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

PRINTED: 02/12/2010
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
	535025	A. BUILDING _____ B. WING _____	C 01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it F225 It is the practice of the facility to ensure that all alleged violations are thoroughly investigated, and prevent further potential abuse while the investigation is in progress. **Corrective Action:** Altercation between Resident #42 and Resident #30 investigation was completed on _1/18/10_. Altercation between Resident #43 and Resident #62 investigation was completed on 1/16/09. 11/5/09 = incident date * **Identification of Others:** NHA will review abuse investigations for last 30 days by 3/1/10 to ensure interviews are present and complete. **Systems/Measures:** 1. RCD/Designee to complete abuse reporting and investigations in-service with IDT members on 2/9/10.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Reaume — TITLE: NHA — (X6) DATE: 2-22-10

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.

RECEIVED Wyoming Dept of Health FEB 22 2010 Office of Healthcare Licensing and Surveys

Accept 3/4/10 Per phone Conversation with Jennifer Reaume, NHA @ 4:05 PM w/agreed changes on 3/4/10

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3/1/10

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F 225	Continued From page 1 by: Based on review of facility investigations, staff interview, and review of policy and procedures, the facility failed to ensure 2 of 3 allegations of abuse were thoroughly investigated. The findings were: 1. Review of an investigation dated 1/18/10 revealed an alleged physical abuse incident between two residents (#42, #30). The investigation notes showed the incident happened during an activity, and was reported and witnessed by the activity coordinator. Further review showed the investigation lacked an interview or statement by the activity coordinator. Interview with the social worker on 1/27/10 at 10:35 AM revealed she had been ill that week, and when she got to this investigation she was rushed to meet the reporting timeline and failed to interview the witness. 2. Review of an investigation dated 11/5/09 ✓ showed two residents (#43, #62) were involved in an allegation of physical abuse. The investigation notes referred to interviews done with a floor nurse and a certified nurses aide that witnessed the incident. Further review showed there were no details of these interviews. Interview with the nursing home administrator on 1/28/10 at 12:12 PM revealed she was unable to find any details about these interviews in the investigation file. Review of the facility policy and procedure related to abuse and neglect prohibition revised March 2009 did not include details of who or how the investigations would be conducted; however, the policy showed, "The facility will conduct an investigation of any alleged abuse/neglect or misappropriation of resident property in	F 225	2. Re-education by ~~NHA/Designee~~ completed for all staff on reporting abuse completed by 1/27/10. 3. RCD/Designee to review all abuse investigations for completeness monthly. 4. Abuse investigations will be logged on the abuse log as they occur by the NHA/Designee. 5. NHA/Designee will complete interview statements in writing for all abuse allegations. Monitoring: **The NHA/Designee will track and trend the results of abuse log/review and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.** Compliance Date 3/2/10	

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F 225	Continued From page 2 accordance with state law."	F 225	1. F241 It is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Corrective Action:** 1. C.NA was provided with 1:1 education on proper discussion of personal resident information in a private manner on 2/17/10 by the SDC/Designee. **Identification of Others:** 1. DON/Designee to complete 5 observations of staff discussions of residents to ensure personal information is provided in a private area. Any issues will be addressed by providing 1:1 re-education. **Systems/Measures:** 1. All staff will be re-educated by SDC/designee on 2/17/10 on providing personal information of residents to other staff members caring for resident in a private area. 2. Ambassadors to complete visual observations daily on staff	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and staff and resident interview, the facility failed to ensure staff supported the dignity of 1 of 1 sample resident(#68). A staff member discussed the resident's bowel incontinence in front of the resident in a disrespectful manner. The findings were: 1. Review of the 7/17/09 significant change and the 10/16/09 and 1/8/10 quarterly Minimum Data Set (MDS) assessments for resident #68 showed s/he was incontinent of bowel and required extensive assistance for all personal care. Observation on 1/25/10 at 3 PM showed certified nurse aide (CNA) #1 provided perineal care for the resident who had been incontinent of bowel. During care, the CNA said "this is the second time today ....[the resident] has greeted me with a BM [bowel movement]..." A second observation of perineal care on 1/26/10 at 9:22 AM revealed the same CNA stated "ooh [the resident] is oozing BM again, a big one is coming...the same thing happened to me yesterday seven times. [The resident] has welcomed me back to this end of the hall two days now." During an interview with this CNA on 1/25/10 at 10:45 AM, she said the resident understands everything but does not speak. The reasonable person would not believe	F 241		

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F 241	Continued From page 3 the statements made by the CNA maintained the resident's dignity. In addition, an interview on 1/27/10 at 11 AM with the director of nursing and corporate nurse consultant revealed the statements made by the CNA were unacceptable and did not maintain the resident's dignity.	F 241	Interactions with resident/families, Ect. To ensure they are speaking with dignity and respect. 3.Random weekly observations will be completed by the DON/designee to ensure staff is reporting personal information about residents in a private area. **Monitoring:** **The NHA/Designee will track and trend the results of visual audits and observations and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.** 5. **Compliance Date** 3/2/10	
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to ensure the mirror above the bathroom sink was accessible for 2 of 2 sample residents (#79, #82) who were each observed in the bathroom in front of their sink. The findings were: 1. Observation on 1/26/10 at 7:21 AM revealed certified nurse aide(CNA) #3 assisted resident #82 into the resident's bathroom in the wheelchair. The resident was positioned in front of the sink. The resident was unable to see himself/herself in the mirror that was located above the sink while seated in the wheelchair. The resident then partially stood up, using the sink for support, and brushed his/her teeth and combed his/her hair. During an interview on 1/26/10 at 2:05 PM, the resident stated he/she liked to use the mirror, but was unable to use it when seated in the wheelchair.	~~F 246~~	F246 It is the intent of the facility to ensure residents have the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. **Corrective Action:** A bid was obtain for mirrors to accommodate residents at wheel chair height. A Capital Expense requests was submitted mirrors will be installed when request is approved and mirrors purchased.	

