hold off on Trimethoprim order, resident has not received any doses of it." (nurse signed this note) 8/13/13 1330 (1:30 PM) "Nursing has been holding Trimethoprim due to confusion on Sulfa allergy. Education wes provided that Trimethoprim alone will not be a problem with Sulfa allergy." (pharmacist signed this note) 8/13/13 6 p - 6 a - "1st dose of Trimethoprim 200 mg PO HS given." There was a lack of evidence to show that the nursing staff followed up with the physician when the physician did not return the call on 8/11/13. The resident was not given her medication for three days since no clarification was obtained.	F 157	D. 5) The DON or designee will perform periodic audits of the residents' medical records to ensure accurate documentation of late entries, observation of CNA reporting of change of condition, adequate assessments related to change of condition, timely notification of physician, and follow-up on physician response. The results of this audit will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	09/20/13
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical	F 274		

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F 274	Continued From page 9 interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to perform a significant change Minimum Data Set (MDS) assessment when the resident had a significant change of condition. This failure involved one of 10 sampled residents (Resident #1). The following are the criteria for significant changes based on improvement: o Any improvement in ADL assistance where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8; o Change in behavior or other symptoms is coded as "improved"; o Decrease in the areas indicating sad or anxious mood as a problem as indicated by symptom presence and frequency, or total severity score, on the MDS o Resident's decision making changes from 2 or 3, to 0 or 1; o Resident's incontinence pattern changes from 2 or 3 to 0 or 1; or o Overall improvement of resident's condition; resident receives fewer supports.	F 274	The facility will perform a significant change Minimum Data Set (MDS) assessment when a resident has a significant change of condition. This will be accomplished by:	

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F 274	Continued From page 10 The findings included: Record review for resident #1 revealed that the resident was admitted on 3/11/13 and had diagnoses that included dementia, depression, anxiety disorder, and leg joint pain. a. Review of the resident's 6/10/13 quarterly and 3/17/13 admission MDS assessments evidenced the following improvements in functioning: 6/13 - Resident required supervision with bed mobility. 3/13 - Resident required extensive assistance with bed mobility. 6/13 - Resident required supervision with transfer. 3/13 - Resident required extensive assistance with transfer. 6/13 - Resident required supervision with locomotion on unit. 3/13 - Resident required extensive assistance with locomotion on unit. 6/13 - Resident required supervision with locomotion off unit. 3/13 - Resident required extensive assistance with locomotion off unit. 6/13 - Resident required supervision with walking in room. 3/13 - Resident required extensive assistance with walking in room. 6/13 - Resident required supervision with walking in the corridor. 3/13 - Resident required extensive assistance	F 274	A. Resident #1 will have a change of condition assessment at her next assessment date. Her observation period started 8/27/13. B. The most recent MDS assessments for each resident will be reviewed by the MDS coordinator and DON to ensure that all assessments were completed on residents that demonstrated a significant change in condition. If any discrepancies are found, a significant change MDS will be completed.	09/20/13 09/20/13

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	61A060	A. BUILDING _____ B. WING _____	08/15/2013

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F 274	Continued From page 11 with walking in the corridor. b. Review of the resident's 6/18/13 Care Conference Summary revealed that the ADL (Activities of Daily Living) Review evidenced that the resident was assessed to need supervision for transfers, bed mobility, locomotion, and eating. c. The resident's "CORP - ADL Detail Report" (Certified Nurse Aide electronic charting printout) for the time period of 8/8/13 to 8/14/13 was reviewed. This review revealed that the ADLs of bed mobility, transfer, walking in room and in corridor, and locomotion in unit and off unit were charted as independent, supervision, or limited assistance with the exception of the charting done by one CNA (H) for one bed mobility and by another CNA (G) twelve times. They indicated that the resident required extensive assistance which questioned accuracy of CNA (G's) documentation. During one of the interviews with the MDSC, the charting by CNA (G) was discussed. Since the charting by this CNA varied so much from the other CNAs, the need for clarification (education) on the definition of extensive assistance and review with the CNA was indicated. On 8/14/13 during interviews with the MDS Coordinator (MDSC), she revealed that she had not done a significant change assessment on this resident because the resident had cyclic functioning. However, she confirmed that she thought a significant change assessment should be done when the resident was due for her next assessment.	F 274	C. 1) Education will be provided for CNA staff on the definition of extensive assistance as it relates to the the charting system. C. 2) The DON, MDS coordinator and BSW will be provided with education on both the identification of change in conditions, as well as implementation of change of condition assessments when a change in condition is identified. D. 1) The DON or designee will audit charting on randomized residents 3x per week for 8 weeks, covering each resident at least once, to ensure consistency in charting by the CNAs. D. 2) The DON will audit MDS assessments to check for change of condition assessments on residents with change in condition, and record on Quality Calendar. The results will be reported to the Quality Advisory Committee as part of the facility-wide continuous quality improvement program.	09/20/13 09/20/13 09/20/13 09/20/13

