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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	B. WING	C 01/08/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

A complaint survey was conducted at Life Care Center of Cheyenne in conjunction with the annual recertification survey from 1/5/15 to 1/8/15. The complaints which were included in the survey were WY00001833, WY00001855, WY00001894, WY00001897, WY00001901, WY00001904, and WY00001969.

The following common abbreviations are used throughout this document:

ADLs:	Activities of Daily Living
ADON:	Assistant Director or Nursing
CNA:	Certified Nurse Aide
DON:	Director of Nursing
LPN:	Licensed Practical Nurse
MAR:	Medication Administration Record
MDS:	Minimum Data Set
RN:	Registered Nurse
mg:	Milligrams
mcg:	Micrograms

Less commonly used abbreviations will be annotated in each deficiency.

F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164	F164 The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. A) Privacy has been provided to resident #2 by closing the blinds during each perineal care. CNA #1, CNA #2 and LPN #1 were educated on 1/29/15 regarding the importance of providing privacy during perineal care to all residents.	02/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 2/2/15

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. POC accepted. DOC = 2/20/15. Message left for Bryan Merrell, NHA on 2/11/15 @ 4:32pm. Janelle Collins, ORN

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Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and policy review, the facility failed to ensure privacy was maintained during care for 1 of 21 sample residents (#2). The findings were:

Observation on 1/5/15 at 4:05 PM showed CNA #1 and CNA #2 provided perineal care to resident #2 in his/her room. During this observation, staff members did not close the blinds, and cars were seen driving down the road from the resident's window. Also, during this observation, LPN #1 entered the resident's room to assist with care and she also did not close the blinds to protect the resident's privacy. Interview on 1/8/15 at 9:45 AM with the DON revealed the facility expectation was to provide privacy to all residents during care.
Review of the facility policy titled "Preservation of

B) The DON or designee will conduct random audits to ensure privacy is being provided during perineal care.

C) The DON or designee will conduct an in-service on or before 02/20/15 with all nursing staff regarding the importance of providing privacy during perineal care.

D) A Performance Improvement tool will be utilized to randomly audit the provision of privacy during perineal care. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by DON or designee.

E) The DON will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.

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F 164	Continued From page 2 Resident Rights" dated 6/17/08 showed staff were educated by Social Services in order to ensure privacy during medical treatments and personal cares.	F 164		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure care plans were individualized for 3 of 24 sample residents (#74, #107, #124). The findings were: 1. Review of the medical record showed resident #124 was admitted on 6/14/14 with diagnoses	F 279	02/20/15 F279 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. A) Resident #124 was discharged from the facility 09/02/2014. Resident #74 was discharged from the facility on 1/20/2015. The DON will ensure a care plan with individualized fall interventions is developed for resident #107. B) The DON or designee will conduct random audits of residents who are determined to be a high fall risk to ensure individualized fall interventions are developed. DON or designee will conduct random audits of other residents' care plans to ensure non-pharmacological approaches are specified. C) The DON or designee will conduct an in-service on or before 2/20/15 with nursing staff that review and revises care	

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including status post hip fracture, osteoarthritis, and muscle weakness. Review of the 6/14/14, 7/13/14 and 8/18/14 fall risk evaluations showed the resident was a high risk for falls. Review of the 6/25/14 care plan for falls showed it was not individualized to meet the specific needs for the resident. Interventions included referral for therapy or restorative screen and treatment "as needed", therapies "as ordered" for strengthening, eye exam "as necessary", assess needs for assistive/supportive device for transfers and ambulation and instruct on appropriate use. In addition, the care plan documented "if used", ensure alarm monitor was in place at all times when in bed or chair "if [resident name] needs" an alarm for safety, ensure alarming pressure pad was in place at all times when in bed or chair "if [resident name] needs" an alarm for safety, ensure call light and all needed items were within reach at all times when in room to avoid reaching for items. Review of the 7/13/14 timed at 12:17 PM nursing notes showed at 7:40 PM the resident was found on the floor in his/her room by the CNA. The resident's knees were on the floor with the upper body in the wheel chair. The resident stated s/he was reaching for the urinal and slipped and fell onto the floor. Review of the fall incident report showed the recommendation was to make sure the urinal was always within reach.

2. Review of the medical record showed resident #74 was admitted on 12/18/14 for a primary diagnosis of pain in the joint involving the shoulder region. Review of the December 2014 MAR showed the resident's acceptable pain level was 5 of 10 (5/10) on a pain scale of 0 to 10 with 10 being the worst. Continued review of the MAR showed on 12/23/14, 12/24/14, and 12/25/14, the

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plans ensuring they are developed and completed appropriately.

D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by DON or designee.

E) The DON will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.

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resident's pain level was documented at 10/10 on the 6 AM to 2 PM shift. Review of the 7/3/12 care plan showed interventions included: attempt non-pharmacological interventions for pain. However, the care plan did not specify any non-pharmacological interventions.