Per Phone Call W/ NHA 3/4/10 4:03pm

will provide hand held mirrors that would need them. Until mirrors can be installed

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F 246	Continued From page 4 2. Observation on 1/26/10 at 7:32 AM revealed CNA #3 positioned resident #79, who was seated in a wheelchair, in front of the sink in the resident's room. The resident washed his/her hands and brushed his/her teeth, and the CNA combed the resident's hair. Only the top of the residents's head was visible in the mirror, located above the sink. 3. During general observations of the facility on 1/28/10, a sample of resident bathroom mirrors were measured and showed the height from the floor to the sink top ranged from 50.5 inches to 51.25 inches. The height from the sink to the bottom of the mirrors ranged from 17.25 inches to 18 inches. Interview with the maintenance director on 1/28/10 at 10:05 AM, revealed residents could receive a lower bathroom mirror upon request; however, lowered mirrors might not be positioned above the sink.	F 246	F246 **Identification of Others:** All resident rooms were identified as needing mirrors installed at wheelchair heights. **System/Measures:** Maintenance/ or designee to ensure rooms have mirrors available for wheelchair heights. Ambassadors are to audit for mirrors during their visits. Monitoring: **The NHA/Designee will track and trend the results of visual audits and observations and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.** 5. **Compliance Date**	3/2/10
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident, family and staff interviews, the facility failed to design an activities program to meet the needs and interests of 1 non-sample resident (#30) and 4 of 17 sample residents (#44, #68, #81, #86). In addition, the facility failed to ensure that one-to-one activities met the needs	~~F 248~~		

JR 3/4/10

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F 248	Continued From page 5 for 8 of 8 non-sample residents (#16, #17, #23, #26, #40, #41, #63, #96) who received one to one activities. The findings were: 1. Observation during the survey from 1/25/10 through 1/27/10 showed resident #81 did not participate in any group activities. Review of the January 2010 activity participation record confirmed the resident did not participate in group activities from 1/25/10 through 1/27/10. The following concerns were identified: a. Review of the activity assessment and progress note dated 10/30/09 showed the resident was confused and unable to answer questions. There was no evidence staff had attempted to complete the activity assessment at a later date; therefore, the resident's interests were not documented. During an interview on 1/28/10 at 10:30 AM, the activity director confirmed there was no completed activity assessment. b. Review of the care plan dated 10/30/09 for activities showed the approach "invite to group activities of interest." However, the care plan did not specify what activities the resident was interested in. On 1/28/10 at 10:30 AM, the activity director agreed that the care plan had not been individualized with the resident's interests. c. Observation on 1/27/10 at 5:35 PM revealed the resident was alert, sitting in a wheelchair, and working on a jigsaw puzzle with his/her daughter. The daughter stated the resident liked jigsaw puzzles and crossword puzzles. The daughter stated the resident did not attend many group activities and wondered if there was somebody in the facility who could work on puzzles with the resident. Review of the January 2010 activity calendar showed an activity related to "puzzles" was not listed as a group	F 248	**F248** It is the intent of the facility to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. **Corrective Action:** 1. Resident #81 was re-evaluated for activities of choice and care plan was updated on 2/20/10. 2. Resident #30 was re-evaluated for subjects and types of books she was interested in and care plan updated on 2/22/10. 3. Resident #44 activity care plan was updated with individualized activity goals and assessment was updated with activities of choice on 2/22/10. 4. Resident #31 Activity needs were re-evaluated on 2/22/10for activity interests. 5. Resident #68 was re-evaluated for activity interests and care plan updated on 2/22/10. 6. Resident #26, #23, #63, #16, #96, #41, #17, and #40 care plans were updated with measureable goals on 2/26/10. **Identification of Others:** Residents with 1:1 Activities have the potential to be affected.	DOC 3/2/10

#85 moved to #31

and All Residents.

Changes per Jennifer Reaume NHA on 3/3/10 phone call. ~3pm

Res 85 also needed in POC JR

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F 248	Continued From page 6 activity. During an interview on 1/28/10 at 10:30 AM, the activity director stated the resident did not receive one-to-one activities from activity staff. 2. Interview with non sample resident #30 on 1/25/10 at 1:45 PM revealed s/he participated in some of the game activities, and liked to read. The resident then revealed the books available at the facility were not ones s/he was interested in. The resident also stated s/he enjoyed listening to audio books; however, these were not available at the facility. Review of the activities assessment done 7/13/09 showed books on tape were marked as being of no interest to the resident. "Reading" was noted as a current interest for the resident; however, the types of books or subject matter this resident was interested in was not included in the assessment. Review of the resident's care plan dated 10/8/09 revealed a goal for the resident was for the resident to participate in a social activity three to five times per week. The plan lacked any personalized approaches. On 1/28/10 at 10:30 AM, the activity director stated care plans were not individualized according to the specific resident interests. She stated she had several templates and selected the one that best fit each resident's needs. 3. Observations during days of survey from 1/25-1/28/10 showed resident #44 was not engaged in activities other than watching television in his/her room, or sitting in the hall in a common area of the facility. Review of the January 2010 activity participation record showed the resident did not participate in any activities during those days except for "talking/conversing/telephone" and "visiting with family or friends." These activities were listed as independent. Interview with the resident on 1/27/10 at 11:05 AM revealed the	F 248	**Systems/Measures:** 1. Re-educate the activity department on proper documentation of activities of choice and goal setting for activities by NHA/designee on 2/24/10 . 2. Care plans/notes will be updated upon admit, quarterly, annually, and with significant changes by Activities. 3. Random audits of notes/care plans will be completed monthly following the RAI process by the NHA/Designee for accurate documentation and proper goals. **Monitoring:** **The NHA/Designee will track and trend the results of audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.**	

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F 248	Continued From page 7 resident was interested in yoga. Review of the activity assessment and care plan dated 12/26/09 did not include this interest. Furthermore, the assessment and care plan did not include any individualized activity goals or plans. On 1/28/10 at 10:30 AM, the activity director stated care plans were not individualized according to resident interests. She stated she had several templates and select of the one that best fit each resident's needs. 4. Review of the activity assessment dated 9/16/09 showed resident #31 had behavioral issues and required encouragement to attend activities. The assessment form had a space for evaluating activity pursuit patterns: current interests, no interests, or past interests in general categories of activities such as games, watching TV, reading, etc. This residents's assessment did not document any individual activity interests, such as the types of books or TV shows the resident enjoyed. The care plan dated 12/15/09 showed the activity goal was for the resident to participate in a social activity four to seven times per week. The plan did not appear to be individualized for this resident. On 1/28/10 at 10:30 AM, the activity director stated care plans were not individualized according to resident interests. She stated she had several templates and selected the one that best fit each resident's needs. 5. Interview with a family member on 1/25/10 at 1:02 PM revealed resident #68 enjoyed music, church services, and games. However, review of the resident's current care plan showed individualized goals or interventions related to activities. In addition, review of the resident's	F 248		

