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

PRINTED: 02/28/2014
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
	535029	A. BUILDING _____ B. WING _____	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	718 OAK STREET SUNDANCE, WY 82729

(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: CAA - Care Area Assessment CNA - Certified Nurse Aide DON - Director of Nursing LPN - Licensed Practical Nurse MAR - Medication Administration Record MDS - Minimum Data Set mg - Milligram mg/ml - Milligrams to Milliliter ml - Milliliter PRN - Pro re nata (as needed) RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	RECEIVED WYOMING DEPARTMENT OF HEALTH MAR 10 2014 Healthcare Licensing and Surveys	
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	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Glen Van Beek
TITLE: Administrator
(X6) DATE: 3/10/2014

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 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure care plans were developed to meet all resident needs for 3 of 9 sample residents (#11, #12, #18). The findings were: 1. Review of the medical record showed resident #11 had diagnoses to include diabetes. Review of the 2/27/13 annual MDS assessment, section K, for swallowing/nutritional status showed the resident received a therapeutic diet. The CAA summary, section V, showed the resident was to have a care plan developed for nutrition. Review of the nutritional evaluation/re-evaluation dated 8/14/13 showed the resident required extensive assistance with his/her meals and was totally dependent on the staff. The physician's order summary sheet dated 12/6/13 showed the resident was to receive a 1800-calorie diet. Review of the care plan last revised on 11/20/13 did not show a care plan was developed for nutrition. 2. Review of the medical record showed resident #12 had diagnoses to include diabetes and coronary artery disease. Review of the 12/9/13 quarterly MDS assessment showed s/he received a therapeutic diet. The physician's order summary report dated 12/6/13 showed the resident was to receive a 1400 calorie diet and was to be weighed every 14 days. Review of the 6/17/13 annual MDS assessment showed a care	F 279	**F279** Resident #11, #12 and #18 care plans were updated to show that they receive a therapeutic diet/fall interventions. All Care plans will be developed upon admission and updated quarterly and PRN any event/order change that would affect the Plan of care. Care plans will be monitored weekly using an audit tool by Assistant Director of Nursing (ADON)/ Director of Nursing (DON)/MDS Coordinator (MDSC) for updates for one month then monthly for 1 year. ADON/DON will report to QAPI quarterly for one year. 3-10-14	3-29-14

3/21/14- this POC accepted between Jim Vm Beck-CEP and Tony Hadden, Surveyor with DOC of 2/13/14.

3/21/14

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F 279	Continued From page 2 plan was to be developed for nutrition. Review of the care plan last revised on 12/6/13 did not show a care plan was developed for nutrition. 3. Review of the nurse's note dated 12/4/13 timed at 11:06 AM showed resident #18 was found on the floor. Review of the physician's note dated 12/4/13 revealed the resident was found out of his/her bed after a fall and was more lethargic and confused. Review of the incident report dated 12/4/13 timed at 5 AM showed actions taken included placement of alarms and bolster pillows; however, review of the care plan did not show a care plan was developed for falls. 4. Interview with the DON on 2/13/14 at 12:30 PM acknowledged the care plans needed to be developed for nutrition and falls.	F 279		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain accurate medication administration records for 1 of 9 sample residents (#16), and failed to follow physician orders regarding calorie-restricted diets and weights for 2 of 2 sample residents (#11, #12). The findings were: Regarding accurate medication administration records:	F 281	JVB 3.10.14	