3. Review of the 12/17/14 care plan showed resident #107 was at risk for falls and injuries due to decreased functional mobility related to a history of falls and a fractured hip, weakness, impaired mobility, and Parkinson's Disease. Further review showed the following concerns regarding fall risk interventions that were not individualized:

a. The approach for implementing alarm monitors was to use at all times or "as needed". Review of the 12/28/14 nursing notes showed the alarm monitor was on at all times. Review of the 12/29/14 nursing notes, timed 11:53 AM, showed the alarm monitor "was discontinued today." However, review of the nursing notes documentation, timed 8:48 PM that same day, showed the alarm monitor "was on at all times." Review of the December 2014 Post-Fall Screening Tools showed the resident fell in the shower room on 12/30/14 and again in his/her room on 12/31/14.

b. The care plan approaches included a referral for therapy or restorative screen and treatment as needed. Review of the therapy notes showed the resident was receiving daily therapy before and at the time of both falls.

c. The care plan approaches included assess for assistive/supportive devices and instruct on appropriate use, "if used." Further review of the fall risk interventions showed no additional information about whether devices were needed; nor were the devices identified.

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4. Interview with the unit manager on 1/8/15 at 8:50 AM revealed care plans were confusing as to how much detail and specificity should be included but staff were working on making them more individualized.

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 staff interview, medical record review, and review of policies and procedures, the facility failed to ensure acceptable standards of nursing practice were followed for monitoring, administration, and documentation of medications for 10 of 24 sample residents (#6, #34, #40, #42, #49, #74, #78, #85, #98, #107). The findings were:

1. Review of the December 2014 and January 2015 MARs showed resident #98 had a diagnosis of hypertension, and orders for Hydralazine 10 mg as needed every 8 hours for systolic blood pressure (BP) over 180. In December 2014 the resident was administered the medication on 4 days (12/2, 12/16, 12/17, and 12/30). Review of the blood pressure record for December 2014 showed a space to record the BP for each of three shifts (days, evenings, and nights). The record was not complete, there were 20 blank spaces where the BPs were not recorded. Review of the January 2015 BP record showed 6 blank spaces when the blood pressure was not

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F 281 F281 The services provided or arranged by the facility must meet professional standards of quality. 02/20/15

A) Resident #98, 49 and 85 will have blood pressures recorded as ordered by physician. Resident #40 has a continuous supply of Celebrex. Resident #78 will continue physician ordered Advair Diskus 500mcg/50mcg by mouth twice a day and when/if omitted nurse will follow facility medication administration policy. Resident #6 will have sliding scale insulin regimen followed per physician order and will have Fentanyl patch placed timely. Resident #74 has been discharged from the facility on 1/20/15. Resident #42 continues on Namenda per physician order. Resident #34 will continue to receive Hydralazine, Toprolol X and Digoxin per physician order and when/if omitted nurse will follow facility medication administration policy. Resident #107 will continue Neurontin and thyroid medication as ordered by physician and when/if omitted nurse will follow facility medication administration policy.

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F 281	Continued From page 6 documented. 2. Review of the December 2014 and January 2015 MARs showed resident #49 had a diagnosis of hypertension, and orders for Hydralazine 10 mg as needed every 8 hours for systolic BP over 170 or diastolic BP greater than 100. In December 2014 the resident was administered the medication on 6 occasions (12/1, 12/4, 12/5, 12/9, 12/12, 12/18). Review of the BP record for December 2014 showed a space to record the BPs for each of three shifts (days, evenings, and nights). The record was not complete, there were 24 blank spaces where the BPs were not recorded. Review of the January 2015 blood BP showed 3 blank spaces when the BP was not documented. 3. Review of the December 2014 and January 2015 MARs showed resident #40 had an order for Celebrex 200 mg daily for generalized pain. The resident had diagnoses that included multiple sclerosis. The following concerns were identified: a. Interview with the resident on 1/5/15 at 3:20 PM revealed there were problems keeping the Celebrex available, and this was upsetting, because it worked well to treat his/her pain. The resident stated this was an ongoing problem and there had been a couple days in January when it was not available. b. Review of the MARs showed the medication was not administered on 1/2/15 and 1/3/15. The nurse noted on the back of the MAR the reason on 1/2/15 was "out of Celebrex." In addition, the December 2014 MAR showed 2 days (12/4 and 12/5) when the initials were circled and it was noted "out" above the 12/4/15 date. There was nothing documented on the reverse side by the nurse related to this	F 281	Medication that requires a blood pressure parameter will have the time the blood pressure was taken and the time the medication was administered. B) The DON or designee will conduct a random audit of facility MAR's to ensure omitted medications are properly documented in accordance with the facility medication administration policy. The DON or designee will routinely audit supply of Celebrex. The DON or designee will audit the documentation of blood pressure records. The DON or designee will audit blood pressure and pulse records to ensure medications were administered at time of vital signs being taken. C) The DON or designee will conduct an in-service on or before 2/20/15 with nursing staff to ensure the following: omissions are being documented in accordance with the facility medication administration policy, documentation of blood pressure and/or pulse when applicable is present upon administration of a medication requiring such documentation, a continuous supply of Celebrex is met and blood pressure records are completed. D) A Performance Improvement tool will be utilized to conduct random	

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medication.

c. Review of the 12/4/14 physician progress note showed the resident's insurance plan limited the number of Celebrex tablets that could be delivered at a time. The plan was to "attempt to obtain a more continuous supply of Celebrex, which the patient wishes to continue despite being offered a different pain medicine."