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F 274	Continued From page 12 There was no evidence that the resident's change of status was recognized as a significant change or that a full comprehensive re-assessment was should have been completed.	F 274		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to do a quarterly Minimum Data Set (MDS) assessment for one of ten sample residents (#3). The findings included: Review of the MDS assessments for resident #3 evidenced there was a 2/4/13 Significant Change of Condition re-assessment and a 4/29/13 Quarterly MDS assessment completed. A quarterly assessment was due to be completed by approximately 7/29/13; this MDS assessment was not found. On 8/13/13 at approximately 4:15 PM, in an interview the MDS Coordinator (MSDC) was asked about the missing assessment. She was unable to locate the assessment. The Social Worker verified that she had recently started tracking the scheduling of the assessments and this resident's assessment was missed. At 4:45 PM, the MDSC reported that a care plan	F 276	The facility will assess each resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This will be accomplished by: A. Resident #3 has had an MDS assessment performed and completed. 08/20/13 B. All other residents' most recent MDS assessments will checked to ensure they are up-to-date, accurate and timely. 08/20/13 C. The DON, MDS coordinator and BSW will be provided with education regarding ensuring that MDS assessments are identified and completed no less than every 3 months. 09/20/13 D. A spreadsheet will be created to track each resident's last ARD date, and to identify when the next MDS assessment is due. Audits for MDS assessments will be performed by DON for each completed MDS assessment to ensure they were completed no less frequently than every 3 months. The results of this audit will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program. 09/20/13	

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F 276	Continued From page 13 conference was done on 8/7/13 (without the assessment information).	F 276		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, record review and staff interviews, the facility failed to provide the care and services necessary to maintain the highest practicable physical well-being of two of 10 sample residents (#4 and #10). Specifically: The facility failed to ensure these residents received timely assessments, evaluation and management of their care when having significant changes in their conditions. Findings include: 1. Resident #4 was admitted to the facility on 11/20/09 with diagnoses which included: Parkinson's, hypertension, depression, anxiety and seizures. The resident was also identified as having a supra pubic catheter for a neurogenic bladder and history of constipation. a. Review of resident #4's medical record revealed changes in the resident's condition documented in the nursing "Progress Notes" which included:	F 309	The facility will provide care and services necessary to maintain the highest practicable physical well-being of our residents. This will be accomplished by:	

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F 309	Continued From page 14 1/12/13- "S/P (supra pubic) catheter leaking, blood in the urine noted. S/P catheter #18 removed using sterile technique. 20 cc H2O w/d (withdrawn) from balloon. S/P catheter #18 replaced, sterile technique maintained. Balloon inflated with 10 cc H2O. Pinkish/yellow urine return in tubing. Foul odor noted in urine. Resident tolerated procedure well." (Note: There was documentation of further assessment or follow up to the physician with the resident having blood and foul smelling urine. The resident's "pocket care plan" noted the resident as having a history of MRSA [Methicillin Resistant Staphylococcus] infection in the urine.) The next entry was (five days later) 1/17/13-1645 (4:45 PM) "Rectal bleeding- resident noted to have bright red rectal bleeding, large amount, dripping out of rectum. Resident denies pain or discomfort associated with this. Call made to Dr. (name) office, left message on (name) answering machine with report of rectal bleeding." (signed by RN) There was no documentation of vital signs or an assessment of this resident by the nurse. 1/17/13 6P-6A "Continues to have small amount of bright red bleeding from rectum. Denies pain or discomfort will continue to monitor at attempt to contact MD again in morning." (There was no documentation of vital signs or further assessment of this resident by the nurse or contact with the physician.) 1/18/13 "No rectal bleeding today (Resident name) out to meals and activities. Bright and alert no problems noted."	F 309	A. Resident #4 has been assessed. No current concerns/significant changes are active at this time which require notification of MD or legal representative/interested family member. Resident #10 has been discharged from the facility.	09/20/13

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F 309	Continued From page 15 1/19/13 "6A-6P No further rectal bleeding noted or reported." (No documentation the resident's physician was contact and notified of blood and foul smelling urine or large amount of blood from the rectum.) The next entry was not until 2/12/13 (23 days later). 2/12/13 The resident was noted to be having issues nausea and vomiting. 2/13/13 The resident started vomiting undigested food and was sent to the emergency room at the hospital for evaluation and treatment. b. Review of the outpatient record dated 2/13/13 showed the resident had an IV infusion of lactated ringers, started on IV antibiotics, given IV medication for nausea and UA (urinalysis) collected. The pharmacy summary notes identified the resident as having a UTI and cultures that grew out an E. coli. Infection. The resident was treated with multiple antibiotics including Cipro from 2/14/13 to 2/19/13, Cefzil for seven days and was on 3/16/13 Macrobid for 10 days. c. Interview with CNA (C) was completed on 8/14/13 after the resident was observed being transferred into the bathroom. The CNA reported that the resident has, "bad hemorrhoids so we tell the nurse when she complains and the nurse will come in and treat them." However, review of the MAR (medication administration record) showed the Anusol HS cream for hemorrhoids and had not been used for the months of August (8/13) or July (7/13) and had only been used once in January (1/13) when the resident was having the rectal bleeding.	F 309	B. 1) All residents' charts will be reviewed to ensure that proper notification is in place, and assessments performed for any concerns or significant changes. B. 2) All residents who have Anusol HC cream prescribed will have their chart reviewed to ensure proper administration of the medication ensuring that the resident is not in pain or uncomfortable.	09/20/13 09/20/13