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F 248	Continued From page 8 "Individual Activity Participation Record" for December 2009 and January 2010 showed no assessment of how effective the activity program was in meeting the physical, mental, and psychosocial needs of this resident. Concerns identified related to the one-to-one activities program: On 1/28/10 the activity director provided the surveyor documentation which showed the following residents received one-to-one activity programming: #26, #23, #63, #16, #96, #41, #17, and #40. Review of the care plans for those residents showed the goal "resident will accept 1:1 visits 1-3 times per week." Each resident had the same goal on his/her plan of care. Each plan lacked specific, individualized activity goals for one-to-one visits. Review of the one-to-one activity documentation for January 2010 for those residents also revealed the residents' responses to the activities were not documented. As a result, there lacked evidence the needs of each resident was being met.	~~F 248~] F250	It is the practice of the facility to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. **Corrective Action:** Resident #82 was discharged home on 2/6/10. **Identification of others:** **Two other married couples reside at the facility** **Systems/Measures:** 1. Re-education was provided by the NHA/Designee in regards social services documentation on 3/2/10. 2. Social Services notes will be reviewed randomly by NHA/Designee to ensure adequate documentation if for the provided for special needs/requests. **Monitoring:** **The NHA/Designee will track and trend the results of chart reviews and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.** Compliance Date: 3/2/10	
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and resident interview, the facility failed to provide social services to meet the psychosocial needs of 1 of 17 sample residents (#82). The findings	F 250		

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F 250	Continued From page 9 were: During an interview on 1/26/10 at 2:05 PM, resident #82 mentioned that s/he was upset because s/he could not share a room with his/her spouse, who also resided in the facility. The resident was told s/he was not allowed to share a room, but did not understand why. In two subsequent interviews (on 1/26/10 at 3:30 PM and 1/28/10 at 7:36 AM), the resident again expressed that s/he wanted to share a room with his/her spouse. According to the 12/28/09 admission Minimum Data Set (MDS) assessment, the resident had no memory deficits and was able to make decisions. The following concerns were identified: a. Review of social services' documentation showed no specific mention of the sleeping arrangements in the facility, but a note dated 1/4/10 documented the resident had frequent concerns about his/her spouse, who also resided in the facility. b. During an interview on 1/28/10 at 9:55 AM, the social worker stated the power of attorney (POA) for the spouse requested that the couple not share a room, because the one spouse was verbally abusive to the other. When asked if those behaviors had occurred in the facility, the social worker stated "I haven't personally witnessed it." Observation during the survey showed the couple were frequently together in common areas and in the resident's room. During the interview, the social worker stated the couple did not have constant supervision when they were together. When asked why the couple was allowed to be together during the day unsupervised, but not share a room, the social worker stated there were "no perfect answers." c. Medical record review showed no evidence	F 250		

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F 250	Continued From page 10 of social services' interventions, such as a re-evaluation of the room assignments or a family meeting to discuss options. Further, there was no evidence the reason the married couple could not share a room together had been explained to the resident. During the interview on 1/28/10 at 9:55 AM, the social worker stated that she assumed the family had talked to the resident about that. The social worker also stated the resident was admitted for a short-term stay, but if admitted for a longer stay, the facility would have evaluated the couple's sleeping arrangement.			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	~~F 250~~ F280 F 280	It is the practice of the facility to 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. **Corrective Action:** Resident #44 weighted utensils was discontinued and care plan updated on 3/2/10. Resident #82 discharged on 2/6/10 **Identification of others:** IDT completed a care plan audit on current residents to ensure care plans are updated with current individualized interventions by 3/2/10. **Systems/Measures:** The IDT will receive education regarding care planning protocols, specifically the completion of care plans based on assessments, and as indicated by the RAP summary. The education will be provided by the company Regional Care Management Coordinator/Designee on 3/1/10. DON/Designee will complete monthly audits of resident care plans to ensure they are updated quarterly and individualized to meet the residents' needs.	

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F 280	Continued From page 11 Based on observation, staff interview and medical record review, the facility failed to assure the care plan was updated to reflect the current condition for 2 of 17 sample residents (#44, #82). The findings were: a. Observation of resident #44 at the breakfast meal on 1/26/10 at 7:45 AM showed s/he received restorative dining services. At that time, the observation, and interview with the restorative certified nurse aide (CNA) who was assisting the resident, revealed no adaptive equipment was being used. Review of the 1/12/10 restorative plan of care this resident, however, revealed the resident was to have weighted utensils at each meal. Interview with the restorative nurse on 1/26/10 at 10:45 AM revealed the resident refused to use the adaptive equipment, but the resident's care plan had not been revised. b. Refer to F309 for details regarding the facility's failure to update the care plan for resident #82 related to positioning.	F 280	**Monitoring:** The DON or designee will track and trend results of the care plan audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure professional standards of practice were maintained related to following physician orders for 4 of 17 sample residents (#1, #79, #94, #68). The findings were: 1. During an observation on 1/26/10 at 9 AM, a	F 281		

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F 281	Continued From page 12 registered nurse (RN #1) administered an antibiotic, Daptomycin 400 milligrams (mg) intravenously (IV) to resident #1 with an infusion pump set at 100 milliliters (ml) per hour. Medical record review disclosed a 12/22/09 physician's order for Daptomycin 400 mg IV at 200 ml per hour, once every 24 hours. A rate of 200 ml per hour was also documented on the January 2010 medication administration record (MAR). Interview with RN #1 on 1/26/10 at 10 AM, revealed staff followed the rate printed on the label by the pharmacist. The label showed the rate was supposed to be 100 ml per hour. At that point RN#1 telephoned the physician for clarification of the order. A new order was obtained that changed the rate to 100 ml per hour. According to "Legal & Professional Issues" by Wolters, Kluwer, Lippincott, Williams & Wilkins, 2009, page 14, if a nurse is unsure of an order, the nurse should clarify the order with the physician prior to carrying it out. 2. Review of the physician's orders for resident #79 showed that on 10/23/09 the physician ordered Rocephin 1 gram (gm) injection to be given once and Cipro 500 milligrams (mg) twice per day for ten days. However, review of the MAR showed that on 10/23/09 the nurse did not give the Rocephin because the resident was sleeping. According to the MAR, the Rocephin was never given. Further review of the MAR showed the Cipro was only administered for eight days: 10/24/09 through 10/31/09. According to the documentation, the medication was not carried over to the November 2009 MAR. As a result, there was no evidence the resident received the full course of the antibiotic as ordered. During an interview on 1/28/10 at 11:45 AM, the director of nursing (DON) stated she was not sure why the	F 281	F281 It is the practice of the facility to ensure the services provided or arranged by the facility meet professional standards of quality. **Corrective Action:** 1. Resident # 1 IV orders were clarified and transcribed to MAR on 1/26/10. 2. Resident #79 physician was notified of medication omissions for rocephin and cipro on 3/2/10. 3. Resident #94 foley was DC'd on 2/8/10. foley reinserted on 2/11/10 due to urinary retention. 4. Resident #68 had a PROM program started by restorative on 2/2/10. **Identification of Others:** Nursing will complete an audit of physician orders to ensure physician orders were transcribed correctly and in a timely manner by 3/2/10. Any discrepancies will be clarified by the physician and clarification orders written. **Systems/Measures:** 1. SDC/Designee to complete re-education to the licensed nurses on completing 5 rights and transcribing orders correctly and timely2/3/10, 2/17/10.	

