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Revised POC accepted 1/20/14 Leslie Brown RN

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

PRINTED: 02/05/2014
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
	535032	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

(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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CAA: Care Area Assessment CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		2/1/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

B Williams | Executive Director | 2/6/14

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

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a care plan was developed to meet the resident's needs for 2 of 22 sample residents (#5, #17). The findings were: 1. Review of the medical record for resident #5 showed s/he had diagnoses that included dementia. Review of the resident's care plan revealed the following concerns: a. The 8/15/12 behavior care plan showed the resident had dementia and cognitive deficits which might affect his/her behaviors. The care plan showed the resident could be resistive to cares and combative at times. The undated interventions included "try to follow the schedule [the resident] had at home as much as possible." However, the home schedule was not defined and there was nothing developed to show what routines might decrease the resident's behaviors. b. The 8/27/12 ADLs functional care plan showed the resident had decreased functional mobility and self-care deficits. An intervention was added to the care plan on 12/17/13 for a mechanical lift to be used for transfers "when appropriate." Interview with LPN #1 on 12/18/13 at 10:40 AM revealed she had added the intervention to the care plan based on an order from therapy. However, review of the care plan showed no parameters as to when the use of a mechanical lift was appropriate. The LPN verified based on the undefined/undeveloped care plan intervention the CNAs providing care would have to determine when the use of the mechanical lift would be appropriate; which was outside of their	F 279	F279 Develop Comprehensive Care Plans The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's highest practicable physical, mental, and psychosocial well-being. A) The Director of Nursing will ensure that a comprehensive care plan is developed for resident #5 to reflect routines that may decrease behaviors and the use of a mechanical lift. A comprehensive care plan will be developed for resident #17 to ensure approaches are present for hip fracture and treatment. B) The Director of Nursing or designee will conduct random audits of other residents' care plans to ensure that comprehensive care plans are developed for routines to decrease behaviors, use of a mechanical lift, and hip fracture with treatment. C) The Director of Nursing will conduct an in-service on or before 02/01/14 with nursing staff that review and revise care plans ensuring they are developed and completed appropriately. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate	

LB 1/20/14

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F 279	Continued From page 2 scope of practice. 2. Review of the rehabilitation service post-fall screening tool dated 8/28/13 showed resident #17 fell in his/her room after sliding out of the bed. According to the 9/14/13 history and physical the resident had an X-ray on 9/3/13 that showed s/he had sustained a left hip fracture. Further, the document showed there were no recommended treatments. Review of the 10/18/13 post-fall screening tool showed the resident "remained" non-weight bearing due to a hip fracture and was a 2 person transfer with the use of a slide board. Review of the 10/23/13 physician orders showed the resident was to continue non-weight bearing "due to fracture." Review of the undated care plan did not show the resident had sustained a hip fracture. Further it did not include the resident's weight-bearing status or that s/he used a slide board for transfers. An interview with the administrator on 12/19/13 at 12:30 PM revealed he would expect the resident's hip fracture and restrictions to be included on the care plan.	F 279	education and/or corrective action will take place. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide services in accordance with the resident's plan of care for 4 of 21 sample residents (#12, #51, #97,	F 282	F282 Services by qualified Person/Per Care Plan The services provided or arranged by the facility must be provided by Qualified	2/1/14