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F 309	Continued From page 18 d. Interview with the DON (Director of Nursing) on 8/15/13 confirmed that the nursing progress notes did not show the resident's physician and family was immediately inform of the resident having changes in his/her or that adequate assesements and treatment were provided. 2. Closed record review for resident #10 revealed that the resident was admitted to the facility on 5/17/12 with diagnoses that included coronary artery disease (CAD), congestive heart disease (CHF), hypertension (HTN), stroke (CVA), depression, agitation, joint pain, and ulceration of the intestine. Further review of the resident's medical record evidenced that the resident was transferred to the hospital on 5/29/13 (per the nurse's late entry progress note). a. Review of the resident's May, 2013 Medication Administration Record (MAR) revealed documentation of low blood pressures (88/50 - 114/56) from 5/19/13 (when the BPs started being charted on the MAR) to 5/28/13 when he was transferred to the hospital. The only evidence that the physician was notified of the low blood pressures or that the nurses assessed the resident's status were noted on the Nurse/Physician communication forms, dated 5/18/13 to 5/28/13. These communications were as follows: 5/18/13 no time specified - "88/47. Resident has been hypotensive, may we request a BP protocol for Atenolol 25 mg QD and Lisinopril 10 mg QD." The physician response was "Please change BP treatment to Lisinopril 10 mg PO QD and Atenolol 25 mg PO QD." This was signed by the physician	F 309	C. 1) Education will be provided to Nurses and CNAs regarding the Change of Condition Policy. Focusing on the following elements: * The CNA is responsible to report any concern or changes in a resident's condition to the nurse immediately. * The nurse is responsible to perform an appropriate assessment of the resident's condition (including vital signs). * Significant changes or concerns, as well as questions involving change in medications where the medication may be held prior to response from MD, will be reported to the MD by the nurse via either phone call or in person. If no immediate response, the physician will be called by each following shift until a response is obtained. * Change in condition charting will take place each shift following the change, including vital signs and assessment of the resident, until a response is received from the physician. C. 2) Pharmacy will provide an inservices for the nursing staff regarding Anusol HC cream.	09/20/13 09/20/13

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F 309	Continued From page 17 on 5/21/13 and it was noted by the nurse on 5/22/13. (Note: The orders for these two medications are the same as the resident was receiving since 7/14/12.) 5/22/13 at 11:20 AM - "Need parameters for hypotensive episodes. Currently taking Lisinopril 10 mg PO QD & Atenolol 25 mg PO QD." The physician response was "He should be treated if his BP numbers are greater than 150/90." The physician signed this communication form on 5/23/13 and it was noted by the nurse on 5/24/13. 5/24/13 no time specified - "_____(resident's name) has been hypotensive. What are parameters you would like his Lisinopril & Atenolol held?" The physician's response was "Pt is deceased". The physician signed this 6/10/13. 5/28/13 at 11:45 PM - "T 94 P 104 R 20 BP 82/52. Res transported to ER - was unresponsive, Cold. Clammy & had episode of N, V, &D. Dx with M.I. Family informed. The physician's response was "Pt is deceased". The physician signed this 6/10/13. (Refer to F157 Physician notification for more detailed information about the resident's blood pressures and medications) b. Review of the resident's nurses' Progress Notes evidenced nurses documented the following: On 5/15/13 for 6 P - 6 A - "Resident has no observable SE (side effects) from decrease in Seroquel. He denied any pain & was cooperative with HS (bedtime) cares. Increase in Norco 10/325 mg to TID (three times a day) appears to	F 309	D. 2) The DON or designee will check for changes in condition, changes in medication, and/or any concerns via report sheets and communication with charge nurse for 5 days per week for 2 weeks, then weekly for 1 month. The results of these observations will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	09/20/13

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F 309	Continued From page 18 be working on pain during HS shift." The next nursing note was written as a late entry dated 5/29/13 after the transfer to ER (emergency room). "At approx 2330 (11:30 PM) on 5/29/13 this RN (Registered Nurse) found resident laying supine.....unresponsive to any stimuli with the exception of ....Irregular HR (heart rate) + rhythm 104 bpm (beats per minute), 82/62, T (temperature) 94, Respirations 20/minute..." [Note: Review of the resident's hospital laboratory reports revealed that the resident was admitted to the Emergency Department of the hospital on 5/28/2013 and the resident's blood was drawn on 5/29/13 at 0031 (12:31 AM). The resident was actually transferred before midnight on 5/29/13.] c. On 8/15/13 in the afternoon, during interviews with the DON) and the MDS Coordinator (MDSC), the surveyor asked if they could locate any more evidence of nurse charting, vital sign records, or documentation to show that the resident's change in condition was assessed and documented by the nurses. The DON and MDSC verified that no additional documentation was available to show that the nurses were monitoring and assessing the resident's condition.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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.	F 323		

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F 323	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to ensure the residents' environment remained as free of accident hazards as possible; and each resident received adequate supervision and assistive devices to prevent accidents. Specifically related to: 1) residents with cognitive impairment being left unattended on the toilet while still attached to a transfer device (Sit to Stand lift) for 3 of 10 sampled residents (#4, #3 and #2), 2) residents not being properly assessed to ensure safe transfers with the equipment being used, 3) resident #3's wheelchair arm was torn which posed a potential for skin tears for this resident who was at a high risk for skin tears, and 4) environmental hazards which included unsecured stove and chemicals accessible to residents. Findings included: 1. Resident #4 was admitted to the facility on 11/20/09 with diagnosis which included: Parkinson's, hypertension, depression, anxiety and seizures. The resident was also identified as having a supra pubic catheter for a neurogenic bladder and history of constipation. a. Observations were made on 8/14/13 with resident #4 being transferred. The resident had	F 323		