4. Review of the December 2014 MAR showed resident #78 had a diagnosis of chronic airway obstruction, with a physician order for Advair Diskus 500 mcg/50 mcg by mouth twice a day. Additional review revealed the resident was not administered the medication from 12/21/14 through 12/31/14. Further, there was documentation dated 12/21/14 that Advair was not available, and again on 12/28/14 and 12/29/14; however, documentation was lacking why the medication was not administered for the intervening six days. Also, documentation dated 12/30/14 timed at 6 PM showed the medication "arrived from pharmacy and given."

5. Review of the November 2014 and December 2014 MARs showed resident #85 had a diagnosis of hypertension, with a physician order for lisinopril 10 mg by mouth every day, and an order dated 10/16/14 to monitor the resident's BP twice a day. Documentation was lacking for the "Blood Pressure Record" on the evening shift on the following days: 12/3, 12/10, 12/13, 12/17, 12/18, 12/19, 12/20, 12/26, 12/27, 12/28, 12/29, 12/30, and 12/31. Review of the January 2015 "Blood Pressure Record" showed documentation was lacking for 1/2/15 and 1/3/15 for the evening shift.

6. Review of the medical record showed resident #6 had diagnoses which included diabetes

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F 281	Continued From page 8 mellitus. Review of the 6/5/13 physician's orders showed the resident was on a sliding scale insulin regimen to manage the diabetes. Review of the December 2014 MAR showed the resident's finger stick blood sugar (FSBS) was 154 mg per deciliter (mg/dl) on 12/29/14 at 7 AM. Further review of the MAR showed the resident was administered 11 units of Novolog insulin at that time. Review of the sliding scale insulin orders showed the required dose of 7 units of Novolog insulin was the prescribed amount for a FSBS reading of 131 mg/dl to 160 mg/dl. The 11 units administered was higher than the prescribed dosage. This same resident, #6, had a diagnosis of generalized pain. Review of the 6/5/13 physician's order showed a Fentanyl patch 50 mcg transdermal every 3 days was ordered for pain. Review of the December 2014 MAR showed the resident was due for a new Fentanyl patch on 12/30/14 however, there was no 50 mcg patch available. Review of the 12/30/14 nurse's medication notes showed "No Fentanyl Patch available..." Review of the January 2015 MAR showed the Fentanyl patch was placed at 12 PM on 1/2/15. The new patch was placed 3 days late. 7. Review of the medical record showed resident #74 had a diagnosis of shoulder pain, depressive disorder, Rheumatoid arthritis (RA), and hypothyroidism. Review of the December 2014 physician's orders showed the resident was prescribed Prednisone 40 mg daily for 4 days beginning 12/26/14 for the RA. Review of the December 2014 MAR showed the medication was circled as not administered on 12/27/14 without explanation as to why the medication was held. In addition, on 12/18/14 the physician ordered Levothyroxine 50 mcg daily for the	F 281	audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by DON or designee. E) The DON will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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resident's diagnosis of hypothyroidism. Review of the December 2014 MAR showed the resident was not administered this medication on 12/23/14, 12/25/14, 12/27/14 and 12/28/14 without explanation as to why it was not administered. Finally, review of physician's orders dated 12/18/14 showed fluoxetine 20 mg was ordered daily for the diagnosis of depressive disorder. Review of the December 2014 MAR showed the resident did not receive this medication on 12/23/14, 12/25/14, 12/27/14 and 12/28/14. Review of the medical record showed no explanation as to why the fluoxetine was not administered. Interview with the unit manager on 1/8/15 at 8:30 AM revealed she was unable to explain why the medications were not administered as ordered.

8. Review of the 6/10/14 physician orders for resident #42 showed the physician ordered Namenda XR 21 mg daily for dementia. Review of the November and December 2014 MARs showed the medication was circled as not administered after 11/19/14. Review of the MARs showed the physician ordered Namenda 20 mg daily as a substitute for the Namenda XR on 12/8/14 (19 days later). Further review showed the reason the resident did not receive the medication was not documented.

9. Review of the physician's orders and MARs for November and December 2014 showed resident #34 was to receive daily doses of Hydralazine and Toprolol X (blood pressure medications) and Digoxin (heart medication). According to the MARs the Hydralazine should not be administered when the diastolic blood pressure was less than 140 and the Digoxin should not be administered when the pulse was less than 60

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beats a minute. Review of the MARs showed no documentation regarding why the resident did not receive the Hydralzine 8 times in November and 12 times in December. Review of the MARs showed the Digoxin was circled as not being administered on 4 days in December without a documented reason. Further review showed on 2 of the 4 days the pulse was 86 and 80. In November there was no documented reason the Digoxin was not administered on 2 days and the Toprol XL was not administered on 4 consecutive days in December.

10. Review of the physician's orders and December 2014 MAR showed resident #107's medications included Neurontin (medication for neuropathic pain)100 mg three times a day and daily doses of thyroid medication. Further review showed the Neurontin was not administered on 12/9/14 and 12/10/14, and the thyroid medication was not administered on 12/5/14, 12/21/14, and 12/22/14. There was no documented reason the medications were not administered.

11. Review of the monthly blood pressure and pulse records for residents #34, #49, #85, and #98 showed no evidence the vital signs that were recorded were taken at the medication administration time. Review of the facility's undated policy titled "Policies for Medication Administration" showed "Medication that requires blood pressure (BP) parameters is charted in the MAR."