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F 281	Continued From page 3 1. Review of the medical record showed resident #16 was originally admitted to the facility on 12/10/12 and had current diagnoses that included congestive heart failure, diabetes mellitus, non-Alzheimer's dementia and chronic lung disease. Review of the resident's MAR for the month of February 2014 revealed two orders for Roxanol solution (a opiod analgesic) 20 mg/ml. The first order was to "Give 0.5 mg/ml orally every 2 hours as needed for comfort related to congestive heart failure" and the second was to "Give 1 mg/ml orally every 2 hours as needed for comfort related to congestive heart failure." Review of physician's orders revealed the original order, dated 12/11/13, was for "1/2 - 1 ml PO [by mouth] Q [every] 2 hours PRN Disp [dispense] 1 bottle (30 cc)." Further review of the MAR revealed the resident had been dosed with Roxanol 15 times between the date of the original order (12/11/13) and 2/12/14. However, the narcotic sign-out sheet for this medication, which would have indicated how the resident had been dosed, was missing. Interview with the DON on 2/13/14 at 11:30 AM confirmed the invalid doses on the resident's MAR, stating the facility was using a new computer system for medication administration, and she believed the invalid dose was a computer entry error. Regarding physician orders for calorie-restricted diets and weights: 2. Review of the medical record revealed resident #11 had diagnoses to include diabetes. The physician's order summary sheet dated 12/6/13	F 281	**F281** Resident #16's orders have been corrected to reflect the correct unit of measurement on the medication. All nurses will be in-serviced about proper order entry by the Director of nursing (DON)/Assistant Director of Nursing (ADON). All new narcotic orders will be reviewed by a second nurse prior to administration. All other new orders will be reviewed by a second nurse during the 24 hour check. All orders will be reviewed by ADON/DON using an audit tool to ensure correct entry/completion into the computer weekly for one month then monthly for one year. ADON/DON will report to QAPI Quarterly for one year. Resident # 12's weights are being done every other week per Dr. orders. All staff will be in-serviced on WHEN to do vital signs and weights. Weights and vital signs are now scheduled to	3-29-14

3/10/14

3/14/14

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F 281	Continued From page 4 showed the resident was to receive a 1800 calorie diet. Observation on 2/12/14 at 11:35 AM showed resident trays were prepared for lunch in the facility's kitchen. The individual portion sizes and the food served were the same for each resident. Review of the dietary kardex located on the serving cart also showed the resident was on an 1800 calorie diet. 3. Review of the medical record showed resident #12 had diagnoses to include diabetes, congestive heart failure and coronary artery disease. The physician's order summary report dated 12/6/13 showed the resident was to receive a 1400 calorie diet. Review of the 11/6/13 physician orders showed weights were to be done every 2 weeks. The following concerns were identified: a. Observation on 2/12/14 at 11:35 AM showed resident trays were prepared for lunch in the facility's kitchen. The individual portion sizes and the food serviced were the same for each resident. b. Review of the weights and vitals summary showed the resident was weighed once in November on 11/17/13, once in December on 12/8/13, and twice in January on 1/14/14 and 1/19/14 with only 5 days between the dates. 4. Review of the menu guide report, used to show what was to be served for different diets, did not indicate any difference in portions between the 1200, 1500, 1800 and 2000 calorie diets. Further, the food served was the same for each menu. An interview with the kitchen supervisor on 2/13/14 at 9:10 AM acknowledged there were no differences in the portion sizes or the food served for the different diets.	F 281	**F281 cont.** be done on Saturday and Sunday with the completion/audit sheet turned into the ADON/DON every Monday am for review of completion. ADON/DON will report to QAPI quarterly for one year. Certified Dietary Manager (CDM) will in-service all dietary staff on the importance of portion sizes. CDM will work with the Dietician to correct the portion sizes for the various calorie diets to assure that all residents get the diets that they have ordered. CDM will monitor diet orders on a monthly basis and report to the IDT team on a quarterly basis. CDM will report diet order compliance to the QAPI committee on a quarterly basis for one year.	3-29-14

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F 281	Continued From page 5 5. An interview with the DON on 2/13/14 at 12:30 PM acknowledged physician orders needed to be followed.	F 281		
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 medical record review and staff interview, the facility failed to follow care-planned interventions for 1 of 9 sample residents (#16). The findings were: 1. Review of the medical record revealed resident #16 was most recently re-admitted to the facility on 9/16/13 and had diagnoses including congestive heart failure, hypertension, and non-Alzheimer's dementia. Interventions listed on the resident's care plan, dated 9/27/13, included: "Monitor weight status and alert dietitian and physician of shift more than 2-3 lbs" (to be completed once each week)," and "Monitor weight weekly." Review of the January 2014 physician's order recapitulation revealed an order dated 10/30/13 for weekly weights. The following concerns were identified: a. Review of recorded patient weights from 10/30/13 to 2/5/14 revealed weights were measured on 11/2/13, 11/13/13, 11/17/13, 11/20/13, 1/8/14, 1/15/14, 1/22/14, and 2/5/14. There was no evidence the resident's weight was measured during the month of December 2013,	F 282	**F282** Resident # 16's weights are being done every other week per Dr. orders. All staff will be in-serviced on WHEN to do vital signs and weights. Weights and vital signs are now scheduled to be done on Saturday and Sunday with the completion/audit sheet turned into the Assistant Director of Nursing (ADON)/Director of Nursing (DON) every Monday am for review of completion. ADON/DON will report to QAPI quarterly for one year. 3-10-14	3-29-14

