POC - accepted 4/27/09 Lynda Brown RN

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

PRINTED: 04/10/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	03/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE 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 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 medical record review, the facility failed to ensure dignity was maintained for 1 (#94) of 21 sample residents. The findings were: 1. Review of the 11/7/08 initial and the 2/13/09 quarterly Minimum Data Set (MDS) assessments for resident #94 revealed s/he understood others. Observation on 3/25/09 at 9:07 AM revealed certified nurse aide (CNA) #1 provided perineal care for the resident who had been incontinent of urine and feces. During the care, the CNA stated, "Boy, you sure made a mess," and the resident responded, "Oh, I'm sorry." The CNA then stated, "It's all right; it's not your fault. You just keep pooping." Observation of this same resident on 3/24 at 5:15 PM revealed a sign posted above the resident's bed which instructed staff to provide oral care four times a day because the resident had "white stuff" on his/her tongue. The signage was visible to anyone who came into the room including visitors.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *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 it is required by the provisions of federal and state law.* **F-241 Dignity** **A. Corrective Action** C.N.A.'s caring for cited resident #94 will be re-educated regarding appropriate, dignified communication with residents by 05/11/09. The sign in resident #94's room was discussed with the Unit Manager and removed by the District nurse during survey on 3/26/09. **B. Identification of Other Residents Having the Potential to be Affected** All residents deserve to be treated in a dignified manner. A total facility resident room search was completed on 4/3/09 and inappropriate signs were removed. **C. Measures/Systemic Changes** Training regarding appropriate communication, respect and dignity will be included in new hire orientation and will be repeated quarterly and as needed for all staff by the SDC/Designee. Education of facility staff related to respect and dignity will be completed by 5/11/09 by the DNS/Designee.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dale Stacho — TITLE: Executive Director — (X6) DATE: 4/20/09

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

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	**F-253 Housekeeping/Maintenance** **A. Corrective Action** On 3/27/09 the contract housekeeping department completed a thorough cleaning of the dining room tables and chairs in the third and first floor dining rooms. The fireplace hearth was cleaned. By 4/30/09, the housekeeping department will complete a cleaning of dining room tables, chairs, and the fireplace hearth as well as other areas in need of cleaning in the facility.	

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F 253	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide effective housekeeping services for two (first floor, third floor) of three nursing floors. The findings were: 1. Observation on the third floor on 3/24/09 at 5 PM, and on 3/25/09 at 9:20 AM revealed four upholstered dining chairs, a rolling chair used by staff to assist with dining, and an armchair located next to the secure unit doors were soiled with dried food, spills and discolorations. In addition, observation on 3/25/09 at 10 AM revealed the edges of the dining tables were not cleaned, and there was dried food stuck onto the edges of two of the eight tables in the dining area. On all days of survey a three-inch ring of dried food/liquid was noted on the fireplace hearth located in the main dining/living area of the third floor. 2. Observation of the first floor main dining room on 3/27/09 at 10:05 AM showed there were three striped chairs with brown ring stains. Interview with the acting housekeeping supervisor on 3/27/09 at 11 AM revealed furniture was to cleaned on a daily basis. She also stated dining tables were to be cleaned after each meal.	F 253	**B. Identification of Other Residents Having the Potential to be Affected** Housekeeping services have the potential to affect the overall sanitary, orderly and comfortable interior of the facility without consistent practice in routine and deep-cleaning procedures. Administrative and Supervisory staff will include observation of housekeeping services during routine rounds. Identification of lack of services will be immediately addressed with housekeeping staff and immediate corrective action will be taken. **C. Measures/Systemic Changes** On 4/14/09 the contract staff for housekeeping services were re-educated by their District Training Manager on the procedure for cleaning the dining room with emphasis on tables and chairs. A deep cleaning schedule was implemented and includes thorough deep cleaning of the dining rooms. Rounds by the Housekeeping Supervisor will be done 5x week for 4 weeks to confirm that the dining room chairs and tables are thoroughly cleaned and the deep cleaning schedule is followed. **D. Monitoring Corrective Action**	
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, staff interview and medical record review, the facility failed to ensure staff	F 281	The contractor's District Training Manager will perform monthly quality rounds for the next three months to verify compliance. Findings will be reported to the Performance Improvement Committee (PIC) monthly for 3 months for review, recommendations and direction as needed. Date of compliance is **May 11, 2009**.	