12. During an interview on 1/7/15 at 11:40 AM, the DON acknowledged the facility's problems with medication administration documentation and availability. Review of the document provided by the DON on 1/6/15 titled "Procedures if

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

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medications are unavailable" showed the nurse was to circle the initials on the MAR and document on the back, the reason the medication was not given. Then the expectation was the nurse would contact the pharmacy.

13. According to Nursing Interventions & Clinical Skills, Perry, Potter and Elkin, 5th Edition, 2012, page 493: Record the administration of each medication on the MAR as soon as you give it.

14. According to the "Nursing Practice Act July 2005 and Administrative Rules and Regulations November 2003" for the Wyoming State Board of Nursing, nurses shall practice under the direction of a licensed physician.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, medical record review, review of facility policy and procedures, the facility failed to ensure the necessary assessments and monitoring was implemented to ensure adequate pain management for 2 of 12 sample residents (#6, #74) who had pain. In addition, the facility failed to ensure the attending physician responded to a notification of a change in

F 281

F309 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. 02/20/15

F 309

A) Resident #74 was discharged from the facility on 01/20/15. Resident #6 has had the Fentanyl patch replaced timely since 1/26/15 and has had pain reassessed within one hour of administration of PRN pain medication. Resident #6 has had sliding scale insulin administered as ordered by physician. Resident #6's physician has responded to fax dated 11/7/14.

B) The Director of Nursing or designee will randomly audit other residents with PRN pain medication orders to ensure that pain has been reassessed within one hour of medication administration,

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condition for 1 of 6 sample resident (#6) who experienced a change in condition. Finally, the facility failed to administer the proper prescribed dose of insulin for 1 of 1 sample residents (#6) who received insulin via a sliding scale. The findings were:

In regard to pain management:

1. Review of the medical record showed resident #74 was admitted on 12/18/14 for a primary diagnosis of pain in the joint involving the shoulder region. Review of the December 2014 MAR showed the resident's acceptable pain level was 5 of 10 (5/10) on a pain scale of 0 to 10 with 10 being the worst. Continued review of the MAR showed on 12/23/14, 12/24/14, and 12/25/14, the resident's pain level was documented at 10/10 on the 6 AM to 2 PM shift. Review of the December 2014 MAR, the pain flow sheet, and the nursing notes showed no evidence the resident was administered any pain medication or provided any non-pharmacological interventions in an attempt to relieve the resident's pain. Interview with the unit manager on 1/8/15 at 8:50 AM verified there was no evidence staff made an attempt to relieve the resident's pain.

2. Review of the medical record showed resident #6 had a diagnosis of generalized pain. Review of the 8/5/13 physician's order showed a Fentanyl patch 50 mcg transdermal every 3 days was ordered for pain. Review of the 2/11/14 physician's orders showed an order for Norco (pain medication) 10/325 mg every four hours as needed was also ordered for pain. The following concerns with pain management were identified:

a. Review of the December 2014 MAR showed the resident was due for a new Fentanyl

F 309

sliding scale insulin is administered as ordered by physician, and that responses are received from physicians when notified of changes in condition.

C) The Director of Nursing or designee will conduct an in-service on or before 02/20/15 with nursing staff to ensure that residents with PRN pain medication are reassessed within one hour of medication administration, sliding scale insulin is administered as ordered by physician, and the importance of receiving a response from physician when notifying of a change in condition.

D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Director of Nursing or designee.

E) The Director of Nursing will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.

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patch on 12/30/14 however, there was no 50 mcg patch available. Review of the 12/30/14 nurse's medication notes showed "No Fentanyl Patch available..." Review of the January 2015 MAR showed the Fentanyl patch was placed at 12 PM on 1/2/15. The new patch was placed 3 days late.

b. Review of the pain flow sheet showed on 1/2/15 at 3:30 PM, the resident complained of pain rated as 8/10. The resident received Norco 10/325 mg, however there was no evidence the resident's pain was re-assessed to determine the effectiveness of the pain medication in relieving his/her discomfort until 9 PM that evening (5 and one half hours) when the resident noted his/her pain level was 7/10. At that time the resident required an additional Norco 10/325 mg tablet.

3. Review of the facility pain management policy revised 3/07 showed: "Nursing staff will monitor and document the effectiveness of the pain management program in the resident medical record..." Interview with the unit manager on 1/8/15 at 8:50 AM revealed her expectation was to have the resident's pain re-assessed within one hour after administration of a pain medication.

In regard to management of diabetes:

Review of the medical record showed resident #6 had diagnoses which included diabetes mellitus. Review of the 6/5/13 physician's orders showed the resident was on a sliding scale insulin regimen to manage the diabetes. Review of the December 2014 MAR showed the resident's finger stick blood sugar (FSBS) was 154 mg per deciliter (mg/dl) on 12/29/14 at 7 AM. Further review of the MAR showed the resident was administered 11 units of Novolog insulin at that

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time. Review of the sliding scale insulin orders showed the required dose of 7 units of Novolog insulin was the prescribed amount for a FSBS reading of 131 mg/dl to 160 mg/dl. The 11 units administered was higher than the prescribed dose. Interview with the unit manager on 1/8/15 at 8:50 AM verified the resident received the incorrect dose of insulin.