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F 282	Continued From page 6 and most recently, two weeks elapsed between the weights measured on 1/22/14 and 2/5/14. b. According to Chen, Michael A. MD, PhD (updated 5/2013) Heart Failure Overview, nlm.nih.gov, retrieved 2/20/14 from http://www.nlm.nih.gov/medlineplus/ency/article/000158.htm, "Weight gain, especially over a day or two, can be a sign that your body is holding onto extra fluid and your heart failure is getting worse." c. Interview with LPN #1 on 2/13/14 at 10:36 AM confirmed no other documentation of the resident's weight was available, and confirmed the resident was supposed to be weighed weekly.	F 282		
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to ensure residents received prescribed calorie-restricted diets for 2 of 2 sample residents (#11, #12). The findings were: 1. Review of the medical record revealed resident	F 325		

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F 325	Continued From page 7 #11 had diagnoses to include diabetes and hyperlipidemia (elevated levels of lipid in the blood). The physician's order summary sheet dated 12/6/13 showed the resident was to receive an 1800 calorie diet. Review of the quarterly MDS assessment dated 8/20/13 revealed the resident received a therapeutic diet, and required total physical assistance with eating. Observation on 2/12/14 at 11:35 AM showed resident trays were prepared for lunch in the facility's kitchen. The individual portion sizes and the food served were the same for all residents. Review of the dietary kardex located on the serving cart showed the resident was on an 1800 calorie diet. Review of the nutritional evaluation/re-evaluation assessment, dated 11/19/12, showed the resident was started on the 1800 calorie diet and weighed 150 pounds. The assessment showed on 8/14/13 the resident had a 3.7% weight gain in 3 months and a 5% weight gain in 6 months. 2. Review of the medical record showed resident #12 had diagnoses to include diabetes and coronary artery disease. Review of the 12/9/13 quarterly MDS assessment showed s/he received a therapeutic diet. The physician's order summary report dated 12/6/13 showed the resident was to receive a 1400 calorie diet for weight loss and diabetes with a start date of 11/1/13. Observation on 2/12/14 at 11:35 AM showed resident trays were prepared for lunch in the facility's kitchen. The individual portion sizes and the food served were the same for all residents. Review of the dietary kardex located on the serving cart also showed the resident was on a 1400 calorie diet. Review of the 6/17/13 annual MDS assessment and 12/9/13 quarterly MDS assessment showed the resident had a weight gain of 2%.	F 325	F 325 Certified Dietary Manager (CDM) will in-service all dietary staff on the importance of portion sizes. CDM will work with the Dietician to correct the portion sizes for the various calorie diets to assure that all residents get the diets that they have ordered. CDM will monitor diet orders on a monthly basis and report to the IDT team on a quarterly basis. CDM will report diet order compliance to the QAPI committee on a quarterly basis for one year.	3-29-14

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F 325	Continued From page 8 3. Review of the menu guide report used to show what was to be served for the different diets did not indicate any difference in portions between the 1200, 1500, 1800 and 2000 calorie diets. Further, there was no difference in the food served. An interview with the kitchen supervisor on 2/13/14 at 9:10 AM acknowledged there were no differences in the portion sizes or the food served for the different diets.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the facility's policy and procedures, the facility failed to ensure the drug regimen was free of unnecessary medications for 1 of 9 sample residents (#12). The findings were: Review of the medical record revealed resident #12 had diagnoses to include depression. Review of the physician order recapitulation report dated 1/6/14 showed the resident was prescribed Cymbalta (a medication for treatment of depression) 60 mg for depressive disorder and doxepin (a medication for treatment of depression) 10 mg. The following concerns were identified: a. Review of the physician orders dated 6/30/14 showed the resident was ordered the second antidepressant (doxepin) without an indication for the medication. Review of the physician progress notes dated 6/14/13 and 7/5/13 failed to show any indication for the addition of the doxepin. Further review of the medical record showed there were no additional physician notes between 6/14/13 and 7/5/13. b. Review of the 6/17/13 annual MDS assessment, section D for mood, completed 13 days prior to the start of the second antidepressant showed the resident denied feeling down, depressed or hopeless during the previous 2 weeks. Further, the total severity score on the resident mood interview was 0, indicating no assessed signs or symptoms of depression. c. Review of the note to attending physician/prescriber dated 12/10/13 revealed the consulting pharmacist questioned the use of two antidepressants, stating concerns of "increased	F 329	**F329** Resident # 12 has a reduction attempt of Doxepin currently underway, started on 03/06/2014. Each resident will have a medication review quarterly done at Interdisciplinary Team meeting (IDT) with the Consultant Pharmacist. Reductions will be attempted unless the attending doctor writes a risk vs. benefit analysis describing the rationale for continuing the psychotropic medication or a documented failure is in the chart. ADON/DON will conduct weekly audits during the IDT. ADON/DON will report to QAPI quarterly for one year. 3-10-14	3-29-14