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F 281	Continued From page 2 followed professional standards in regard to following physicians' orders for 2 (#35, #120) of 21 sample residents. The findings were: 1. Review of a 3/3/09 faxed "change in medical condition" communication to the physician of resident #120 showed the resident was having increased urinary incontinence, and the urine had a strong odor. The nursing suggestion on the communication form was to have a UA (urinalysis) and culture, if needed. The form was returned on the same day with a signed order for a straight catheter UA and culture if indicated. The order was noted by nursing staff on 3/8/09 (five days after the order was received). Review of the laboratory documentation revealed the urine specimen was collected on 3/9/09. Interview with the third floor unit manager on 3/25/09 at 1:20 PM revealed that while it was not usual for the nurse to note an order five days after receipt, it was expected orders would be noted as soon as possible. 2. Review of the 2/3/09 weekly pressure ulcer report for resident #35 revealed the resident was admitted to the facility with a pressure ulcer on his/her right foot. According to the medical record the resident returned to the facility from the wound care clinic on 3/16/09 with a physician's order for dressing changes, including instructions to "keep a horseshoe podiatry foam around the wound to offload" the pressure on the resident's foot. Interview on 3/26/09 at 3:30 PM with the resident revealed sometimes the nurses changed the dressing on the resident's foot and discarded the horseshoe podiatry foam (the foam). The resident said this upset him/her because the foam effectively reduced the pressure and pain on his/her sore foot when s/he walked. Review of the	F 281	**F-281 Comprehensive Care Plans/ Professional standards** **A. Corrective Action** Resident chart (including physician orders and laboratory data) for cited resident #120 was reviewed by the Interim DNS. The urinalysis completed on 3/9/09 was negative and the resident presently does not have any signs or symptoms of a UTI. Resident chart for cited resident #35 was reviewed by the Interim DNS regarding orders for the ulcer on the right foot. The horseshoe podiatry foam was replaced when the issue was identified and has been monitored by the licensed nurse for placement each shift. This is noted in the TAR (Treatment Administration Record). The Interim DNS observed placement of the horseshoe foam on 4/3/09 and 4/10/09 to confirm appropriate placement. **B. Identification of Other Residents Having the Potential to be Affected** Physician orders for the past two months will be reviewed by the DNS/Designee to confirm that orders for lab and wound treatments were carried out in a timely manner. Immediate corrective action will occur if any orders were not followed up timely.	

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F 281	Continued From page 2 followed professional standards in regard to following physicians' orders for 2 (#35, #120) of 21 sample residents. The findings were: 1. Review of a 3/3/09 faxed "change in medical condition" communication to the physician of resident #120 showed the resident was having increased urinary incontinence, and the urine had a strong odor. The nursing suggestion on the communication form was to have a UA (urinalysis) and culture, if needed. The form was returned on the same day with a signed order for a straight catheter UA and culture if indicated. The order was noted by nursing staff on 3/8/09 (five days after the order was received). Review of the laboratory documentation revealed the urine specimen was collected on 3/9/09. Interview with the third floor unit manager on 3/25/09 at 1:20 PM revealed that while it was not usual for the nurse to note an order five days after receipt, it was expected orders would be noted as soon as possible. 2. Review of the 2/3/09 weekly pressure ulcer report for resident #35 revealed the resident was admitted to the facility with a pressure ulcer on his/her right foot. According to the medical record the resident returned to the facility from the wound care clinic on 3/16/09 with a physician's order for dressing changes, including instructions to "keep a horseshoe podiatry foam around the wound to offload" the pressure on the resident's foot. Interview on 3/26/09 at 3:30 PM with the resident revealed sometimes the nurses changed the dressing on the resident's foot and discarded the horseshoe podiatry foam (the foam). The resident said this upset him/her because the foam effectively reduced the pressure and pain on his/her sore foot when s/he walked. Review of the	F 281	**C. Measures/Systemic Changes** Education of nursing staff related to appropriate follow up of lab and treatment orders will be completed by 5/11/09 by the DNS/Designee. Physician Orders will continue to be monitored by a chart check completed by the Licensed Nurses on the night shift. Any orders that were not carried out will be reported to the oncoming shift nurse for follow-up. The Health Information Manager will copy physician orders daily during business hours and provide the copy to the (Interim) DNS/Designee for review and follow-up with Unit Managers to ensure orders are carried out in a timely manner. **D. Monitoring Corrective Action** The DNS/Designee will conduct random weekly audits of physician orders for the next 30 days to ensure orders are carried out in a timely manner. Findings will be reported to the Performance Improvement Committee (PIC) for review, recommendations and direction as needed. Date of compliance is **May 11, 2009.**	