fb 1/20/14

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F 282	Continued From page 3 #104). The findings were: 1. Review of the medical record for resident #97 showed s/he was most recently admitted to the facility on 9/2/13 with diagnoses that included heart failure, dysphagia and history of hip fracture. Review of the resident's care plan for "Risk of Pressure Ulcers" with an onset date of 4/23/13 showed the following approach: "Offer beverages at meals, at hydration times, and provide adequate fluids at bedside within reach. The following concerns were identified: a. Observation of the resident's room on 12/16/13 at 2:33 PM revealed the resident was asleep in bed. No fluids were observed at the bedside, or anywhere in the room. A sign on the wall above the bed read, "Nectar Thick Liquids." Subsequent observations on 12/18/13 at 4:15 PM, and 12/19/13 at 8:45 AM and 11:40 AM revealed no fluids were available at the bedside, or anywhere in the room, and an empty waterpitcher was next to the sink. b. Interview with RN #1 on 12/19/13 at 11:50 AM confirmed fluids were supposed to be available to the resident at the bedside. 2. Review of the medical record for resident #104 showed s/he was admitted to the facility on 10/7/11 and had a current diagnosis of non-Alzheimer's dementia. Review of the resident's 10/1/13 annual MDS assessment showed the resident was frequently incontinent of bladder, wore incontinence products for dignity and protection, and required extensive assistance with toileting. Review of the resident's care plan for incontinence, with an onset date of 10/21/11 revealed interventions included "Frequently remind and encourage to call for assistance with toileting" and "Toilet upon rising, before and after	F 282	persons in accordance with each resident's written plan of care. A) The director of Nursing or designee will ensure that the incontinence care plan for resident #104 is updated and followed, the incontinence care plan for resident #12 is updated and followed, and the ADL care plan for resident #51 is followed as directed. Resident #97 has been discharged from the facility. B) The Director of Nursing or designee will conduct random audits of other residents' care plans to ensure that care plans for patients with nectar thick liquids, incontinence, and application of splints are being followed appropriately. C) The Director of Nursing will conduct an in-service on or before 2/1/14 with nursing staff ensuring care plans are followed appropriately. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 282	Continued From page 4 meals, at hs [bedtime] and as needed." The following concerns were identified: a. Observation on 12/18/13 at 4:30 PM revealed the resident was asleep in bed. At 4:35 PM the resident was awakened for dinner by CNA #4. The CNA asked the resident at that time, "Can I change your brief?" No offer was made to take the resident to the toilet. The CNA noted at that time the resident was "soaked" and had previously been checked when the CNA began her shift at 2 PM (2 1/2 hours earlier), at which time the resident's brief was dry. Interview with the CNA at that time revealed the resident was rarely taken to the toilet, as s/he was "difficult to get to cooperate." b. Interview with RN #1 on 12/19/13 at 11:50 AM confirmed the resident was supposed to be toileted as specified by his/her care plan. 3. Review of the 10/28/13 significant change MDS and CAA summary for resident #12 showed the resident was frequently incontinent of bladder, wore a disposable brief for dignity and protection, and required extensive assistance with toileting needs. Review of the 10/28/13 care plan interventions showed staff were directed to provide toileting assistance every morning, before and after meals, at bedtime, and when needed. Observation on 12/17/13 at 8:20 AM revealed CNA #1 wheeled the resident from the dining room to his/her room and transferred him/her to bed. At that time the CNA did not check or change the resident's disposable brief or provide toileting assistance. Continued observation of the resident from 8:20 AM until 11 AM (2 hours 40 minutes) revealed staff did not provide toileting assistance or incontinence care. At 11 AM CNA #5 was observed providing urinary incontinence care for the resident. At that time the CNA	F 282		

SB 1/20/14

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F 282	Continued From page 5 confirmed the resident had not received toileting assistance or incontinence care after breakfast and his/her incontinence brief was wet. 4. Review of the 1/1/13 care plan for resident #51 showed s/he was to wear bilateral knee splints when in bed to decrease the risk of pressure ulcers. Observation on 12/16/13 at 3:15 PM showed the resident was in bed sleeping. At 3:55 PM CNA #3 assisted the resident with getting up. At that time it was noted the resident was not wearing the splints. Observation of a posted instruction above the resident's bed showed a photograph of the splint and instructed the device be worn while in bed. When asked at that time the CNA verified the splints had not been applied and stated they should be worn as instructed. Interview with the resident at that time revealed s/he was not sure where the splints were; the resident stated "I don't know where it's at, I used to have them."	F 282		
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, staff interview and record review, the facility failed to provide consistent monitoring for 1 of 3 sample residents (#12) who	F 309	F309 Provide Care and Services For Highest Well Being Each resident must receive and the facility	2/1/14