3/7/14

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F 329	Continued From page 10 side effects with 2 or more similar agents being used for the same condition." Further, the pharmacist requested a diagnosis for the use of the medication doxepin. The physician failed to provide an indication for the medication. Review of the facility policy and procedure for antipsychotic medication use revised April 2007 showed; "The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications." Interview with the DON on 2/13/14 at 12:30 PM confirmed there was no further documentation to show the indication(s) for the addition of the second antidepressant.	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by; Based on staff interview, and review of medical records and the menu guide report, the facility failed to follow calorie restricted diets prescribed by the physician for 2 of 2 sample residents (#11, #12). The findings were: 1. Review of the medical record showed resident #11 had diagnoses to include diabetes. The physician's order summary sheet dated 12/6/13 revealed the resident was to receive an 1800 calorie diet. Review of the dietary kardex located	F 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

(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 367	Continued From page 11 on the serving cart also showed the resident was on an 1800 calorie diet. 2. Review of the medical record revealed resident #12 had diagnoses to include diabetes, congestive heart failure and coronary artery disease. The physician's order summary report dated 12/6/13 showed the resident was to receive a 1400 calorie diet. 3. Observation on 2/12/14 at 11:35 AM showed resident trays were prepared for lunch in the facility's kitchen. The individual portion sizes and the food served were the same for each resident (including residents #11 and #12). 4. Review of the menu guide report, used to show what was to be served for different diets, and did not indicate any difference in portions between the 1200, 1500, 1800 and 2000 calorie diets. Further, the food served was the same for each menu. An interview with the kitchen supervisor on 2/13/14 at 9:10 AM acknowledged there were no differences in the portion sizes or the food served for the different calorie restricted diets. 5. An interview with the DON on 2/13/14 at 12:30 PM acknowledged physician diet orders needed to be followed.	F 367	**F 367** Certified Dietary Manager (CDM) will in-service all dietary staff on the importance of portion sizes. CDM will work with the Dietician to correct the portion sizes for the various calorie diets to assure that all residents get the diets that they have ordered. CDM will monitor diet orders on a monthly basis and report to the IDT team on a quarterly basis. CDM will report diet order compliance to the QAPI committee on a quarterly basis for one year.	3-29-14
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 under sanitary conditions	F 371		

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F 371	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure sanitary conditions in 1 of 1 kitchen. The findings were: 1. Observation on 2/10/14 at 3:25 PM showed the following concerns in the kitchen: a. The vents above the stove and grill had an accumulation of dust. b. The trap located along the back of the grill had an accumulation of grease with food particles. In addition, the stove had a build-up of baked-on food. c. Observation of the ice machine/dispenser showed the water reservoir had cloudy liquid in it. In addition, the back of the ice machine had a white build-up where the water ran down the surface. The vent had an accumulation of dust located on the side of the machine. d. The "clean" side of the dishwashing station showed the floor under the washer had a buildup of deposits. e. Two of the three hand-washing stations had scrub brushes for multiple use. The brushes were not labeled with a name or date. Interview with the dietary supervisor on 2/12/14 at 11:45 AM concerning the brushes revealed she was uncertain how long the brushes had been sitting at the sink, the frequency of their use or who was using them before entering the kitchen to prepare the food. She acknowledged multiple-use brushes should not be used by the	F 371	**F371** The vents above the stove and grill, the grill (including the grease trap in the back), the ice machine/dispenser, and the floor on the clean side of the dishwashing station were cleaned on February 14, 2014. The nail scrub brushes were removed immediately. The Certified Dietary Manager (CDM) will set up a cleaning schedule for dietary staff to follow and will monitor for compliance. CDM will report quarterly to the QAPI committee for one year or until committee recommends completeness. 3-10-14	3-29-14