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F 323	Continued From page 20 been asleep in her recliner. Staff asked the resident if she wanted to be transferred into her wheelchair for lunch. The resident then asked to sit on the toilet before being transferred to the wheelchair. CNAs (D) and (B) proceeded to use the standing lift for the transfer. A sling was placed on the resident and attached to the lift. The resident was brought to a standing position and rolled into the bathroom and placed on the toilet. The staff then gave the resident the call bell and left the room with the resident still attached to the sling while on the toilet. CNA (D) was asked if the resident is left unattended? Staff reported, "Yes, we usually give her 15 minutes on the toilet. We come back and check her about every five minutes or so. We don't leave her sit very long because she has really bad hemorrhoids." The CNAs then went to assist other residents. The DON (Director of Nursing) was in the hall and informed of the concern with the resident being left unattended in the bathroom. The DON intervened and stayed with the resident until she was transferred into her wheelchair. The facility failed to ensure this resident who was at high risk for falls was not left unattended in the bathroom. b. Review of resident #4 medical record revealed changes in the resident's condition documented in the nursing "Progress Notes" which included the resident having tonic/clonic seizures and being sent to the ER (emergency room) of the hospital on 4/8/13. After that incident the resident has had medication adjustments to control her seizures. The resident was also noted to be a high fall risk with falls on 5/14/13 and 8/1/13 from her recliner. The falls resulted when the resident attempted to get up by herself.	F 323	The facility will ensure the residents' environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by: A. 1) Residents #4, #3, and #2 are attended at all times while attached to a transfer device. 08/30/13 A. 2) Resident #3's wheelchair armrest have been replaced. 08/30/13 A. 3) The Stove has been removed from the dining room as it is not used. 08/30/13 A. 4) The door to the clean utility room has been closed and locked; and will remain closed and locked when not in use. 08/15/13	

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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 323	Continued From page 21 c. Review of the current MDS (minimum data set) quarterly assessment dated 7/29/13 identified the resident as having severe cognitive impairment with a BIMS score of 7. She required extensive assistance of two staff with bed mobility, transfers, dressing, toilet use and was identified as having falls. d. Review of resident #4's current medications revealed the resident is currently on three anticonvulsant's (Dilantin, Keppra and Klonopin), Norcco for pain, Pristq for depression, Lopressor for hypertension and Ditropan for bladder spasms. The resident also finished a series of antibiotics for UTI (urinary tract infections) on 8/6/13. e. Review of the PT (physical therapy) evaluation dated 3/4/13 noted treatment diagnosis was for muscle weakness and debility. The primary concern was decreased in ROM (range of motion) and functional strength. It also noted the resident having poor posture and needing two assist with sit to stand transfers. f. Review of the resident's "Care Plan" dated 7/30/13 for ADL/self deficit included: "Toilet use: extensive, she may do better on some days depending on function R/T(related to) Parkinson's Sx (symptoms). Occ. incontinent of urine. She can void past her catheter. Offer toileting assist often. (Resident name) will attempt to toilet herself but is Very High Fall Risk. Encourage to call and wait for assistance. Make sure call light is always in reach." The care plan also addressed falls with multiple interventions, however it does not address the use of the sit to stand lift or leaving the resident unattended in the lift on the toilet.	F 323	B. 1) All residents will be evaluated to ensure that the proper transfer device is being used. All residents who require transfer devices are accompanied at all times when they are attached to the device .	09/20/13
			B. 2) All resident's armrests are to be observed, and any armrests with tears in the fabric to be replaced.	09/20/13
			B. 4) All rooms with hazardous materials will be closed and locked when not in use.	09/20/13

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	53A050	A. BUILDING _____ B. WING _____	08/15/2013

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F 323	Continued From page 22 (Note: Per manufacturers's instructions that sit-to-stand lifts are devices designed to transfer a patient between two seating surfaces. These include surfaces such as a commode, chair,, wheelchair and bed. Sit to stand lifts are only used on patients that have some leg mobility and can put some pressure on their legs when standing.) 2. Record review for resident #2 revealed that the resident was admitted to the facility on 1/29/13 with diagnoses that included dementia, hypertension, history of hip fracture, and depressive disorder. a. Review of the resident's 7/18/13 quarterly MDS assessment evidenced that the resident required extensive assistance by one or two staff members for bed mobility, transfer, dressing, eating, toilet use, personal hygiene, and bathing. The resident was assessed to have bilateral limitation in his range of motion on his upper and lower extremities. The resident was assessed as frequently incontinent of urine. The staff had assessed the resident to have short and long term memory problems. b. On 8/14/13 at 8:53 AM, during an observation of resident #2, he was transferred from his chair to the toilet by CNAs (E and G) with the Sit-to-stand lift. The resident was placed on the toilet and left with the lift attached. Staff left the room. The resident was checked at 9:03 AM when he indicated that he was not done and the CNA left the room again. At 9:15 AM, CNAs (B and E) transferred the resident from the toilet to the recliner.	F 323	C. 1) Education to be completed with all nursing and CNA staff to ensure that residents who use mechanical lifts (Sara Lifts)are accompanied at all times by a staff member when attached to the device. C. 1) The nursing staff will be provided with an inservice regarding the logistics and importance of filing a maintenance request for any wheelchair armrests that have holes/tears. C. 4) Education with the nursing staff to ensure that rooms with chemicals inside are closed and locked when not in use.	09/20/13 09/20/13 09/20/13