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F 281	Continued From page 13 Rocephin was not given. She stated nursing staff should have called the physician to see if he wanted to discontinue the order. The DON also stated the Cipro should have been given for two days in November. 3. Medical record review for resident #94 showed a 1/8/10 physician order to remove the urinary catheter. Review of the daily nursing summary documentation dated from 1/8/10 through 1/22/10, revealed that the resident had the catheter each of those days. Interview with the DON on 1/28/10 at 3 PM, revealed staff failed to follow the physician's order to remove the catheter. 4. Review of the open medical record for resident #68 showed a physician's order was written on 11/28/09 for passive range of motion (PROM) to the legs and arms. Interview with the DON on 1/28/10 at 10:30 AM and the restorative nurse on 1/28/10 at 9:05 AM revealed this resident did not receive the restorative PROM. Reference for findings #2, 3, and 4: Review of the Wyoming Nurse Practice Act of July 2005, pages 3-6, revealed nurses must practice under the direction of a physician.	F 281	2. Daily audits of T.O.s will be completed by Unit Managers/Designee to ensure 5 rights and proper transcription of orders is completed on the MAR/TAR. 3. DON/Designee to randomly check orders for 5 rights and proper transcription of orders to the MAR/TAR weekly X4, then monthly. **Monitoring:** The DON or designee will track and trend results of the 5 rights/T.O. audits, MAR/TAR audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to provide medication to ensure relief from pain and/or failed to ensure comfort with positioning for 3 of 17 sample residents (#1, #29, #82). The findings were: 1. Review of the history and physical dated 12/9/09 showed resident #82 wore a hinged knee brace due to a fracture of the lower left leg. Review of physical therapy notes dated 12/22/09, 12/29/09 and 1/12/10 revealed the resident was most comfortable and had decreased pain if the left leg was positioned on an elevated leg rest while seated in a wheelchair. The following concerns were identified: a. Observation on 1/26/10 at 7:21 AM revealed a certified nurse aide (CNA #3) transferred the resident into the wheelchair, and assisted the resident with activities of daily living (ADLs). The CNA did not put the leg rests on the wheelchair; therefore, the left leg was not elevated. The resident remained without the left leg positioned on an elevating leg rest until 8:10 AM, when a licensed practical nurse (LPN #2) assisted the resident from the dining room to the resident's room in order to put the leg rests on the wheelchair. b. Review of the resident's current care plan, dated 12/14/09, showed positioning of the left leg in the wheelchair was not addressed. During an interview on 1/27/10 at 11:05 AM, the physical therapy assistant (PTA #1) stated the resident preferred to have the left leg elevated when in the wheelchair because it gave the resident the most pain relief. The PTA stated positioning of the left leg in the wheelchair "was not something we	F 309	F309 It is the practice of the facility to ensure each resident receives and the facility provides 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. **Corrective Action:** 1. Resident #82 was discharged 2/6/10 2. Resident #29 percocet was received on 1/12/10 and administered per MD order. 3. Resident #1 has had the duragesic patch in place per MD order since 3/2/10. ? and update @ as of 3/2/10 **Identification of others:** DON/Designee to complete audit of residents MARs/TARs for pain medications that have not been available. All medications not available will be re-ordered from the pharmacy. Residents without foot pedals will be reviewed for need by nursing on 3/2/10 **Systems/Measures:** 1. SDC to complete in-service for licensed nurses regarding procedure for ordering and receiving medications from	

Changes per NHA QR on 3/3/10 phone conversation @ ~ 3pm.

QR 3/4/10

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F 309	Continued From page 15 would care plan," because the resident was cognitive and could communicate preferences to staff. c. During an interview on 1/28/10 at 7:36 AM, the resident stated his/her leg was "more comfortable" when it was elevated on a leg rest. The resident stated staff did not always remember to position the leg on a leg rest. 2. Review of a 12/10/09 pain assessment for resident #29 revealed the resident had pain in the back and legs, which was relieved by taking Percocet. Review of physician's orders showed the resident was to receive Percocet 5/325 milligrams (mg), one to two tablets, every four hours as needed for pain. The following concerns related to this resident's pain management were identified: a. Review of nursing notes dated 1/10/10 and 1/11/10 showed no Percocet was available, so the resident was given Tylenol instead, for pain. According to the MAR, on 1/11/10 the resident was given Tylenol 650 mg for a pain level of "5" (on a scale of 1-10). However, the effectiveness of the medication was not documented. b. During an interview on 1/27/10 at 3:30 PM, the DON and LPN #3 stated the Percocet had not been available for a few days because the pharmacy was waiting for a new prescription from the physician. When asked if the Tylenol controlled the resident's pain, LPN #3 stated it was "OK," but that the resident preferred Percocet. c. During an interview on 1/28/10 at 8:55 AM, the resident verified that the facility had been out of his/her pain medication "for a couple of days." The resident stated Tylenol was "not as effective" as Percocet.	F 309	2. Daily audits of MARs/TARs completed by Unit Managers/Designee to ensure medications are available. 3. DON/Designee to complete random audits of MARs/TARs weekly X4, then monthly for pain medication availability. **Monitoring:** The DON or designee will track and trend results of the MAR/TAR audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	

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F 309	Continued From page 16 3. Medical record review for resident #1 showed diagnoses, which included osteoarthritis, anxiety state, and an infected right knee. The review also showed a 9/1/09 physician's order for transdermal administration of fentanyl (pain medication) at 75 micrograms per hour by patch. Review of the December 2009 MAR showed that on 12/19/09, the fentanyl patch was "not available." No further MAR documentation for fentanyl was noted until 12/22/09, when the medication was withheld for right knee surgery. Interview with the resident on 1/25/10 at 11 AM revealed s/he did not always get ordered medications due to unavailability. The resident further stated that facility staff addressed her pain issues appropriately.	~~F 309~~	**F311** It is the practice of the facility to ensure that a resident is given the appropriate treatment and services to maintain or improve his or her abilities in ADLs do not deteriorate unless the deterioration was unavoidable. **Corrective Action:** Resident #68 was evaluated by nursing and an upper and lower extremity PROM program started on 2/2/10 x2 days a week per POA **Identification of Others:** Residents with decline of ROM have been identified. Those will be reviewed and a program started where appropriate by the restorative department. **Systems/Measures:** 1. RCD/Designee to provide re-education of providing restorative care to residents with the restorative department on 2/9/10 2. Nursing staff will be re-educated on reporting via 24 hour report any changes with resident ROM, restorative needs, etc by SDC on 2/17/10. 3. Restorative department to complete weekly meeting to ensure programs are appropriate and to ensure programs are set up, implemented and followed as required.	
F 311 SS=G	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 1 of 5 sample residents (#68) with a decline in activity of daily living (ADL) abilities received restorative services. This lack of services likely contributed to the resident ' s decline in functional status and resulted in an avoidable decline in the resident ' s physical capability. Findings were: Review of resident #68 ' s medical record revealed an annual Minimum Data Set (MDS) assessment dated 1/16/09 that documented this resident required limited assistance of one person for ambulation in the resident ' s room or in a corridor and extensive assistance with all other activities of daily living (ADLs). Approximately one	F 311		