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F 281	Continued From page 3 March 2009 medication administration record and 3/24/09 nurse's notes revealed staff changed the dressing on the resident's pressure sore on 3/23/09 and discarded the foam. Further review revealed the discarded foam was not replaced until the following day, 3/24/09. Interview on 3/26/09 at 4:40 PM with the first floor unit manager verified the foam that was discarded on 3/23/09 should have been replaced in order to be in compliance with the physician's orders. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician.	F 281		
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure edema was assessed and treated in a timely manner for one (#112) of one sample resident who had edema. In addition, the facility failed to ensure care was provided in a timely manner to prevent bowel incontinence for one (#112) of nine sample residents who were incontinent of bowel. The findings were: 1. Observation on 3/24/09 from 3:50 PM to 7:50	F 309	**F-309 Quality of Care** **A. Corrective Action** A physical assessment of cited resident (#112) was completed regarding bilateral edema of the lower extremities on 3/26/09 (as noted in the summary statement of deficiencies). On 3/26/09 a telephone order was received for CMP, BNP and CBC. As a result of the lab work, a physician order was obtained for an additional diuretic (HCTZ) 12.5mg p.o daily on 3/27/09. The care plan was updated regarding treating the edema. A physician's order was obtained on 04/14/09 for an Ace wrap to the bilateral lower extremities to assist in management of edema. An assessment was completed regarding bowel incontinence on 04/17/09 to evaluate if the approach of prompted toileting remains appropriate. The assessment indicates that prompted toileting remains appropriate for this resident. Skin assessment presently demonstrates that this resident's skin is intact and there is no sign of redness or skin breakdown in the peri-rectal area. An in-service was provided to the cited C.N.A.s caring for resident #112 regarding this resident's prompted toileting schedule on 03/26/09. The care plan was updated based on the assessment and resident care needs.	

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F 309	Continued From page 4 PM revealed the lower legs of resident #112 were visibly swollen. Certified nurse aide (CNA) #2 was observed on on 3/24/09 at 7:50 PM as she assisted the resident to bed. The CNA stated the resident's feet and legs were much more swollen than the last time she had cared for the resident. On 3/25/09 at 9 AM and, again, at 2:40 PM the resident's lower legs were observed to be significantly swollen. Review of the care plan (with a goal date of 5/20/09) showed the resident had edema. The approaches included monitoring the edema, applying compression stockings per physician's order, and administering diuretics per physician's order. Review of the March 2009 medication administration record revealed the resident received the diuretic, aldactazide, on a daily basis for treatment of the edema. Interview with the third floor unit manager on 3/26/09 at 1:20 PM revealed the CNA had not reported the resident's edema that was observed on 3/24/09. The unit manager also stated there was no order for compression stockings. She stated there was not any routine monitoring being done related to the resident's edema, but that it was addressed when noticed. After the interview, the unit manager and the interim director of nursing (DON) completed an assessment for the resident's edema. Review of the nursing assessment dated 3/26/09 at 1:30 PM revealed the resident had 3+ to 4+ edema to his/her bilateral lower calves. 2. Observation of resident #112 on 3/24/09 for four hours from 3:50 PM to 7:50 PM, revealed s/he was not assisted to the bathroom during that time frame. Observation at 7:50 PM revealed the resident had been incontinent of bowel. Review of the 2/22/09 quarterly Minimum Data Set assessment, revealed the resident required	F 309	**B. Identification of Other Residents Having the Potential to be Affected** Residents with edema or with bowel incontinence will be reviewed by 5/11/09 for appropriateness of care and care plans will be updated as needed. **C. Measures/Systemic Changes** Nursing staff will be in-serviced by 5/11/09 regarding the importance of following the plan of care for residents with bowel incontinence and appropriate assessment, reporting and management of edema. The DNS/Designee will conduct random rounds to determine if resident care needs are being met for the next 30 days. Any observations of failing to follow plans of care for individual residents will be immediately addressed and corrective action will occur. **D. Monitoring Corrective Action** The DNS/Designee will report outcomes of random rounds to the Performance Improvement Committee for review, recommendations and direction as needed. Date of compliance is **May 11, 2009.**	