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F 323	Continued From page 23 c. Review of the resident's care plan revealed that the resident was at risk for falls. 3. Record review for resident #3 revealed that the resident was admitted to the facility on 5/1/09 and had diagnoses that included dementia with behaviors, bipolar disorder, osteoarthritis, diabetes, urinary tract infections (UTI), and restless leg syndrome. a. Review of the resident's 4/29/13 quarterly MDS assessment evidenced that the resident was assessed to require extensive assistance by one or two staff members for the bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to have limitations in her range of motion with impairment on one side for the upper extremity and on both sides of the lower extremities. The resident was noted to be occasionally incontinent. The staff assessed the resident to have short and long term memory problems and to be moderately impaired with decision making. b. On 8/14/13 at 9:22 AM, an observation of the staff transferring the resident from her wheelchair to her commode, using the sit to stand lift. When CNAs (D and B) transferred her, the straps were wrapped around her upper arms and the waist belt slid up to her armpits. The resident complained of pain and was seated in the wheelchair. The belt was adjusted and the transfer continued. The resident's legs were bent as she was not supporting herself and she complained of pain. Once the resident was on the toilet, the lift was left attached to her. The DON was present and observed the transfer. The resident was left alone. The staff checked on her	F 323		

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F 323	Continued From page 24 a couple of times before she indicated that she was done. At 9:50 AM, the resident was stood up using the lift. She indicated that she was in a lot of pain throughout the transfer. The resident's legs were bent when she stood up. She was moved to the bed. c. Record review revealed that the resident had a fall on 5/7/13 at 2:30 AM. She was found on the floor with her head and arms resting on the bed (per the incident report). d. The resident #3's left wheelchair arm was observed to be torn. This was verified by the DON during observations of the resident's transfer and skin assessment. The resident was observed wearing geri gloves to protect her arms. The DON confirmed that the resident had fragile skin. ENVIRONMENTAL HAZARD: On 8/15/13 at 9:00 AM the environmental tour was completed with the DON, maintenance director and maintenance staff member. The dining room was checked and found the stove had a special protective cage over the controls which was not locked or secured. The maintenance director stated, "I made the protector but it is supposed to have a zip tie to prevent access or being turned on by accident." However, it was open allowing access to the controls to turn the stove on. Additionally staff looked for the zip ties in the drawers by the stove but none were found. CHEMICAL HAZARDS: On 8/13/13 at 9: AM, an initial tour was completed with staff (A). A room located across the hall from nurses station identified as the clean utility room was unlocked. The room door was	F 323	D. The DON or designee will perform safety audits 3x per week for 3 weeks, 1x per week for 2 weeks, then then monthly for the following items: safe transferring with Sara Lifts / mechanical lifts, ensuring armrests do not have tears/holes in them, and ensuring that rooms with chemicals are closed and locked when not in use. The results of these audits will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	09/20/13

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F 323	Continued From page 25 open with bottles of liquid sitting on the cupboard. The bottles were identified by staff as massage oils with a hand written name on each bottle. However they did not have " Warning Labels " which identified risks associated with indigestion and or eye exposure. The room was not locked and posed a potential risk for wandering residents. On 8/15/13 at 9:28 AM, the door to the Clean Utility Room was observed to be open. There were bottles of massage oils sitting on the counter. There was a can of disinfectant spray (Bac End II) sitting on the top shelf of a cart. In the drawer labeled "E" there were 10 disposable razors. The Administrator was walking in the hall outside of this room. She verified that the door was supposed to be locked.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning	F 356		

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F 356	Continued From page 26 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 include the required information on their nurse staffing posting document. The findings include: Required nurse staff posting information which was not included was, "The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides." 1. On 8/13/13 observation revealed that the facility's daily staffing and census sheet for staff posting was located at the nurses station and was incomplete. 2. Review of the postings sheet for all days of	F 356	The facility will include the required information on their nurse staffing posting document. This will be accomplished by: A. Staffing information corrected to include correct amount of hours for nurse and CNA each day.	08/20/13
			B. Each day the DON or designee will count and total the hours on the staffing sheet.	08/20/13
			C. Education will be conducted with the DON, MDS coordinator, office manager and charge nurse on ensuring hours are counted each day as the staffing information is posted.	09/20/13
			D. The DON or designee will perform audits 5x/week for 2 weeks, then monthly. The results of these audits will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	09/20/13

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F 356	Continued From page 27 survey did not list the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. 2. Interview with the Director of Nursing on 8/15/13 confirmed that the posting did not list the actual hours worked by Registered Nurses, Licensed Nurses, and Certified Nurse Aides per shift. The facility failed to ensure nurse posting included all the required information.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (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, record review, and staff interview, it was determined that the facility failed to store, prepare, and serve food under sanitary conditions. Specifically: 1) Dishwashing machine did not always reach the	F 371		