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F 311	Continued From page 17 year later (1/8/10) the facility completed a quarterly assessment for this resident that showed this resident was unable to walk at all, with any level of assistance during the assessment look back period. This resident also declined from requiring extensive assistance with " locomotion " on or off the unit per the annual MDS assessment to being totally dependent for any locomotion as of the date of the quarterly assessment. Finally, the resident declined from needing extensive assistance with eating according to the previous annual assessment to a current status of being totally dependent on staff for eating at the time of the January 2010 quarterly assessment. Review of the annual 2009 assessment and the quarterly 2010 assessment show no decline in mental capability. The following concerns were noted with regard to the resident ' s decline in ADL status: a. A physician ' s order, dated 11/28/09, revealed the resident was to receive passive range of motion (PROM) for the arms and legs. However, medical record review showed no evidence the resident had been assessed by staff for specific PROM needs, nor was there evidence the resident was receiving or had received PROM services. b. Interview with the director of nursing (DON) and the clinical nurse consultant on 1/28/10 at 11:30 AM revealed the resident received rehabilitation therapy upon admission in 2006, but once the established rehabilitative goals were reached, the resident transitioned to restorative services to maintain the resident ' s abilities for transferring and ambulation. According to this interview, restorative services were discontinued in June and there had been no re-assessment of the resident ' s need for restorative services since then.	F 311	4. DON/Designee to review restorative programs monthly to ensure program is followed. **Monitoring** The DON or designee will track and trend results of the meeting minutes and review of restorative programs and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	

3/4/10

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F 311	Continued From page 18 c. Observation during the survey dates from 1/25/10 through 1/28/10 showed the resident was unable to ambulate and required total staff assistance for ADLs. Interview with the clinical nurse consultant and the DON on 1/28/10 at 11:30 AM also revealed the resident 's range of motion and ADL status had deteriorated since June 2008, and the resident should have been reassessed.	~~F 311~~	F312 It is the practice of the facility to ensure that the residents receive the care and services needed because he/she is unable to do their own ADL care independently. **Corrective Action:** SDC provided re-education to the C.NAs re: providing proper pericare to incontinent residents for resident #68 and Resident #85 on 2/3/10, 2/17/10 **Identification of others:** Residents that are incontinent have the potential to be affected. **System/Measures:** 1.SDC provided re-education to the C.NAs re: providing proper pericare to incontinent residents including using the ~~Wiping~~ Wipe in the prper manner on 2/3/10, 2/17/10. proppee 2.Random weekly audits of pericare will be completed by the SDC/Designee to ensure pericare is completed correctly. 3. All newly hired CNAs will be educated on pericare during general orientation by the SDC/Designee. 4.Unit Managers/Designee will randomly observe pericare of residents on a weekly basis X4, then monthly X2, then quarterly.	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure staff provided adequate perineal care during 3 of 5 observations for 2 sample residents (#68, #85). The findings were: 1. Review of the 10/16/09 and the 1/8/10 quarterly Minimum Data Set (MDS) assessments for resident #68 revealed s/he was incontinent of bowel and was totally dependent upon staff for personal hygiene. The following concerns were identified: a. Observation on 1/25/10 at 3 PM revealed certified nurse aide (CNA) #1 provided perineal care to the resident who was incontinent of bowel. Observation showed the CNA used the same area of a wipe twice, which was soiled with feces, to cleanse the buttocks. With the same soiled wipe, the CNA cleaned a healing pressure sore	F 312		

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F 312	Continued From page 19 on the right hip. b. Observation on 1/26/10 at 9:22 AM showed CNA #1 used the same area of a soiled wipe twice on four occasions while providing perineal care. In addition, observation showed she used the same area of three different wipes twice while cleaning the buttocks and anal area where feces was oozing. 2. Review of the 9/25/09 annual and the 12/18/09 quarterly MDS assessments for resident #85 showed the resident was incontinent of bladder daily, but with some control present and required limited assistance of one staff member for personal hygiene. The following concerns were identified: a. Observation on 1/25/10 at 11:50 AM showed the resident's slacks and disposable brief were soaked with urine. At the time of the observation CNA #3 provided perineal care. The CNA was observed to use the same area of a wipe three times to cleanse the resident's buttocks. In addition, the CNA did not cleanse the anterior perineal area, which had also been in contact with urine due to the saturated condition of his/her brief. Interview with the CNA on 1/25/10 at 12:10 PM revealed she had forgotten to change from a soiled to a clean area of the wipe between cleansing strokes. She also said she was taught to put gloves on prior to providing personal care and to remove them when finished with the care. b. Observation on 1/26/10 at 8:05 AM showed the resident's disposable brief was again saturated with urine. Observation showed CNA #4 provided perineal care, but did not cleanse the anterior groin area which had also been in contact with the urine saturated brief.	F 312	**Monitoring:** The DON or designee will track and trend results of the pericare audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date 3/2/10	
F 314	483.25(c) PRESSURE SORES	F 314		

BR 3/4/10

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F 314 SS=D	Continued From page 20 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff implemented measures to prevent and treat skin breakdown for 2 of 4 sample residents (#68, #79) who had or were at risk for skin breakdown. The findings were: 1. Review of the 10/2/09 Braden Scale (skin assessment tool) for resident #68 showed s/he was at high risk for skin breakdown. Review of skin assessment records showed the resident had a pressure sore on the right hip, which had developed on 12/9/09. The following concerns were identified: a. Observation on 1/25/10 at 3 PM showed the pressure sore remained reddened, but was no longer open. Review of the 12/14/09 care plan revealed the resident's bed was to have a pressure relieving surface. Observation on 1/25/10 at 10:45 AM showed the resident had a MedaSTAT low air loss mattress on the bed. Review of the manufacturers's instructions revealed the following instructions for use: "This device incorporates a waterproof cover that is moisture vapor permeable; therefore it is	F 314	**F314** It is the practice of the facility, based on comprehensive assessment of a resident, to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores form developing. **Corrective Action:** 1. Resident #68 draw sheet was removed on 1/27/10. 2. Resident #79 sacrum has been healed since 2/10/10. **Identification of others:** Residents deemed high risk for skin breakdown were identified and excess linens were removed from the beds. Residents treatments will be observed to ensure treatment ordered by the doctor is being followed by nursing. **System/Measures:** 1. SDC/Designee completed an in-service for nursing and resident ambassadors re: who is high risk and what linens can be on resident beds on 2/17/10,3/2/10.	