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F 309	Continued From page 5 extensive assistance for toileting. Review of the care plan (with a goal date of 5/20/09) showed the resident had an identified problem of bowel incontinence. The approaches to address this problem included prompted voiding before and after meals, bedtime, and as needed. Interview with the third floor unit manager on 3/26/09 at 1:20 PM verified that the care plan was current and should be followed.	F 309	**F-312 ADL care** **A. Corrective Action** C.N.A.s caring for the cited residents (#8, #5, #23, #94, #112) will complete pericare competencies with return demonstrations by 5/11/09. Cited residents have been evaluated for intact skin and have shown no negative outcomes as a result of care.	
F 312 SS=E	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 personal hygiene for 5 of 11 residents during random observations of personal care. The findings were: 1. Observation on 3/24/09 at 6:10 PM revealed CNA #3 assisted resident #8, (who had been incontinent of both urine and feces) to the toilet. Continued observation revealed the CNA provided perineal care, but did not thoroughly cleanse the feces from the resident's lower left thigh area. Interview on 3/26/09 at 5:30 PM with the CNA revealed the CNA did not realize the resident had not been thoroughly cleansed during the observation of care 3/24/09 at 6:10 PM. 2. Observation on 3/25/09 at 11:30 AM of care provided for resident #5 revealed CNA #4	F 312	**B. Identification of Other Residents Having the Potential to be Affected** C.N.A.s caring for residents in the facility will undergo pericare competencies with return demonstrations by 5/11/09 to indicate their ability to follow correct procedures. Residents are assessed weekly for intact skin. **C. Measures/Systemic Changes** Once the competencies have been completed, the DNS/Designee will conduct random observations of the C.N.A.s performing pericare for the next 30 days to determine if competency training was effective. Follow-up education will occur if observation of C.N.A. performance does not meet expectations. **D. Monitoring Corrective Action** Outcomes of competency training for peri-care and random observations of C.N.A.s performing peri-care will be reported to the Performance Committee (PIC) for review, recommendations and direction as needed. Date of compliance is **May 11, 2009.**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE 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 312	Continued From page 6 assisted the resident to the toilet. The CNA then removed a urine-soiled brief and put a clean disposable brief on the resident without cleansing the resident's perineal area. Interview on 3/25/09 at 12:04 PM with the CNA revealed she "forgot" to cleanse the resident. 3. Observation on 3/25/09 at 12:04 PM of care provided for resident #23 revealed CNA #4 and #5 removed the urine-soiled brief and put a clean disposable brief on the resident without cleansing the resident's perineal area. Interview with the CNAs, at that time, revealed they knew they should have provided perineal cleansing after incontinence, but they "forgot." 4. Review of the 2/13/09 quarterly Minimum Data Set (MDS) assessment for resident #94 revealed the resident was incontinent of bowell all or almost all of the time. The MDS also showed this resident was totally dependent on staff for his/her personal hygiene. Observation on 3/24/09 at 5:15 PM revealed the resident had been incontinent of bowel and bladder. Observation revealed CNA #2 used the same area of a wipe soiled with feces, four times and another wipe soiled with feces, three times. 5. Review of the 2/22/09 quarterly MDS assessment for resident #112 revealed s/he was incontinent (all or almost all of the time) of bowel and bladder and required extensive assistance for toileting. Observation on 3/24/09 at 7:50 PM revealed CNA #2 assisted the resident to the toilet. Observation revealed the resident had been incontinent of both urine and feces. Observation of perineal care provided by the CNA revealed she used one wipe in the same area three times and another wipe in the soiled area four times,	F 312		