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F 371	Continued From page 28 temperatures required for washing and sanitizing the dishes, 2) Ice machines were not being cleaned and sanitized per manufacturer's instructions, and 3) Mighty shakes were re-frozen and a large container of bread crumbs was observed to be sitting open in the dry storage room. The findings included: 1. On 8/13/13 at 9:35 AM, during the initial tour of the kitchen and dining room with the Dietary Supervisor (DS), the following observations were made: a. In the dry storage room, there was a large white bin which held a large bag of bread crumbs. The top of the bin and the bag were open. b. The DS was asked about the cleaning of the ice machine which was located in the kitchen. He said that it was cleaned weekly by the dietary staff. The DS revealed that ice was emptied out and the inside of machine was wiped down with sanitizing solution. c. Observation of the dishwasher being run through four cycles evidenced the following temperatures in Fahrenheit: Wash 122 degrees; Rinse 155 Wash 127; Rinse 171 Wash 133; Rinse 180 Wash 137; Rinse 180. Dietary staff member (I) was present and verified the temperatures. In an interview, she stated that last week the temperature for the wash cycle was low. She documented it in the log and reported it	F 371	The facility will store, prepare, and serve food under sanitary conditions. This will be accomplished by: A. Dishwasher temperatures are reaching appropriate water temperatures with each washing and sanitizing phase. Ice machines are cleaned and sanitized per manufacturer's instructions. Re-frozen mighty shakes are thrown away. Bread crumb container are stored properly in dry storage room. B. Dishwasher temperatures will be observed to ensure appropriate water temperature. Ice machines will be checked to ensure they have been cleaned and sanitized per manufacturer's instructions. Mighty shakes will be checked to ensure they are not re-frozen. All storage items in dry storage room will be checked to ensure they are stored properly with tops of bins and bags closed.	09/20/13 09/20/13

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F 371	Continued From page 29 to the DS. The DS was present at the time staff member (I) reported this to the surveyor. The DS said that he was not aware of the low temperatures. d. Observation of the refrigerator which was located in the dining room evidenced frozen Mighty Shakes in the freezer section. The DS indicated that dietary puts the Mighty Shakes out frozen and that nursing takes these out and dates them when they need them for a resident. There was one shake with resident #6's name on it. The DS confirmed that the nursing staff would have thawed that and placed it back in the freezer to re-freeze it. It lacked a date and should not be re-frozen after being thawed. 2. During the environmental tour of the facility on 8/15/13 from 9:00 AM to 10:00 AM with the DON, Maintenance Director and Maintenance staff member, two issues were investigated which included: 1) Dish machine not reaching proper temperatures for wash cycle or sanitizing cycle, 2) Ice machine not being sanitized per manufacturer's instructions. a. The DS (dietary supervisor) was asked to run a load through the dish machine. The temperature on the machine showed the wash cycle was 150 degrees and rinse/sanitizing cycle at 178 degrees not reaching the proper temperature. The DS checked the machine and reported the load of pots and pans was overloaded. He removed some of the pans and re-ran the machine which then showed 152 wash and 181 rinse. He reported that he would have to reeducate staff to not overload the machine. The Maintenance Director reported the machine	F 371	C. Maintenance will have education regarding proper cleaning and sanitization of ice machines, as well as appropriate water temperature for the dishwasher. The dietary staff will have an inservice regarding proper storage of items in dry storage, mighty shake storage/use, and appropriate dishwasher temperatures. 09/20/13 The nursing staff will have an inservice regarding not refreezing the mighty shakes. 10/08/13 D. The dietary manager or designee will perform audits 3x/week for 2 weeks, then weekly x1 month on proper dishwasher temperatures, mighty shakes to ensure not being re-frozen, and proper storage of items in dry storage room. Audits will be conducted by maintenance 3x/week for 2 weeks, then weekly x1 month on proper dishwasher temperatures. The dates of ice machine cleaning and sanitizing will be posted on the side of the ice machine itself. The results of these audits will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program. 09/20/13	

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F 371	Continued From page 30 had a new sensor which was put on approximately 6 months ago. During the past week maintenance was called to check the machine but he was not sure what had been done to the machine. He reported he would follow up to ensure the machine was reaching proper temperatures consistently. b. The staff was then asked about the two ice machines, one which was located in the kitchen and a second one was a counter top ice machine, in a small room, across from the nurses station. The Maintenance Director reported that both dietary and maintenance were responsible for the cleaning of the machine. He stated, "We did some checking yesterday about sanitizing the ice machines, to flush the inside of the machine. It is supposed to be done at least every six months per manufacturing instructions but it has not been done. We will have maintenance start doing it. I have been here many years and it has never been done." Further interview with the Maintenance Director revealed that the cleaning and flushing of the ice machine was not on his cleaning schedule. There was no record of when the ice machines had been properly cleaned or that manufacturer specifications for cleaning had been followed. The dietary supervisor reported the dietary staff wiped out the ice bin but had not done any further cleaning or sanitizing of the ice machines. Authoritative Reference: FDA, US Public Health Service Food Code 2009, Maintenance and Operation: 4-501.110 Mechanical Warewashing Equipment,	F 371		