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3/1/10

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F 314	Continued From page 21 recommended to limit bed linens to one sheet in order to maximize the system's performance...Only "breathable" incontinent pads are recommended for use with this device." Observation on 1/25/10 at 3 PM and again on 1/26/10 at 9:22 AM showed there was a sheet folded in half, producing two layers of linen, and a disposable pad creating three layers between the resident and the mattress designed for pressure reduction. Interview with the DON on 1/27/10 at 10:30 AM revealed she was aware only one layer of linen was to be used with this type of mattress and staff were so instructed. b. Observation on 1/25/10 at 3 PM revealed a certified nurse aide (CNA #1) provided perineal care for the resident who had been incontinent of bowel. Observation showed the wipe was soiled with feces, and the CNA used the same soiled area of the wipe twice to cleanse the resident's buttocks. to cleanse the buttocks. Finally, with the same soiled wipe, the CNA was observed to clean a healing pressure sore on the resident's right hip. 2. Review of pressure ulcer documentation in the medical record dated 1/22/10 showed resident #79 had a stage 2 pressure sore on the coccyx/left buttock, which was initially identified on 12/30/09. Review of a physician order dated 12/31/09 revealed staff were to cleanse the sacral area with wound cleanser, apply skin preparation around open area on left buttock and cover the wound with hydrocolloid every four days and as needed. The following concerns were identified: a. During an observation of resident #79 on 1/26/10 at 3:10 PM, licensed practical nurse (LPN) #4 used a wound cleanser and four by four gauze pads to clean a sacral wound. The area	F 314	2. SDC/Designee completed an in-service for licensed nurses on following MD orders for treatments. If treatment not available contact the MD for temporary orders until supplies available. Nurses to place supplies needed on 24 hour report. Central supply to order supplies needed weekly. 3. Unit Manager/Designee to randomly observe residents that are high risk for skin breakdown weekly to ensure linens are used properly on beds to prevent skin breakdown. 4. Ambassadors will observe resident beds daily to ensure linens are used appropriately on high-risk residents for skin breakdown. 5. Braden scales to be completed by nursing following the RAI process to identify new at risk residents for skin breakdown. 6. DON/Designee to observe skin treatments weekly X4, then monthly X2, then quarterly to ensure treatment is appropriate per MD order.	

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F 314	Continued From page 22 appeared clean and without drainage. The wound was approximately 0.5 cm in width and length, and was superficial in depth, and had a smaller, darkened area in the center. The LPN applied optifoam dressing to the wound, instead of the hydrocolloid dressing as ordered. During an interview with the LPN immediately afterward, she stated the facility was out of hydrocolloidal dressings. b. During an interview on 1/28/10 at 11:45 AM, the DON stated if a dressing wasn't available, nursing staff was supposed to let her know, so she could contact the physician to get new orders. She stated she was unaware hydrocolloid dressings were not available. Hydrocolloid dressings have specific characteristics and functions, according to Smith, Duell, & Martin: 2007 Clinical Nursing Skills (7th Edition), Prentice-Hall, Inc., hydrocolloid dressings contain "hydroactive particles that absorb exudate to form a hydrated gel over wound. When dressing removed, gel separates from dressing, which protects newly formed tissue."	F 314	**Monitoring:** The DON or designee will track and trend results of the ambassador rounds and observations and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315	F315 It is the practice of the facility to ensure that 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. **Corrective Action:** C.NAs were re-educated by the SDC on regarding providing proper catheter care for Resident #68 on 3/2/10.	

SB 3/4/10

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F 315	Continued From page 23 by: Based on observation, staff interview, medical record and policy review, the facility failed to ensure staff provided adequate catheter care for 1 (#68) of 5 sample residents who had indwelling urinary catheters. The findings were: Review of the 7/17/09 significant change assessment and the 10/16/09 and 1/8/10 quarterly Minimum Data Set (MDS) assessments for resident #68 showed s/he had an indwelling urinary catheter. The following concerns were identified: a. Observation of perineal care on 1/26/10 at 9:22 AM showed a certified nurse aide (CNA #1) used the same wipe that had been used to clean the resident's anterior perineal area to cleanse the resident's catheter tubing. The same area of this wipe was used four separate times, and the CNA used back and forth strokes while cleaning the catheter tubing. Review of the facility's policy on indwelling catheter care, revised 7/03, page 2, showed the following instructions: "To avoid contaminating the urinary tract, always clean by wiping away from--never toward--the urinary meatus." b. The same CNA did not cleanse the opening of the catheter bag after she emptied it. During an interview on 1/27/10 at 2 PM, the infection control coordinator said the opening spout of a catheter bag should be cleaned with soap and water each time it is opened in order to prevent introduction of germs. The infection control coordinator also said wipes were not to be used more than once in the same area, especially soiled wipes.	F 315	**Identification of others:** need doc Residents with Foleys have the potential to be affected. **Systems/Measures:** 1. SDC provided re-education for the C.NAs re: performing proper Foley catheter care and cleaning the drainage tip on 2/3/10, 2/17/10. Wipes should only be used once and wiped away from the meatus. 2. SDC to complete weekly random observations of Foley care provided to residents by the C.NAs. 3. Unit Managers/Designee to complete weekly random observations of Foley care provided to residents by the C.NAs. 3/2/10 **Monitoring:** The DON or designee will track and trend results of the Foley catheter care observations and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.	
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident	F 323		

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F 323	Continued From page 24 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure hazardous chemicals were secured. In addition, the facility failed to safely transport one non-sample resident (#48) in a wheelchair. The findings were: 1. Observation on 1/25/10 at 8:45 AM showed the following wound care items were on the top of a dresser in resident room #12: Iodine Prep, Betasept, Antifungal powder, Argleas powder, one tube of skin repair cream, one tube of calizine lotion, one soiled washcloth, and a pair of gloves turned inside out. The items were placed in a plastic wash basin and were accessible to any resident who might enter the room. Interview with the director of nursing (DON) on 1/27/10 at 10:30 AM revealed wound care supplies should have been stored in the treatment cart for safety purposes, instead of being stored in plain sight in a resident's room. Observation on 1/27/10 at 1:30 PM (two days later) showed the wound care items remained accessible on the top of the dresser. 2. Medical record review for resident #48 revealed that according to the 12/18/09 quarterly Minimum Data Set assessment the resident required extensive assistance with transfers and supervision for locomotion. During an observation	F 323	F323 It is the practice of the facility to 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. **Corrective Action:** Room #12 treatment supplies were removed from the bedside and discarded on 1/29/10. Resident #48 has been evaluated for foot pedals on 3/2/10. A skin assessment of the feet was completed on 3/2/10. No skin breakdown noted. **Identification of Others:** Residents without foot pedals will be reviewed for need for foot pedals by Nursing on 3/2/10. Resident rooms were inspected by ambassadors on 2/1/10 for improper items left at bedside. All items were removed. **System/Measures:** 1. SDC provided re-education for all staff on removing items that are deemed unsafe to the residents and placing foot pedals on resident wheelchairs where needed on 2/17/10.	