In regard to a change of condition:

Review of the medical showed a fax notification was sent to the attending physician of resident #6 on 11/7/14 at 2:30 PM. This fax was in regard to a change in condition which was observed by the wound care clinic's physician. The change in condition of concern was increased lethargy while at the wound clinic. Further review of the fax notification showed nursing included the resident's blood pressure (BP) readings and pulse for the attending physician's review and noted the resident was on Meloprotol for his/her BP. On the fax, the nurse requested a reply from the attending physician as to what his evaluation and possible change in treatment was. Review of the entire medical record showed no evidence the attending physician acknowledged or responded in regard to the change in condition. Interview with the unit manager on 1/8/15 at 9:30 AM verified there was no evidence the attending physician responded to the fax. Further, there was no evidence nursing staff followed up with the attending physician to send a second notification to inquire about any change in treatment. The unit manager said an effort to re-contact the physician should have been made. Review of the facility change in resident condition or status policy, undated, showed "Nursing services will be responsible for notifying the

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F 309	Continued From page 15 resident's attending physician when. ..there is significant change in the resident's physical, mental, or emotional status."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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, medical record review, facility policy procedure review, and review of professional references, the facility failed to ensure staff provided appropriate incontinence care for dependent residents during two random observations which affected resident #2 and #20. The findings were: 1. Review of the 10/23/14 quarterly MDS assessment revealed resident #2 required extensive assistance with personal hygiene. The following concerns were noted: a. Observation on 1/5/15 at 4:05 PM showed CNA #2 removed the resident's wet and soiled brief and CNA #1 wiped the resident's perineum front to back three times with the same visibly soiled commercial disposable washcloth. During this observation, LPN #1 applied prescription cream to the resident's anus and buttocks, and then to the labia. The aides then assisted the resident to the restroom. After the resident used the toilet, CNA #1 wiped the resident's perineum front to back twice with the same visibly soiled	F 312	F312 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. A) Resident #2 and #20 have received appropriate perineal care since 01/26/15. CNA #1 and CNA #2 were educated on 01/28/15 regarding using wipes that are not visibly soiled. LPN #1 was educated regarding the proper technique for applying cream. B) The Director of Nursing or designee will randomly audit perineal care to ensure that CNAs use wipes that are not visibly soiled and that LPNs properly apply creams per nursing practice. C) The Director of Nursing or designee will conduct and in-service on or before 02/20/15 with nursing staff to ensure that perineal care is provided with wipes that are not visibly soiled and that creams are applied appropriately. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Director of Nursing or designee.	02/20/15

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F 312	Continued From page 16 commercial disposable washcloth. b. Interview on 1/5/15 at 4:30 PM with CNA #1 revealed she was new and was hurried during the care she provided, and did not remember what she had done. c. Interview on 1/5/15 at 4:31 PM with LPN #1 verified that she applied the cream back to front, instead of front to back. 2. Review of the 10/14/14 quarterly MDS assessment revealed resident #20 required extensive assistance with personal hygiene. The following concerns were noted: a. Observation on 1/5/15 at 4:35 PM showed CNA #2 removed the resident's wet and soiled brief and wiped the resident's perineum front to back twice with the same visibly soiled commercial disposable washcloth. b. Interview at that time with the CNA verified this was her normal practice. 3. Interview on 1/8/15 at 9:45 AM with the DON revealed CNAs were trained in perineal care according to the Wyoming Nursing Assistant Candidate Handbook. 4. Review of the Wyoming Nursing Assistant Candidate Handbook dated October 2014 showed "...Washes genital area, moving from front to back, while using a clean area of the washcloth for each stroke..." 6. Review of the undated facility procedure titled "Peri-care" showed "...If wipe [commercial disposable washcloth] is visibly soiled then discard into trash and get a clean one..." 6. According to the seventh edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith,	F 312	E) The Director of Nursing will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 312	Continued From page 17 Duell and Martin, 2008, page 239, "...Clean soiled area by cleansing from front to back...Rationale: prevents contamination...Use a different cloth for each area of the perineum..."	F 312		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff and pharmacist interview and medical record review, the facility failed to ensure a medication error rate of less than 5 percent (%). Four medication errors were observed out of 26 opportunities for error. This resulted in an error rate of 15.38%. The findings were: 1. Observation on 1/6/15 at 8 AM showed RN #1 gave resident #78 Spiriva 18 mcg one inhalation, immediately administered Advair Diskus 500 mcg/50 mcg one inhalation, and five minutes later gave albuterol sulfate 2.5 mg/3 ml via nebulizer. Review of the December 2014 physician orders recapitulation revealed the following: Spiriva 18 mcg two separate inhalations, and albuterol sulfate 1.25 mg/3 ml via nebulizer four times a day. In addition, polyethylene glycol 17 Gram packet was ordered, but not offered to the resident. Interview at that time with the nurse revealed she usually waited one minute between inhalers, but she was nervous and forgot. Additionally, she never asked the resident to inhale Spiriva more	F 332	F332 The facility must ensure that it is free of medication error rate of five percent or greater. A) Resident #78 has had orders for Spiriva and albuterol sulfate have been clarified with the physician. RN #1 has been educated on the 5 Rights of Medication Administration, offering all ordered medications, and following protocol of administering inhalations of medications. B) The Director of Nursing or designee will randomly audit medication administration to ensure inhaled medications are administered according to facility protocol. C) The Director of Nursing or designee will conduct an in-service on or before 02/20/15 with licensed nursing staff to ensure medication administration is done in accordance with facility protocol. D) A Performance Improvement tool will be utilized to conduct random audit. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing will report the results of audits at the monthly Performance Improvement meeting. The	02/20/15

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than once because the resident got angry with her; however, the physician had not been notified of the resident's preference for one inhalation, nor had the resident been educated on the importance of taking two inhalations. Further, the resident was not offered the polyethylene glycol 17 Gram packet because the medication was not available. Finally, the nurse stated she had not checked the original albuterol sulfate order against the medication label on the package.