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F 371	Continued From page 31 Wash Solution Temperature. (A) The temperature of the wash solution in spray type warewashers that use hot water to sanitize may not be less than: (1) For a stationary rack, single temperature machine, 74°C (165°F);Pf (2) For a stationary rack, dual temperature machine, 66°C (150°F); Pf (3) For a single tank, conveyor, dual temperature machine, 71°C (160°F);Pf or (4) For a multitank, conveyor, multitemperature machine, 66°C (150°F).Pf (B) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 49°C (120°F). Pf 4-501.111 Manual Warewashing Equipment, Hot Water Sanitization Temperatures. If immersion in hot water is used for sanitizing in a manual operation, the temperature of the water shall be maintained at 77°C (171°F) or above. P 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A) Except as specified in ¶ (B) of this section, in a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 90°C (194°F), or less than: Pf (1) For a stationary rack, single temperature machine, 74°C (165°F);Pf or (2) For all other machines, 82°C (180°F). Pf (B) The maximum temperature specified under ¶ (A) of this section, does not apply to the high pressure and temperature systems with wand-type, hand-held, spraying devices used for the in-place cleaning and sanitizing of equipment such as meat saws. Cleaning of Equipment and Utensils 4-602.11 Equipment Food -Contact Surfaces and	F 371		

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F 371	Continued From page 32 Utensils. (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

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F 441	Continued From page 33 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that staff used appropriate hand hygiene during cares to minimize the potential for cross contamination and the spread of infections. Additionally, the facility failed to maintain resident care equipment in a clean, sanitary manner. The findings included: REFERENCES: CDC MMWR 2005 / 54 (09): 220-223, Recommended Infection-Control And Safe Injection Practices to Prevent Patient To Patient Transmission of Bloodborne Pathogens: Diabetes Care Procedures & Techniques "...Environmental surfaces such as glucometers should be decontaminated regularly and anytime contamination with blood or body fluids occurs or is suspected. Glucometers should be assigned to individual patients. If a glucometer that has been used for one patient must be reused for another patient, the device must be cleaned and	F 441	The facility will ensure that staff use appropriate hand hygiene during cares to minimize the potential for cross contamination and the spread of infection. The facility will maintain resident care equipment in a clean, sanitary manner. This will be accomplished by:	

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F 441	Continued From page 34 disinfected..." GLUCOSE MONITORING and MEDICATION PASS: 1. On 8/13/13 starting at 5:20 PM, during an observation of the medication pass in the dining room, nurse (A) performed glucose monitoring on resident (#11). The plastic box containing the glucose monitoring equipment was sitting on the right extended shelf on the medication cart. The glucose monitor was taken out of the box, prepared for use, and taken to the table where the resident was seated. When the procedure was completed, the nurse placed the glucose monitor on the medication preparation area of the cart where it stayed for several minutes. Then it was returned to the plastic box without cleaning. 2. On 8/15/13 starting at 5:25 PM, during an observation of the medication pass in the dining room, nurse (A) performed glucose monitoring on resident (#11). The plastic box containing the glucose monitoring equipment was sitting on the right extended shelf on the medication cart. The glucose monitor was taken out of the box, prepared for use, and taken to the table where the resident was seated. When the procedure was completed, the nurse placed the monitor on the medication preparation area of the cart where it stayed for several minutes. Then it was returned to the plastic box without cleaning. The nurse verified that this was the facility's new glucose monitoring device and it was used for all of the residents who required glucose testing. There was no evidence the glucose monitor was being cleaned and disinfected between resident use.	F 441	A. Appropriate hand hygiene is utilized during cares with residents. Glucose monitoring machine is cleaned after each use. Medications are given to resident #12 in appropriate, sanitary manner. Resident #2's pericares are performed correctly. B. Staff members will be observed changing gloves when going from dirty surfaces to clean surfaces. Glucose machine will cleaned properly between residents to ensure proper infection control. Medications will be administered in a proper manner malataining infection prevention practices. Pericare will be properly performed on all residents.	09/20/13 09/20/13

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F 441	Continued From page 35 3. During the 8/15/13 5:25 PM medication pass observation, nurse (A) was observed to prepare medications for resident #12. The nurse counted the medications after preparing them. She indicated that one was missing. She found the missing pill in the bottom of the medication drawer where the resident's medication cards were stored. The nurse used a medication cup to pick up the medication and then she placed the medication in the plastic bag and proceeded to crush it with the other medications. The medication cart drawer is not a clean surface. PERI CARES: 4. Review of the resident #2's 7/18/13 quarterly MDS assessment evidenced that the resident required extensive assistance by one or two staff members for bed mobility, transfer, dressing, eating, toilet use, personal hygiene, and bathing. The resident was assessed as frequently incontinent of urine. On 8/14/13 at 8:53 AM, during an observation of resident #2, he was transferred from his chair to the toilet by CNAs (E and G) with the Sit-to-stand lift. When the resident was finished using the toilet, he was stood up using the lift. Using the same pair of gloves, the CNA (E) performed peri-care and put the resident's clean brief on him. 5. Record review for resident #3 revealed that the resident had a history of urinary tract infections (UTI) and had been on antibiotics which were started on 7/30/13 for a UTI with E. Coli as the cultured organism.	F 441	C. The nurses and CNA staff will be provided an inservice regarding the proper method of changing gloves between "dirty" and "clean" areas, especially focusing on changing gloves between performing pericare and putting on a new brief. Education will be provided to nurses to emphasizing the importance of cleaning the glucose monitor after each use. Pharmacy will provide the nursing staff with an inservice regarding standards for preventing contamination during medication pass. An inservice will be provided for the nurses and CNAs on proper infection prevention when performing pericare with emphasis placed on changing gloves after pericare and before dressing the resident and transferring them.	09/20/13