Change per NHA 3/3/10 phone call

8F 3/4/10

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F 323	Continued From page 25 on 1/26/10 at 8:20 AM, the resident was transported by wheelchair from the north nurse's station dining room by a certified nurse aide (CNA #5.) The observation revealed there was no foot support on the wheelchair, and the resident's feet were sliding and bouncing against the floor. The resident was wearing socks without shoes. The floor had a metal division strip, and when wheeled across the strip, the resident's heels bounced noticeably against the floor. The resident did not raise his/her feet and was not instructed or assisted to do so. Interview with the CNA on 1/26/10 at 8:35 AM revealed she was not unaware the resident's feet were sliding and bouncing on the floor during transport.	F 323	2. Ambassadors to complete observations for unsafe items at bedside daily. Items identified will be removed and staff re-educated as needed. 3. Unit managers/Designee to complete observations of resident rooms for unsafe items at bedside daily. Items identified will be removed and staff re-educated as needed. **Monitoring:** The DON or designee will track and trend results of the Foley catheter care observations and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Compliance Date : 3/2/10	
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	~~F 425~~		

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F 425	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure medications were available for administration in a timely manner for 4 (#1, 29, #85, #101) of 20 sample residents. The findings were: 1. Review of the January 2010 physician's orders recapitulation for resident #86 showed an 8/21/08 order for Aricept (used to manage in dementia) daily at bedtime. Further review showed a 9/25/09 order for Zyprexa Zydis daily (for psychosis). Review of the October 2009 medication administration record (MAR) showed Zyprexa Zydis was unavailable for administration on 10/2, 10/5, 10/6, 10/7, 10/9, 10/14, and 10/29. In addition, Aricept was out of stock on 10/8 and 10/26. 2. Review of the September 2009 physician's orders for resident #101 showed a 6/12/09 order for Metformin (for diabetes) twice daily and a 6/13/09 order for Methadone (for pain) three times per day. Review of the July 2009, August 2009, and September 2009 MARs revealed the Methadone was not available for administration on 7/6, 7/19, 8/7, 8/12, 8/27, 8/31, 9/11, 9/12 and 9/18. Review of the same MARs showed the resident did not receive the Metformin on 7/4, 7/30, 7/31, 8/8, 8/14, 8/18, 8/20, 8/31, 9/9 and 9/11. 3. Refer to F309 for details regarding the facility's failure to ensure Percocet was available for resident #29. 4. Refer to F 309 for details regarding failure of the facility to make physician ordered medication	F 425	F425 **Corrective Action:** 1. Resident #85 Aricept and Zydis medications have been administered per MD order ~~since 2/24/10~~. 3/1/10 2. Resident #101 Discharge on 5/20/09 3. Resident #29 has been receiving her percocet since 1/12/10. (Refer to F309). 3/1 4. Resident #1 has the duragesic patch in place per physician orders ~~since 3/2/10~~. 3/1 **Identification of Others:** Nursing to complete an audit of the MARs/TARs to ensure medication is available. Any medications identified as not available will be re-ordered from the pharmacy. **Systems/Measures:** 1. Nurses will be re-educated by the SDC/Designee in re: to procedure for ordering medications, if medication not available the licensed nurse needs to contact the primary care physician for further orders on 2/17/10. 2. Audits of MARs/TARs completed by Unit Managers/Designee to ensure medications are available.	

Changes per NHA phone call 3/3/10

3/4/10

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F 425	Continued From page 27 available for resident #1. Interview with the director of nursing (DON) on 1/28/10 at 10:30 AM revealed she was aware medications were unavailable periodically. She stated there were sometimes problems between the pharmacy and the facility as far as medication orders and delivery were concerned. She said the process for refill of medications was for the nurse passing medications to send a facsimile (fax) for the specific medication to the pharmacy when the supply reached seven. The pharmacy was then to deliver the medications after 10 PM the evening the fax was received. The DON said the process did not always work as it should. The DON stated when medications were not available, the nurse called the physician for orders to omit administration resulting in the resident missing the dose.	F 425	3. DON/Designee to complete random audits of MARs/TARs weekly X4, then monthly for pain medication availability. **Monitoring:** The DON or designee will track and trend results of the MAR/TAR audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control records and policies and procedures, the facility failed to ensure staff	F 441		

3/4/10

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 28 followed appropriate infection control practices during random observations for 1 non-sample (#37) and 3 sample residents (#68, #85, #79). The findings were: 1. Observation on 1/26/10 at 9:22 AM showed certified nurse aide (CNA) #1 provided personal morning care for resident #68. The following concerns were identified: a. Observation showed CNA #1 and CNA #3 placed a clean shirt on the resident over a soiled and saturated percutaneous endoscopic gastrostomy (PEG) tube dressing. b. Observation on 1/25/10 at 3 PM revealed certified nurse aide (CNA) #1 provided perineal care to the resident who was incontinent of bowel. Observation showed the CNA used the same area of a wipe twice, which was soiled with feces, to cleanse the buttocks. With the same soiled wipe, the CNA cleaned a healing pressure sore on the right hip. In addition, during the observation the CNA placed the indwelling catheter bag on the floor while she provided the perineal care. c. Observation on 1/25/10 at 3 PM showed CNA #1 held the resident's right knee during perineal care with gloves on that were soiled with feces; there were several scabs where the CNA touched the knee. The CNA also picked up clean linens with the same soiled gloves and placed them on the bed. d. Refer to federal citation F315 for details regarding inadequate catheter care. e. Observation on 1/25/10 at 3 PM revealed CNA #6 moved the catheter bag from the head of the bed to the foot of the bed then, without washing or sanitizing her hands, she placed the nasal cannula in the resident's nares.	F 441	**F441** It is the practice of this facility to ensure that the facility has an infection control program which is effective for investigating, controlling and preventing infections. **Corrective Action:** 1. CNAs were educated on proper infection controls practices hand washing between gloving, and peri-care for Residents #68, #85, #79, and #37. (Also see F315). 2. Room #9, #24, #28, and #45 call light cords were shortened on 3/2/10. The call light cords in the bathroom were shortened above the floor. **Identification of Others:** All residents have the potential to be affected by this practice. **Systems/Measures:** 1. C.NAs were re-educated on hand washing and gloving by the SDC on, 2/17/10.	