1/20/14

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F 309	Continued From page 6 had non-pressure wounds. The findings were: Review of the 10/28/13 significant change MDS for resident #12 showed the resident had moderate cognitive impairment and required extensive assistance with ADLs. Review of the medical record showed the resident had recurrent episodes of diarrhea; and the antibiotic therapy for this condition was completed on 12/12/13. Review of a physician's order, dated 10/26/13, directed staff to apply Lantaseptic ointment to the resident's coccyx every shift and when needed for local skin infection and subcutaneous tissue. Observation on 12/16/13 at 3:30 PM revealed CNA #2 was providing fecal incontinence care for the resident. Observation of the care revealed the resident's entire buttock and coccyx areas were red and excoriated. Further observation revealed the resident verbalized pain and discomfort when the CNA touched the excoriated areas. The following concerns were identified: a. Interview on 12/17/13 at 11:15 AM with RN #1 revealed staff were to document the condition of the resident's skin on the weekly skin integrity and data collection form and apply Lantaseptic to the resident's excoriated areas every shift and when needed. At that time the RN reviewed the skin integrity form and stated the resident had excoriated areas on his/her buttocks on 11/26/13, but the 12/3/13 and 12/10/13 forms did not show the excoriated areas were present or had resolved. The RN further stated it was difficult to know whether the areas had improved, worsened, or healed based on the monitoring documentation. b. During an interview on 12/18/13 at 6:51 AM CNA #1 stated the excoriated areas had been present since the resident started having diarrhea stools in November 2013. However, review of the	F 309	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. A) The Non-Pressure Skin Condition Record for resident #12 has been updated to reflect current skin condition monitoring. B) The Director of Nursing or designee will conduct random audits of other residents' Non-Pressure Skin Condition records to ensure monitoring is in place and will conduct random skin checks. C) The Director of Nursing or designee will conduct an in-service on or before 2/1/14 with licensed nursing staff on updating and monitoring non-pressure skin issues using the Non-Pressure Skin Condition Record. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been	

RM 1/20/14

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F 309	Continued From page 7 12/17/13 weekly skin integrity form showed staff first documented the open excoriated areas on the resident's buttock and coccyx on 12/17/13 (a day later than the 12/16/13 date when observed by the surveyors and CNA #2.) Review of the medical record showed no evidence staff consistently monitored and treated excoriated areas on the resident's buttocks and coccyx as they should have.	F 309	achieved.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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, staff interview and medical record review, the facility failed to ensure 2 of 20 sample residents (#12, #104) with incontinence received appropriate treatment and services to maintain normal bladder function and to prevent urinary incontinence. The findings were: 1. Review of the 10/28/13 significant change MDS assessment and CAA summary for resident #12 showed the resident was frequently incontinent of bladder, wore a disposable brief for	F 315	F315 No Catheter, Prevent UTI, Restore Bladder Based on the 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 as necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to	2/1/14

RB 1/20/14

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F 315	Continued From page 8 dignity and protection, and required extensive assistance with toileting needs. Review of the corresponding care plan showed staff were directed to provide toileting assistance every morning, before and after meals, at bedtime and when needed. Observation on 12/17/13 at 8:20 AM revealed CNA #1 wheeled the resident from the dining room to his/her room and transferred him/her to bed. At that time the CNA did not check or change the resident's disposable brief or provide toileting assistance. Continued observation of the resident from 8:20 AM until 11 AM revealed staff did not provide toileting assistance or incontinence care for 2 hours and 40 minutes. At 11 AM CNA #5 was observed providing urinary incontinence care for the resident. At that time the CNA confirmed the resident had not received toileting assistance or incontinence care after breakfast as directed in the care plan. 2. Review of the medical record for resident #104 showed s/he was admitted to the facility on 10/7/11 and had a diagnosis of non-Alzheimer's dementia. Review of the resident's 10/1/13 annual MDS assessment showed the resident was frequently incontinent of bladder, wore incontinence products for dignity and protection, and required extensive assistance with toileting. In addition, review of the resident's "Assessment for Bowel and Bladder Training" dated 10/7/13 revealed the resident to be a "Candidate for toileting, timed or scheduled voiding." Finally, review of the resident's care plan for incontinence, with an onset date of 10/21/11 revealed interventions included "Frequently remind and encourage to call for assistance with toileting" and "Toilet upon rising, before and after meals, at hs [bedtime] and as needed." The	F 315	restore as much normal bladder function as possible. A) The Director of Nursing or designee will ensure that residents #12 and #104 are reassessed for toileting programs using the Assessment for Bowel and Bladder Training and that the care plans are updated and followed appropriately. B) The Director of Nursing or designee will conduct random audits of other residents to ensure that the Assessments for Bowel and Bladder Training match residents care plans are being followed appropriately. C) The Director of Nursing or designee will conduct an in-service on or before 2/1/14 with licensed nursing staff on the importance of following incontinence care plans. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Social Services Director or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 315	Continued From page 9 following concerns were identified: a. Observation on 12/18/13 at 4:30 PM revealed the resident was asleep in bed. At 4:35 PM the resident was awakened for dinner by CNA #4. The CNA asked the resident at that time, "Can I change your brief?" No offer was made to take the resident to the toilet. The CNA noted at that time the resident was "soaked" and had previously been checked when the CNA began her shift at 2 PM (2 1/2 hours earlier), at which time the resident's brief was dry. Interview with the CNA at that time revealed the resident was rarely taken to the toilet, as s/he was "difficult to get to cooperate." b. Interview with RN #1 on 12/19/13 at 11:50 AM confirmed the resident was supposed to be toileted as specified by his/her care plan.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to maintain a medication error rate under 5 percent (%). Three medication errors were observed out of 25 opportunities for error, which resulted in an error rate of 12%. The findings were: 1. An observation on 12/17/13 at 4:15 PM showed RN #3 gave resident #76 calcium 600 mg (milligrams) with vitamin D 200 units from the stock medications. Review of the admission	F 332	F332 Free of Medication Error Rates of 5% or More The facility must ensure that it is free of medication error rates of five percent or greater. A) Orders for residents #76 and #19 have been clarified by physician for calcium 600 mg with vitamin D 200 units. Order for resident #137 has been clarified to multivitamin with minerals.	2/1/14