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F 441	Continued From page 36 Review of the resident's 4/29/13 quarterly MDS assessment evidenced that the resident was assessed to require extensive assistance by one or two staff members for the bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, personal hygiene, and bathing. The resident was noted to be occasionally incontinent. On 8/14/13 at 9:22 AM, an observation of the staff transferring the resident from her wheelchair to her commode, using the sit to stand lift. At 9:50 AM, the resident was stood up with the lift. The CNA (E) wiped the resident's rectal area and then the resident's brief and pants were pulled up. No peri-care was done to the resident's front perineum or groin area. There was a large amount of dark amber colored urine in the commode. The same gloves were used for the peri-care, dressing, and transferring the resident to bed.	F 441	D. Compliance rounds will be performed by DON or designee to assure proper cleaning of glucose monitor between residents, pericares and hand hygiene. These compliance rounds will be performed 3x/week for 2 weeks, then 1x/week for 1 month, then monthly. The pharmacist or designee will conduct audits of medication administration weekly x3 weeks, then monthly. The results of these audits will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	09/20/13
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		

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F 514	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that the residents' medical records were accurate and complete for 4 of 10 sampled residents (#4, #10, #6 and #5) and one supplemental resident #11. The findings included: 1. Review of the residents' medical records had inaccurate and incomplete documentation for the following: 1) resident needing diabetic management and the administration of sliding scale insulin and 2) resident having significant change in condition which required assessments and monitoring. The clinical record failed to contain sufficient information of the resident's assessments and follow up to ensure care was provided timely. (Cross refer to F309) 2. Review of residents MARs (medication administration record) contained and order which included: 1) "Tylenol (Acetaminophen) po each shift, Document amount given not to exceed 4000 mg/24 hours. 6A and 6P". There was not a specific dose identified with each entry. 2) "Tylenol 325 mg 2 tablets Po PRN Pain". a. Residents #6 and #5 MAR both had the above order noted on their MARS. b. Interview with Nurse (J) reported "Tylenol (Acetaminophen) po each shift, Document amount given not to exceed 4000 mg/24 hours. 6A and 6P" was not actually a medication order but a tracking method used for tracking total	F 514	The facility will ensure that the residents' medical record are accurate and complete. This will be accomplished by: A. Orders on MARs for resident #6 and #5, requesting documentation of amount of Tylenol given each shift, have been removed beginning on the month of September 2013. Resident #11 MAR written description clarified regarding the appropriate insulin dose times. 09/01/13 B. Orders on MARs for all residents, tracking the amount of Tylenol given each shift, have been removed beginning September 2013 to reduce the chance of confusion. All residents with Insulin orders have been reviewed. No further issues needing clarification have been identified. 09/01/13	

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F 514	Continued From page 38 amount to Tylenol given per shift. c. Review of the July and August, 2013 MARs for resident #3 evidenced the following Tylenol (acetaminophen) or combination Tylenol medication orders: 3/8/2011 Tylenol 325 mg 2 tablets PO TID (5:00 AM, 11:00 AM, and 5:00 PM) 5/1/2009 Tylenol PO Each shift Document amount given not to exceed 4000 mg/24 hours Lortab (Hydrocodone and acetaminophen) 5-500 mg 1 tablet PO PRN Pain. During the interview with nurse (J), she revealed that the total amount of acetaminophen was documented for this resident. When the documentation on this resident's August MAR was reviewed with nurse, she verified that the amount of Tylenol in the Lortab was not included in the daily totals. The tracking was inaccurate and confusing. 3. Review of the insulin documentation on the August MAR for resident #11 evidenced the following: 6/24/13 Novolog give one unit for every 15 Grams of carbohydrate eaten meals and snacks. (times on MAR 11:30 AM and 5:30 PM) 6/24/13 Novolog give one unit for every 10 Grams of carbohydrate eaten meals and snacks. (time on MAR 7:30 AM). Review of the resident's physician orders and Nurse/Physician Communication forms failed to clarify the 15 or 10 grams for which meals.	F 514	C. Inservices with be conducted with nurses, MDS coordinator and DON regarding the removal of the confusion Tylenol totaling documentation; the information will also focus on the importance of identifying and clarifying orders so they are easily understandable on the MARs. D. The pharmacist or designee will perform audits 1x/week for 2 weeks, then monthly to ensure orders are understandable and clear. The results of these audits will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	09/20/13 09/20/13

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F 514	Continued From page 39 On 8/15/13 in the afternoon, an interview with the Director of Nursing (DON) and nurse (A) revealed that the one unit for 10 grams was for the breakfast meal. A signed communication form which was dated 6/24/13 was found for this. No order or clarification was found that the 15 grams only applied at lunch and dinner. This was verified by the DON and nurse (J). The MAR was inaccurate and confusing.	F 514		