2. Interview on 1/8/15 at 8:30 AM with the consultant pharmacist showed the expectation is to wait one minute between inhalations of the same medication, and to wait five minutes between inhalations of different medications.

3. According to the seventh edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell and Martin, 2008, page 568, medications should be given according to physician order.

F 356 SS=B 483.30(e) POSTED NURSE STAFFING INFORMATION

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

F 332

report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.

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F 356

F356 The facility must post the following information on a daily basis: Facility name, current date, the total number and actual hours worked by registered nurses, licensed pratical nurses, certified nurse aides along with resident census.

A) The nursing staffing data board has been reposted outside of the staffing office.

B) The Executive Director will randomly audit the nursing staffing board to ensure it is posted daily.

C) The Executive Director will conduct an in-service on or before 02/20/15 with staffing coordinators to ensure nursing

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F 356	Continued From page 19 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: Observation upon entrance into the facility on 1/5/15 at 9:50 AM and periodically throughout the survey which concluded on 1/8/15, revealed there was no posting of the required nurse staffing anywhere in the facility. On 1/8/15 at 1:10 PM an interview with the staff member responsible for posting the nurse staffing stated the posting was taken down during the remodeling of the unit and just had not yet been re-posted.	F 356	staffing board is posted and is up-to-date. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Executive Director or designee. E) The Executive Director will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times	F 368	F368 The facility must offer snacks at bedtime daily. A) Bedtime snacks ordered for all residents on 1/29/15. Dietary staff to begin bedtime snack rounds on 2/2/15. B) The Dietary Director will randomly audit bedtime snacks by asking residents if	02/20/15

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F 368	Continued From page 20 comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident interview, and review of facility policy, the facility failed to ensure snacks were offered to all the residents at bedtime. The resident census was 123. The findings were: Confidential interview on 1/6/15 at 2 PM with ten residents revealed the residents had to ask for a bedtime snack. Each resident confirmed they could ask for a snack, and would receive one, but they were not routinely offered a bedtime snack. Review of the facility policy titled "House Nourishments/Snacks" dated October 2008 showed "...House supplements/snacks will be offered to residents at...HS (bedtime)."	F 368	they were offered a bedtime snack the next day. C) The Director of Nursing will conduct an in-service on or before 02/20/15 with nursing staff and the Dietary Director will have an in-service with dietary staff to ensure that bedtime snacks are regularly passed to all residents. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Dietary Director. E) The Dietary Director will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less three months or until ongoing compliance has been achieved.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	F371 The facility must procure from sources approved or considered satisfactory by Federal, State, or local authorities, and store, prepare, distribute and serve food under sanitary conditions. A) The walk-in refrigerator condenser was cleaned, floor mounted electrical outlets,	02/20/15

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F 371	Continued From page 21 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of cleaning schedules and staff interview, the facility failed to ensure sanitary conditions in 2 of 2 kitchens. The findings were: 1. Observation on 1/5/15 at 10 AM revealed several items and areas in the main kitchen which were in need of cleaning. The following concerns were identified: a. The walk-in refrigerator condenser unit had a build-up of black dust on the fan blades and the outside casing. The condenser was observed on 1/7/15 at 11:50 AM to be in the same unclean condition. b. The floor mounted electrical outlets near the steam table were noted to have a build-up of grease and grime covering the sides and tops of the outlet box. Observation of the outlets on 1/7/15 at 11:15 AM revealed they remained in an unclean condition. c. The walls and ceiling tiles near the beverage station were soiled with liquid splatters and dust. These conditions remained when observed on 1/7/15 at 11:15 AM d. The ice machine in the kitchen was noted to have considerable build up of dust on both of its side vents. In addition, the walls and ceiling near the ice machine were soiled with dust. The	F 371	walls and ceiling tiles near the beverage station, ice machine in the kitchen, and Arrowhead kitchen air conditioner have all been cleaned on 01/29/15. On 01/29/15 boxes in the walk-in freezer were free from mounds of ice. B) The Dietary Director will randomly audit the walk-in refrigerator, floor mounted electrical outlets, walls and ceiling tiles near the beverage station, ice machine in the main kitchen, and Arrowhead kitchen air conditioner to ensure these items are not visibly soiled. The Dietary Director will randomly audit weekly cleaning schedule to ensure all tasks are completely as assigned daily. C) The Dietary Director will conduct an in-service on or before 02/20/15 with dietary staff to ensure that nonfood-contact surfaces are kept free of an accumulation of dust, dirt, food residue, and other debris. The Dietary Director will also in-service dietary staff regarding the importance of completing the dietary weekly cleaning assignments. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Dietary Director. E) The Dietary Director will report the results of audits at the monthly Performance Improvement meeting. The report will include any problems and/or	