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F 312	Continued From page 7 both were soiled with feces. In addition she used a wipe which was soiled with feces to wipe the urethral area twice. Using the same fecally contaminated wipe, the CNA used back to front strokes to cleanse the perineal area three times. Interview with the CNA on 3/24/09 at 8 PM revealed she knew she should not use a soiled area of the wipe more than once and that strokes should be from front to back.	F 312	**F-315 Urinary Incontinence** **A. Corrective Action** Resident (#112) was re-assessed for appropriate toileting needs on 04/13/09. A thorough skin assessment was completed and confirmed that the resident's skin is clear and intact. The care plan was updated.	
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate care and services for incontinence was provided for 1 (#112) of 9 sample residents with bladder incontinence. The findings were: Review of the 2/22/09 quarterly Minimum Data Set assessment for resident #112, revealed the resident required extensive assistance for toileting. Review of the care plan (with a goal date of 5/20/09) showed the resident had an identified problem related to urinary incontinence. The care plan approaches included prompted voiding before and after meals, at bedtime, and as	F 315	**B. Identification of Other Residents Having the Potential to be Affected** Records of incontinent residents will be audited by 05/11/09 to confirm that a current bladder assessment is in place and accurately care planned. **C. Measures/Systemic Changes** C.N.A.s will be re-trained by 05/11/09 to validate that they understand and follow the toileting plan for each resident. A CNA care plan is being utilized to identify the resident's needs as it relates to toileting. Once the re-education has been completed; the DNS/Designee will conduct random observations of the C.N.A.s performing toileting of residents per care plans over the course of the next 30 days to determine if training was effective. Follow-up education will occur if observation of C.N.A. performance does not meet expectations. **D. Monitoring Corrective Action** The DNS/Designee will report the findings of random observations to the Performance Improvement Committee (PIC) monthly for 2 months for review, recommendations and direction as needed. Date of compliance is **May 11, 2009.**	

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F 315	Continued From page 8 needed. Observation on 3/24/09 for a four hour period, from 3:50 PM to 7:50 PM, revealed the resident was not assisted to the bathroom. At 7:50 PM it was noted the resident had been incontinent of urine. Interview with the third floor unit manager on 3/26/09 at 1:20 PM revealed the care plan was correct and current and should be followed.	F 315		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain a medication error rate under five percent (%). Four errors occurred out of 47 opportunities for error, resulting in an error rate of 8.5%. The findings were: 1. Observation of medication pass on 3/26/09 at 8:05 AM revealed resident #91 had orders for Razodyne and Lovenox to be administered at 8 AM. However, the two medications were unavailable. Interview with registered nurse (RN) #2 at the time revealed she planned to call the pharmacy to obtain the medications. Review of the physician's orders written on 3/26/09 at 8 AM revealed an order to hold the Razodyne and Lovenox until received from the backup pharmacy. Observation later that day, at 5:30 PM, revealed the medications had just arrived from the pharmacy. Interview with the unit manager at that time revealed she had obtained an order from the physician to "hold" the 8 AM dose of	F 332	**F-332 Medication Errors** **A. Corrective Action** The physician orders for resident #91 have been reviewed and medications are available for this resident. Residents #34 and #36 have been evaluated by the consulting pharmacist on 04/06/09 and suffered no harm as a result of swallowing after rinsing Advair. A statement has been added to their MARs prompting nurses to have residents swish and spit after Advair use. Physician orders have been clarified to include the language "swish and spit". **B. Identification of Other Residents Having the Potential to be Affected** An audit was conducted on 03/26/09 to confirm that resident's medications were available. A statement has been added to the MAR of each individual receiving a steroid inhaler to prompt him or her to "swish and spit" after use. **C. Measures/Systemic Changes** A medication log will be implemented to track the ordering and the timely delivery of medications.	

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F 332	Continued From page 9 Razodyne until it was delivered by the pharmacy and to discontinue the Lovenox. 2. Observation on 3/27/09 at 8:40 AM showed RN #3 administered 1 puff of Advair inhaler to resident #34, followed by oral medications and water. Interview on 3/27/09 at 10 AM with the RN revealed she did not know the manufacturer's pharmaceutical insert for Advair instructed the user to "swish and spit" after using Advair. Interview on 3/27/09 at 1:35 PM with the pharmacist confirmed the medication should be administered according to the manufacturer's instructions. This information was also relayed to the unit manager by the pharmacist at the same time. 3. Observation on 3/27/09 showed licensed practical nurse (LPN) #1 administered 1 puff Advair to resident #36 at 8:30 AM, followed by oral medications and water. After administration of the medication, the LPN and surveyor together then read the manufacturer's pharmaceutical insert in the Advair box which instructed the user to "swish and spit" after using Advair. The LPN said s/he was unaware of these instructions.	F 332	The ED, DNS, and District Director of Clinical Operations (DDCO) met on 4/9/09 with the Pharmacy Representative for collaboration and timely resolution of concerns. In-servicing will be completed by 05/11/09 by the DNS/Designee regarding the Pharmacy process, so that medications arrive on time and per physician order. Training of staff will include instructions to have residents "swish and spit" after the use of steroid inhalers. The DNS/Designee will conduct random observations of these procedures for the next 30 days and corrective action taken as needed. **D. Monitoring Corrective Action** The DNS/Designee will report the findings of random observations to the Performance Improvement Committee (PIC) monthly for 2 months for review, recommendations and direction as needed. Date of compliance is **May 11, 2009.**	
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		