1/30/14

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F 332	Continued From page 10 physician orders dated 2/14/13 showed the resident was prescribed "calcium carbonate with vitamin D (500 mg/1250 mg) one tablet daily." 2. An observation on 12/17/13 at 4:05 PM showed RN #3 gave resident #19 calcium 600 mg with vitamin D 200 units from the stock medications. Review of the physician orders dated 11/26/13 showed the resident was prescribed calcium carbonate 600 mg with vitamin D3 400 units one tablet daily. 3. An interview with RN #4 on 12/18/13 at 11:15 AM confirmed the above mentioned medications were not administered as ordered and needed further clarification. 4. An observation on 12/17/13 at 8:20 AM showed RN #5 gave resident #137 one multivitamin with minerals from the stock medications. Review of the physician orders dated 12/16/13 showed the resident was prescribed multivitamin only and did not show s/he was to receive the minerals. An interview with RN #6 on 12/18/13 at 11 AM verified the medication was not given as ordered and needed to be clarified.	F 332	B) The Director of Nursing or designee will conduct random audits of patients receiving calcium with vitamin D and multivitamins with minerals to ensure medications are administered according to the physician order. C) The Director of Nursing or designee will conduct an in-service on or before 2/1/14 with licensed nursing staff on medication administration and the importance of administering medications as ordered by the physician. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	
F 371 SS=E	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	F 371		2/1/14

JB 1/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536032	A. BUILDING _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

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F 371	Continued From page 11 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure food was prepared and served under safe temperature conditions. The findings were: Observation on 12/18/13 at 4:05 PM showed preparation for the evening meal was underway. The menu consisted of several cold items including "cornslaw." Cook #1 was serving meals when it was noticed temperatures for the cold items had not been taken. At that time the surveyor requested the temperatures be taken. At 4:30 PM the dietary manager calibrated a thermometer with ice water and then took the temperature of the "cornslaw." The temperature reading showed 65 degrees Fahrenheit (F). A second temperature reading was taken with a different thermometer and the result was 68 degrees F. The calibrated thermometer was used to measure the temperature of the pureed "cornslaw" and it was found to be 70 degrees F. At 4:45 PM the dietary manager verified these items were not at a safe temperature and an alternate would be served. She further revealed she and the dietary staff working had not prepared the food and were not sure what the ingredients of the slaw included. In addition, there were no temperatures recorded to show what the temperature of the food was when it was first prepared.	F 371	F371 Food Procure, Store/Prepare/Serve-Sanitary The facility a must procure food from sources approved or considered satisfactory by federal, state, or local authorities and store, prepare, distribute and serve food under sanitary conditions. A) The dietary staff provided a substitute for cornslaw during the survey. The four residents that were given cornslaw were placed on alert charting during the survey. B) The Dietary Manager or designee will conduct daily audits of temperatures of cold food prior to being served to patients.. C) The Dietary Manager or designee will conduct an in-service on or before 2/1/14 regarding the importance of temping cold food items. D) A performance Improvement tool will be utilized for random audits. Any problems identifled will result in immediate education and/or corrective action will take place. The audits will be conducted by the Dietary Manager or designee. E) The Dietary Manager or designee will	