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	535032		C 01/08/2015

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F 371	Continued From page 22 dust was still present on 1/7/15 at 11:15 AM 2. Observation on 1/7/15 at 11:55 AM showed the Arrowhead kitchen had a wall mounted air conditioner which was visibly soiled with a build-up of dust and grime. The air conditioner was located above a preparation table adjacent to the steam table. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. Review of the weekly cleaning schedule for the week of 1/5/15 showed cleaning assignments were made by position and shift; however were not signed off as being completed. Interview with the dietary manager on 1/5/15 at 11:50 AM verified the cleaning needed to be better planned and accomplished more regularly. Additionally, the dietary manager notified the maintenance department in regard to the dusty air filters in the ice machine. 4. Observation on 1/5/15 at 10 AM showed ice mounds formed on 5 boxes of food located in the walk-in freezer. These boxes were stored in the area of the freezer under the condenser unit. Interview with the dietary manager on 1/5/15 at 11:50 AM verified there was an ongoing problem with ice in this area of the freezer. According to Food Code 2013, U.S. Public Health Service: 3.305.11 "(A) Except as specified in ¶¶ (B) and	F 371	trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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F 371	Continued From page 23 (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination..."	F 371		
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure 2 of 24 sample residents (#6, #42) received physician services for medication management in a timely manner. The findings were: 1. Review of the medical record showed a fax notification was sent to the attending physician of resident #6 on 11/7/14 at 2:30 PM. This fax was in regard to a change in condition which was observed by the wound care clinic's physician. The change in condition of concern was increased lethargy while at the wound clinic. Further review of the fax notification showed nursing included the resident's blood pressure readings and pulse for the attending physician's review and noted the resident was on Metoprolol	F 385	F385 The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. A) Resident #6's physician was refaxed on 01/28/15 with a response received on 01/29/15. Resident #42 continues on Namenda 20 mg daily. B) The Director of Nursing or designee will randomly audit faxed requests to physicians to ensure timely response is received. C) The Director of Nursing or designee will conduct and in-service on or before 02/20/15 to ensure that faxed requests to physicians receive timely responses. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Director of Nursing or designee. E) The Director of Nursing will report the result of audits at the monthly Performance Improvement meeting. The report will include any problems and/or	02/20/15

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F 385	Continued From page 24 for his/her blood pressure. On the fax, the nurse requested a reply from the attending physician as to what his evaluation and possible change in treatment was. Review of the entire medical record showed no evidence the attending physician acknowledged or responded in regard to the change in condition. Interview with the unit manager on 1/8/15 at 9:30 AM verified there was no evidence the attending physician responded to the fax. Further, there was no evidence nursing staff followed up with the attending physician to send a second notification to inquire about any change in treatment. The unit manager said an effort to re-contact the physician should have been made. Review of the facility change in resident condition or status policy, undated, showed "Nursing services will be responsible for notifying the resident's attending physician when....there is significant change in the resident's physical, mental, or emotional status." 2. Review of the 6/10/14 physician orders for resident #42 showed the physician ordered Namenda XR 21 mg daily for dementia. Review of the November and December 2014 MARs showed the medication was not administered after 11/19/14. Interview with LPN #2 on 1/7/15 at 12:55 PM revealed the resident did not receive the medication because it was no longer covered by the insurance company. At that time she also stated the physician was notified about this as soon as the insurance company informed the facility, but the repeated requests from the nursing staff for the physicians to address this concern were ignored. She further stated she was not aware of a process that would ensure a timely response from the physicians. Review of the physician notification and order forms showed the physician ordered Namenda 20 mg daily on	F 385	trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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12/8/14 (19 days later) as a substitute for the Namenda XR that the insurance company did not cover.

F 425 SS=D 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff, pharmacist, and resident interview, and medical record review, the facility failed to ensure medications were available for resident administration on a timely basis for 3 of 24 sample residents (#6, #40, #42) and 1 non-sample resident (#78). The findings were.

F 385

F 425 F425 A facility must provide and emergency drugs and biological to its residents, or obtain them under an agreement. A facility must provide pharmaceutical services to meet the needs of each resident. 02/20/15

A) Resident #40 has a continuous supply of Celebrex. Resident #6 has had Fentanyl patch replaced timely since 01/26/15. Resident #42 continues on Namenda 20 mg daily.

B) The Director of Nursing or designee will randomly audit availability of resident medication during medication administration.

C) The Director of Nursing or designee will conduct an in-service on or before 02/20/15 with nursing staff to ensure availability of resident medication during medication administration. Director of Nursing has in-serviced contracted pharmacy on 01/13/15 to ensure availability of resident medications.

D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Director of Nursing or designee.

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F 425	Continued From page 26 1. Review of the November and December 2014 and January 2015 MARs showed resident #40 had an order for Celebrex 200 mg daily for generalized pain. The resident had diagnoses that included multiple sclerosis. The following concerns were identified: a. Interview with the resident on 1/5/15 at 3:20 PM revealed there were problems keeping the Celebrex available, and this was upsetting, because it worked well to treat his/her pain. The resident stated this was an ongoing problem and there had been a couple days in January when it was not available. b. Review of the MARs showed the medication was not administered on 1/2/15 and 1/3/15. The nurse noted on the back of the MAR the reason on 1/2/15 was "out of Celebrex." In addition, the December 2014 MAR showed 2 days (12/4 and 12/5) when the initials were circled and it was noted "out" above the 12/4/15 date. There was nothing documented on the reverse side by the nurse related to this medication. The November 2014 MAR showed 3 days (11/18, 11/9, 11/20) when the medication was "out." c. Review of the 12/4/14 physician progress note showed the resident's insurance plan limited the number of Celebrex tablets that could be delivered at a time. The plan was to "attempt to obtain a more continuous supply of Celebrex, which the patient wishes to continue despite being offered a different pain medicine." 2. Review of the medical record showed resident #6 had a diagnosis of generalized pain. Review of the 6/5/13 physician's order showed a Fentanyl patch 50 mcg transdermal every 3 days was ordered for pain. Review of the December 2014 MAR showed the resident was due for a new	F 425	E) The Director of Nursing will report the result of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.	