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F 371	Continued From page 13 kitchen staff. An interview at 12:25 PM revealed the supervisor did not know when the vents located above the stove and grill had been cleaned. Further, she was not certain when the stove and grill, including the grease trap, were last cleaned. The accumulation of deposits under the dishwasher occurred because the water softener, which was located under the dishwasher, overflowed and the staff had been unable to clean the deposits off the floor. In addition, she stated the kitchen staff de-limed the ice machine weekly. The supervisor stated a log for cleaning kitchen appliances was not currently maintained. Interview with the maintenance director on 2/13/14 at 10:30 AM revealed he had not been made aware of the deposits on the floor in the dishwasher room. Further, the vents located over the stove and grill were deep cleaned every 6 months by an outside contractor and the kitchen staff were to clean the vents in between. The vents were last cleaned by the contractor in September 2013. According to Food Code 2013, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." According to the 2013 Food Code, U.S. Public Health Service, Hands and Arms, 2-301.11, Clean Condition: "The hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared.....	F 371	gb 3-10-14	

3/21/14 gm

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F 371	Continued From page 14 The greatest concentration of microbes exists around and under the fingernails of the hands. The area under the fingernails, known as the "subungal space," has by far the largest concentration of microbes on the hand and this is also the most difficult area of the hand to decontaminate. Fingernail brushes, if used properly, have been found to be effective tools in decontaminating this area of the hand. Proper use of single-use fingernail brushes, or designated individual fingernail brushes for each employee, during the handwashing procedure can achieve up to a 5-log reduction in microorganisms on the hands."	F 371		
F 431 SS=D	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		

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F 431	Continued From page 15 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, medical record review, and staff interview, the facility failed to maintain a system accounting for controlled substances in sufficient detail to enable an accurate reconciliation and to facilitate the timely detection of controlled substance diversion for 1 sample resident (#16), and failed to ensure medications opened and available for use were visibly labeled with the date opened and/or the expiration date in 7 of 7 insulin vials, and 1 of 1 insulin pens. The findings were: 1. Review of the medical record revealed resident #16 was originally admitted to the facility on 12/10/12 and had current diagnoses that included congestive heart failure, diabetes mellitus, non-Alzheimer's dementia and chronic lung disease. Review of the resident's MAR for the month of February 2014 revealed two orders for Roxanol solution (a opiod analgesic) 20 mg/ml. The first order was to "Give 0.5 mg/ml orally every 2 hours as needed for comfort related to congestive heart failure" and the second was to "Give 1 mg/ml orally every 2 hours as needed for	F 431	**F431** A separate locked cabinet is in place in the medication room as of 02/27/2014 for Narcotics that have been discontinued/expired or the patient has died. All nurses will be in-serviced on the log (Narcotic Tracking Form) that has been instituted to ensure tracking for Narcotic substances from time of entry into the facility to completion or destruction by pharmacist. Weekly audits by Director of Nursing (DON)/Assistant Director of Nursing (ADON) using an audit tool will be done to ensure proper use of the log/cabinet. Weekly audits will be done for one month then monthly for one year. ADON/DON will report quarterly to QAPI for one year. All nurses will be inserviced on the insulin policy. All vials/syringes are dated and initialed when the vial is accessed after ensuring that it is not expired. DON/ADON will	3-29-14