JB 1/20/14

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F 371	Continued From page 12 According to Food Code 2013, U.S. Public Health Service: 3-501.16 "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, potentially hazardous food (time/temperature control for safety food) shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5ºC (41ºF) or less."	F 371	report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when 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.	F 431		2/1/14

JB 1/30/14

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F 431	Continued From page 13 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 expired medications were not available for resident administration in 2 of 5 medication carts. The findings were: 1. Observation of the East and West Hall medication carts on 12/18/13 from 4:15 PM to 5:05 PM revealed the following expired medications were in the medication drawers: Zofran 4 mg (expired 9/10/13), Pepcid 20 mg (expired 6/30/13), Promethazine HCL 25 mg (expired 9/30/13), Nifedipine ER 30 mg (expired 11/30/13), Prilosec 20 mg (expired 7/31/13), Metoprolol Succinate 25 mg (expired 11/30/13), Zofran 4mg (expired 10/12/13), and facility stock medication generic antidiarrheal medication (expired 10/2013). 2. Interview with RN#1 and RN #2 on 12/18/13 at 5:50 PM, confirmed the medications were currently being administered to the residents. They revealed a system for ensuring expired medications were not administered from the East and West Hall medication carts had not been	F 431	F431 Drug Records, Label/Store Drugs and Biologicals The facility must employ or obtain the services of a licensed pharmacist who establishes system of records 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. A) The expired medications identified during survey were removed and destroyed during survey. All other nursing carts were audited for expired mediations during survey. B) The Director of Nursing or designee will conduct weekly audits of all nursing carts to ensure expired medications are not being administered to residents. C) The Director of Nursing or designee	

1/30/14

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F 431	Continued From page 14 implemented. The RNs stated the facility did not have a system for checking the medications for expiration dates when the medications were delivered from the pharmacy, nor was there a periodic auditing system for checking medication outdates.	F 431	will conduct an in-service on or before 2/1/14 with licensed nursing staff regarding the importance of ensuring expired medications are not available for resident administration. D) A performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take place. the audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	
F 441 SS=D	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	F 441		2/1/14

1/30/14

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F 441	Continued From page 15 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 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, staff interview and review of the facility's policy and procedures, the facility failed to ensure infection control procedures were followed related to the glucometer for 2 of 2 random observations. The findings were: 1. An observation on 12/16/13 at 4:35 PM showed RN #7 took the glucometer (blood sugar monitor) and its storage case to resident room #95. The RN placed the case directly on the bedside table without a barrier. After the RN had completed the test, she placed the case directly on the medication cart and wiped the glucometer with a sani-cloth with bleach and placed it directly	F 441	F441 Infection Control, Prevent Spread, Linens The facility must establish and maintain an infection control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. A) Glucometers from each nursing cart were cleaned with a sani-cloth with a 1:10 bleach dilution. Nurses identified with deficient practice during survey were immediately educated.	

1/30/14

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F 441	Continued From page 16 into the bag without first allowing it to dry. The RN then placed the contaminated case into the medication cart. 2. An observation on 12/17/13 at 4:10 PM showed RN #3 completed a fingerstick for glucose monitoring for resident #113 using a glucometer. After the RN completed the test, she placed the glucometer in her uniform pocket then placed it in the medication cart without first cleaning the instrument. An interview with the RN immediately following the observation revealed she needed to clean the glucometer before placing it into the medication cart. 3. Review of the policy and procedure entitled; Cleaning and Disinfecting of the Glucometer, dated 3/10 showed a barrier was to be placed on the table surface. The glucometer was to be placed on the barrier. 4. Review of the product information used by the facility for disinfecting equipment located at www.pdipdi.com (accesses on 12/24/13) showed the sani-cloth with a 1:10 bleach dilution is an effective disinfectant against microorganisms to include bloodborne pathogens, viruses and multiple drug resistant organisms. However, the product required a 4 minute contact time to be an effective disinfectant.	F 441	B) The Infection Control Nurse or designee will conduct random audits on nurses' use of glucometers to ensure they are cleaned appropriately. C) The Infection Control Nurse or designee will conduct an in service on or before 2/1/14 on the importance of properly cleaning and storing glucometers. D) A Performance Improvement tool will be utilized for random audits. Any problems identified will result in immediate education and/or corrective action will take action. The audits will be conducted by the Infection Control Nurse or designee. E) The Infection Control Nurse or designee will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems/trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

LB 1/20/14