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F 356	Continued From page 10 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to complete the nurse staff posting at the beginning of each shift during four of four days of survey. The findings were: Upon entrance into the facility on 3/24/09 at 1:05 PM, observation revealed the nurse staff posting dated 3/24/09 had all three shifts posted at the same time. Observation on 3/25/09, 3/26/09, and 3/27/09 revealed all three shifts were again posted at the same time. During an interview with the business office staff on 3/27/09 at 1:35 PM, she stated she posted the nurse staffing for the entire day (all three shifts) each day at 3 PM Monday through Friday. She further stated she placed the nurse staff postings for the weekend and holidays ahead of time. Observation on	F 356	**F 356 Nurse Staffing** **A. Corrective Action** Mountain Towers Staffing Coordinator/Designee now posts the appropriate staffing for each shift, each day per regulation. Copies are maintained in a notebook for easy accessibility. **B. Identification of Other Residents Having the Potential to be Affected** The procedure for the posting was reviewed with the Staffing Coordinator/Designees on 04/15/09 and they understand that an updated posting must be in place just prior to each shift, each day. **C. Measures/Systemic Changes** Education of the nursing staff will be completed by 5/11/09 by the DNS/Designee. Designees have been instructed on how to maintain this process after hours and on the weekends. **D. Monitoring Corrective Action** The ED/Designee will routinely monitor the staff posting to see that this process is maintained per regulation. Findings will be reported to the Performance Improvement Committee (PIC) monthly for 3 months for review and recommendations. Date of compliance is **May 11, 2009.**	

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F 356	Continued From page 11 3/27/09 at 3:15 PM revealed the nurse staff postings for 3/27/09, 3/28/09, 3/29/09 and 3/30/09 were posted outside the family room on the first floor.	F 356	**F444 Preventing Spread of Infection**	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to ensure staff followed accepted hand hygiene practices during 1 (#112) of 11 observations of perineal care. The findings were: Review of the 2/22/09 quarterly Minimum Data Set assessment for resident #112 revealed the resident had been incontinent of bowel and bladder all or almost all of the time. It was also noted the resident required extensive assistance for toileting. Observation on 3/24/09 at 7:50 PM revealed the resident had been incontinent of both urine and feces. Observation of perineal care provided by certified nurse aide (CNA) #2 revealed, after she had cleansed the resident of urine and feces, she cleaned feces off the rim of the toilet seat, and without removing these soiled gloves, the CNA obtained a clean nightgown and placed it on the resident. The CNA then removed the soiled gloves and without any additional hand hygiene, she transferred the resident to bed. Interview with the CNA on 3/24/09 at 8 PM,	F 444	**A. Corrective Action** C.N.A.'s caring for Resident #112 will be trained on hand washing techniques by 5/11/09. The DNS/Designee will complete Handwashing competencies with C.N.A.s by 05/11/09. **B. Identification of Other Residents Having the Potential to be Affected** An All-Staff meeting was held on 4/15/09 reviewing infection control guidelines (including handwashing) to avoid the possibility of spreading infections in the facility. **C. Measures/Systemic Changes** The DNS/Designee will do random observations of hand washing on a weekly basis for the next 30 days. Handwashing technique education will be conducted by the SDC/Designee for C.N.A.'s upon hire and annually. **D. Monitoring Corrective Action** Findings of the random observations for handwashing will be reported to the Performance Improvement Committee (PIC) for the next 2 months for review, recommendations and direction. Date of compliance is **May 11, 2009.**	