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F 441	Continued From page 29 2. Observation on 1/25/10 at 11:50 AM showed staff did not use adequate infection control practices while providing perineal care for resident #85. Observation on 1/25/10 at 11:50 AM showed the resident's slacks and incontinence brief were soaked with urine. After the CNA removed the wet incontinence brief and wet slacks, she touched the bathroom door knob, wheelchair arms, the closet door and clean garments inside, all without removing the soiled gloves. The CNA then placed the clean slacks and incontinence brief on the resident, touching the resident's bare arms and legs with the soiled gloves as she did so. The resident used his/her bare hands to pull up the briefs and slacks where they were touched with the CNAs soiled gloves. The CNA then removed her gloves and assisted the resident into the dining room for lunchtime. The CNA did not wash the residents hands prior to lunch; however, per the request of the surveyor the residents hands were washed prior to eating. 3. Observation on 1/26/10 at 7:32 AM revealed certified nurse aide (CNA) #3 assisted resident #79 into the bathroom. After performing perineal care on the resident, without removing her gloves, the CNA removed the gait belt from around the resident's waist. The CNA then removed those gloves, and donned another pair of gloves without performing hand hygiene first. The CNA then combed the resident's hair, set up the resident's oral care supplies, and then put the gait belt in her scrubs pocket. 4. During an observation of non-sample resident #37 on 1/25/10 at 11:25 AM, certified nurse aide (CNA) #2 held his left hand up and transported the resident to his/her room by wheelchair with his right hand. The CNA stated his left hand became	F 441	2. Ambassadors will complete observations of call light cords to ensure they are not dragging on bathroom floors daily. 3. SDC to complete weekly random observations of hand washing and gloving by staff. 4. Unit managers to randomly observe staff for use of gloves and proper hand washing weekly. **Monitoring:** The DON or designee will track and trend results of the observations of hand washing/gloving, and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	

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2/1/10

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F 441	Continued From page 30 soiled when he touched the resident's pants leg. The CNA further stated the resident's pants leg was probably soiled with incontinent urine and/or stool. Continued observation showed the CNA toileted the resident, but reached around the resident with his unwashed left hand and touched the resident's shirt. The CNA then washed his hands and donned gloves to provide personal care, but did not change the resident's shirt. The resident was incontinent of urine and stool, which required personal care that included a change of pants. Interview with the CNA immediately after the observation revealed he should have washed his hands prior to resident care, or should have changed the resident's soiled shirt, but he forgot. 5. Random observations on 1/26/10 and 1/27/10 showed resident bathroom call light cords were lying on the floor in rooms #9, #24, #28, and #45. All resident bathroom cords were found to be long enough to reach the floor when not secured. During an interview with the maintenance director on 1/28/10 at 9:30 AM, he stated new call lights were recently installed in resident bathrooms, and the cords reached beyond floor length. He further stated the cords would need to be trimmed due to infection control issues.	F 441	F465 It is the practice of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. **Corrective Action:** The needle found in south medication room station was removed and discarded in a sharps container by the unit manager on 1/29/10. Sharps containers installed in both medication rooms by maintenance on 1/29/10. **Identification of others:** Both medication rooms were inspected for exposed needles. No other issues identified. **Systems/Measures:** 1. SDC to complete in-service for licensed nurses re: proper handling/disposing of sharps. 2. Unit managers/Designee will complete daily checks of medication rooms/stations X7 days then weekly. 3. Random audits of the medication rooms will be conducted by the DON/Designee monthly.	
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a safe environment for	F 465		

SR 3/4/10

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F 465	Continued From page 31 staff. The findings were: During an observation of the south nurse's station medication room on 1/27/10 at 6:10 AM, a used 12 cc syringe and uncapped attached needle were viewed on the counter. The observation also showed a "sharps" container was unavailable for disposition of contaminated syringes and needles. An observation of the north nurse's station medication room on 1/27/10 at 6:30 PM showed no available "sharps" container in the room. During an interview with the south nurse's station unit manager immediately upon observation of the syringe and needle, she verified the items had been used. She further stated the syringe and needle should have been disposed of properly in a "sharps" container in a timely manner. She also stated no "sharps" containers were available in the south or north nurse's station medication rooms. According to Smith, Duell, and Martin, 2007 "Clinical Nursing Skills" (7th Edition) Prentice - Hall, Inc., most needlestick injuries "occur after use and before disposal. Puncture-proof sharps disposal containers continue to play an important role in preventing injury."	F 465	**Monitoring:** The DON or designee will track and trend results of the observations of Medication rooms and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10 F502 It is the practice of the facility to provide or obtain laboratory services to meet the needs of residents. **Corrective Action:** 1. Resident #82 discharged 2/6/10. 2. Resident #68 labs were completed on 11/2/09. **Identification of Others:** Nursing completed an audit on labs to identify any omissions or lack of notification to MD on 3/2/10.	
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory tests were completed in accordance with	F 502		

Changes per NHA phone Call on 3/3/10

3/4/10

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F 502	Continued From page 32 physician's orders for 2 of 17 sample residents (#68, #82). The findings were: 1. Review of physician's orders dated 12/19/09 revealed the following: "UA with C & S" [urinalysis with culture and sensitivity]. However, review of the laboratory report for the UA collected 12/19/09 showed a culture, but no sensitivity. During an interview on 1/27/10 at 4:45 PM, the infection control practitioner stated he called the laboratory, and they told him they did not do a sensitivity. 2. Review of the medications for resident #68 revealed s/he received Coumadin (anticoagulant) daily. Review of the medical record revealed a 10/16/09 physician's order for a prothrombin time (PT) and international normalized ratio (INR) laboratory test in two weeks which would be 10/30/09. Review of the laboratory test results showed the test was performed on 11/2/09 which was 2 days late. Results from this test indicated a dosage change from 4 milligrams (mg) daily to 6 mg on Tuesdays, Thursdays, Saturdays and Sundays and to 7 mg on Mondays, Wednesdays, and Fridays. Interview with the director of nursing and clinical nurse consultant on 1/27/10 at 11 AM revealed they did not know why the test was late.	F 502	**Systems/Measures:** 1. SDC to complete in-service for licensed nurses in regards to obtaining proper lab orders and follow up by 3/2/10. Labs are drawn Monday thru Friday. Any labs written on off days will be completed on the next lab draw day unless otherwise ordered by the physician. 2. Unit Manager/Designee will review labs weekly for completion and MD notification. 3. IDT to review telephone orders daily for new labs to ensure completed and reported to MD as needed. **Monitoring:** The DON or designee will track and trend results of the lab/telephone order audits and report findings to the QA&A committee monthly, the QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 4 months then reassess the need for continued monitoring based on compliance. Compliance Date: 3/2/10	