3-10-14

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F 431	Continued From page 16 comfort related to congestive heart failure." This medication can be dosed either by milligrams (mg) or by milliliters (ml) by cannot be dosed by mg/ml (milligrams to milliliters). Review of the physician's orders dated 12/11/13 revealed the original order was for "1/2 - 1 ml PO [by mouth] Q [every] 2 hours PRN [as needed] Disp [dispense] 1 bottle (30 cc)." Further review of the resident's MAR revealed the resident had been dosed with Roxanol 15 times from the date of the original order (12/11/13) to 2/12/14. However, the narcotic sign out sheet for this medication, which would have indicated how much Roxanol the resident had received was missing, and at the time of survey the bottle of Roxanol contained only 3 ml. Interview with the DON on 2/13/14 at 11:30 AM confirmed the invalid doses on the resident's MAR, and further confirmed the narcotic sign out sheet for this medication could not be located and the facility was unable to fully account for the Roxanol that had been removed from the bottle. 2. Observation of the medication room on 2/12/14 at 10:20 AM showed 7 of 7 opened and available for use insulin vials (4 Lantus brand, 1 Humalog brand, 2 Novalog brand) and 1 of 1 in-use (Victoza brand) insulin pens in the drawer were not labeled with date opened or expiration date. Interview with RN #1 on 2/12/14 at 10:40 AM confirmed the insulin vials were not labeled with the date opened or expiration date. The RN stated that nursing had been told opened insulin vials were acceptable to use until the manufacturer's expiration date, so long as the vials were refrigerated.	F 431	**F431 continued.** audit weekly using an audit tool to ensure compliance for one month then monthly for one year. ADON/DON will report quarterly to QAPI for one year. Resident #16's Roxanol was accounted for. In-servicing was done with all nurses to ensure understanding of proper Narcotic management and procedures. Sign out sheets will be monitored weekly by ADON/DON using an audit tool for one month then monthly for one year to ensure compliance. ADON/DON will report to QAPI quarterly for one year. 3-10-14	3-29-14

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F 431	Continued From page 17 Review of the facility's policy for "Insulin Administration," showed when administering insulin: "Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening)." Review of the manufacturer's recommendations for Humalog, Novalog and Lantus brands of insulin revealed that, once opened, these insulin vials should be discarded after 28 days. Review of the manufacturer's recommendations for Victoza brand insulin pens revealed that they should be discarded 30 days after first use.	F 431		3-7-14
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 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		3/7/14

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F 441	Continued From page 18 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 proper handwashing was implemented during 1 random observation. The findings were: Observation on 2/11/14 showed CNA #1 checked the incontinence pad for resident #11 with an ungloved hand. After determining the pad was dry, the CNA then assisted the resident's roommate without first cleansing her hands. The CNA repositioned the roommate's blanket, moved the oxygen tank and removed the sit-to-stand lift from the room. Interview on 2/13/14 at 12:30 PM with the infection control nurse acknowledged the CNA needed to cleanse her hands before assisting the	F 441	**F441** All CNAs will be in-serviced on proper hand hygiene including opportunities to perform hand hygiene in different situations. All CNAs will be monitored weekly for correct hand hygiene including utilizing each opportunity for hand hygiene for one month then monthly for one year by Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Infection Preventionist (IP) using an audit tool. ADON/DON will report to QAPI quarterly for one year. 3-10-14	3-29-14

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F 441	Continued From page 19 resident's roommate and removing the lift. Review of the policy and procedure for handwashing/hand hygiene revised April 2012, showed; "...If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain complete and accurate records of controlled substance administration for 1 sample resident (#16). The findings were: Review of the medical record for resident #16 revealed s/he was originally admitted to the facility on 12/10/12 and had current diagnoses	F 514	JVB 3-10-14	

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F 514	Continued From page 20 that included congestive heart failure, diabetes mellitus, non-Alzheimer's dementia and chronic lung disease. Review of the resident's MAR for the month of February, 2014 revealed two orders for Roxanol solution (a opiod analgesic) 20 mg/ml. The first order was to "Give 0.5 mg/ml orally every 2 hours as needed for comfort related to congestive heart failure" and the second was to "Give 1 mg/ml orally every 2 hours as needed for comfort related to congestive heart failure." Review of the physician's orders dated 12/11/13 revealed the original order was for "1/2 - 1 ml PO [by mouth] Q [every] 2 hours PRN [as needed] Disp [dispense] 1 bottle (30 cc)." Further review of the resident's MAR revealed the resident had been dosed with Roxanol 15 times from the date of the original order (12/11/13) to 2/12/14. However, the narcotic sign out sheet for this medication, which would have indicated how much Roxanol the resident received with each dose was missing, and at the time of survey the bottle of Roxanol contained only 3 ml. Interview with the DON on 2/13/14 at 11:30 AM confirmed the narcotic sign out sheet for this medication could not be located and the facility was unable to fully account for the Roxanol that had been removed from the bottle.	F 514	**F514** Resident #16's Roxanol was accounted for. In-servicing was done with all nurses to ensure understanding of proper Narcotic management and procedures. Sign out sheets will be monitored weekly by Assistant Director of Nursing (ADON)/Director of Nursing (DON) using an audit tool for one month then monthly for one year to ensure compliance. ADON/DON will report to QAPI quarterly for one year. GVB 3-10-14	3-29-14

3/11/14