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F 444	Continued From page 12 revealed she knew she should have removed her gloves after providing perineal care. Review of the facility policy on handwashing, revised 4/28/07, revealed instructions to wash hands after assisting others with toileting, after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn, between tasks and procedures on the same resident when contaminated with body fluids to prevent cross-contamination of different body sites, and intermittently after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments.	F 444	**F465 Other Environmental Condition** **A. Corrective Action** Upon completion of the construction on 03/25/09, the sawdust and debris were removed from the resident care area. **B. Identification of Other Residents Having the Potential to be Affected** The Maintenance Director will monitor other contractors who may conduct work in the future to determine if they are appropriately using protective barriers as necessary for the containment of construction dust and debris. Immediate action will be taken if requirements are not met. **C. Measures/Systemic Changes** The Maintenance Director will educate contractors at the time work is to be performed to utilize barriers that will prevent sawdust and debris in resident care areas. **D. Monitoring Corrective Action** The Maintenance Director will report any concerns regarding construction worker practices to the ED and the Performance Improvement Committee (PIC) for review, recommendations and direction. Date of compliance is **May 11, 2009.**	
F 465 SS=E	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 ensure a sanitary environment was maintained during a construction project on two of three floors. A project involving electrical alterations was noted to be in progress at the time of the survey. The findings were: 1. Observation on 3/25/09 at 10 AM revealed a construction project was underway at the third floor nurses' station. Five residents were noted to be in the dining area next to the nursing stations. Intermittent observations throughout the day showed sawdust accumulated on the desk at the nurses' station and on the countertop above the	F 465		

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F 465	Continued From page 13 desk. Observation also showed a nurse preparing medications for administration to residents at the medication cart, which was located directly next to the counter that was contaminated with sawdust and debris. At 10:30 AM the aroma of sawdust was evident. At 10:45 AM, five ceiling panels were removed, which caused dust and debris to fall into the nurses' station area and contaminate the top of the medication cart. Observation revealed there was no protective barrier around the construction site. 2. Observation on the second floor on 3/25/09 at 9:25 AM showed two contractors working in the ceiling above the nurses' station. At the time of the observation, two staff members were at the nurses' station and several residents were in the adjacent hallway and in the dining area across from the nurses' station. Debris from the ceiling area was observed to fall on the nursing statin, as well as on a medication cart parked next to the station. 3. Interview on 3/26/09 at 10 AM with the infection control coordinator revealed she was providing no infection control monitoring of this project.	F 465	**F502 Laboratory Services** **A. Corrective Action** The chart for resident (#98) was reviewed by the Interim DNS on 04/01/09. A PT/INR was drawn on 3/27/09. The Physician was notified with the therapeutic results. The PT/INR order was changed on 3/27/09 to discontinue weekly PT/INR. STAT PT/INR was obtained on 3/27/09. An order was received on 3/30/09 stating that a PT/INR was to be re-checked on 4/1/09 and continue current Coumadin orders. **B. Identification of Other Residents Having the Potential to be Affected** An audit of records will be completed by 05/11/09 to confirm that labs have been performed as ordered by physicians. **C. Measures/Systemic Changes**	
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 staff interview and medical record review, the facility failed to ensure a weekly laboratory test was completed as ordered for 1	F 502	A lab tracking book has been implemented that will confirm that labs are ordered, drawn, and test results are received. Audits are being completed 5 x per week for 2 months by the Unit Manager/Designee to maintain this process. **D. Monitoring Corrective Action** Findings of the audits will be reported to the Performance Improvement Committee (PIC) monthly for 2 months for review, recommendations and direction as needed. Date of compliance is May 11, 2009.	

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F 502	Continued From page 14 (#98) of 21 sample residents. The findings were: Review of the medications for resident #98 revealed s/he received Coumadin [anticoagulant] daily. Review of the 2/17/09 physician's order revealed an order for a prothrombin time (PT) and international normalized ratio (INR) laboratory test weekly. Review of the test performed on 2/24/09 revealed the results were abnormally high with the PT being 12.4 (normal is 9.8 - 11.5) and the INR was 1.2 (normal is 0.9-1.1). Review of the medical record and laboratory reports revealed there was no test performed the weeks of 2/23/09, 3/2/09, 3/9/09, 3/16/09, and 3/23/09. During an interview with the district director of clinical operations on 4/2/09 at 11:20 AM, it was verified that the tests had not been performed weekly as ordered.	F 502		