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Fentanyl patch on 12/30/14 however, there was no 50 mcg patch available. Review of the 12/30/14 nurse's medication notes showed "No Fentanyl Patch available..." Review of the January 2015 MAR showed the Fentanyl patch was placed at 12 PM on 1/2/15. The new patch was placed 3 days late.

3. Review of the December 2014 MAR showed resident #78 had a diagnosis of chronic airway obstruction, with a physician order for Advair Diskus 500 mcg/50 mcg by mouth twice a day. Additional review revealed the resident was not administered the medication from 12/21/14 through 12/31/14. Further, there was documentation dated 12/21/14 that Advair was not available, and again on 12/28/14 and 12/29/14; however, documentation was lacking why the medication was not administered for the intervening six days. Also, documentation dated 12/30/14 timed 6 PM showed the medication "arrived from pharmacy and given." In addition, observation on 1/6/15 at 8 AM showed RN #1 gave resident #78 medications. However, polyethylene glycol 17 Gram packet was ordered, but not offered to the resident. Interview at that time with the nurse revealed the medication was not available from the pharmacy.

4. Review of the 6/10/14 physician orders for resident #42 showed the physician ordered Namenda XR 21 mg daily for dementia. Review of the November and December 2014 MARs showed the medication was not administered after 11/19/14. Interview with LPN #2 on 1/7/15 at 12:55 PM revealed the resident did not receive the medication because it was no longer covered by the insurance company. At that time she also stated the physician did not address this concern

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F 425	Continued From page 28 until 12/8/14. Review of the physician notification and order forms showed the physician ordered Namenda 20 mg daily on 12/8/14 as a substitute for the Namenda XR the insurance company did not cover. Interview on 1/8/15 at 8:35 AM with the pharmacy consultant revealed he did not know the insurance company discontinued coverage of the medication. 5. During an interview with the pharmacist consultant on 1/8/15 at 8:30 AM, he said part of the problem with the lack of timely provision of medications was because of the insurance requirements imposed upon the pharmacy. The pharmacist further said the problem was identified in November and he was trying to resolve the issues.	F 425		
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	F441 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) Housekeeper #1 has been educated on proper use of PPE and hand hygiene. CNA #4 has been educated regarding proper cleaning or disposal of O2 nasal cannula when it touches the floor. CNA #1 and CNA #2 were educated on proper hand hygiene. B) The Director of Nursing or designee will conduct random audits of laundry staff to ensure proper use of PPE and proper hand hygiene. The Director of Nursing will conduct random audits of residents needing extensive assistance with ADLs	02/20/15

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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 policies and procedures, the facility failed to ensure staff followed appropriate infection control practices when performing hand hygiene, adjusting oxygen tubing, and handling dirty linen during 3 random observations. The findings were:

In regards to linen:

1. On 1/7/15 from 7:05 AM to 7:20 AM housekeeper #1 gathered the dirty linen from 3 different soiled linen rooms and placed it in a wheeled linen cart. During the observation the housekeeper wore the PPE (personal protective equipment) gown with the front opened and some of the un-bagged soiled linen had direct contact with her clothing. Further observation revealed the housekeeper opened and closed each linen

F 441

to ensure O2 tubing is properly cleaned or is disposed of does when touching the floor. The Director of Nursing or designee will conduct random audits of CNA hand hygiene during care of residents needing extensive assistance with ADLs.

C) The Director of Nursing or designee will conduct an in-service on or before 02/20/15 with nursing staff to ensure proper cleaning or disposal of O2 nasal cannula after touching the floor and to ensure that proper hand hygiene used during ADL care for residents requiring extensive assistance. The Director of Nursing will conduct an in-service on or before 02/20/15 with laundry staff to ensure proper use of PPE and proper hand hygiene.

D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Director of Nursing or designee.

E) The Director of Nursing will report the result of audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until ongoing compliance has been achieved.

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F 441	Continued From page 30	F 441		

room door and handled the dirty linen while wearing the same pair of gloves. On 1/7/15 at 7:20 AM, the DON observed the housekeeper and verified the housekeeper was not following the facility's infection control procedures and wearing the gown backwards did not provide adequate protection.

In regards to oxygen tubing:

Review of the 10/14/14 quarterly MDS assessment showed resident #20 was coded as needing extensive assistance with ADLs. Observation on 1/5/15 at 4:55 PM showed CNA #4 retrieved the resident's oxygen tubing from the floor and placed the cannula on the resident's face. Interview at that time with the CNA revealed he usually cleaned the cannula and tubing with soap and water, but "didn't think about it." Interview on 1/8/15 at 9:45 AM with the ADON revealed the facility expectation was to clean oxygen tubing after it has been on the floor, or to replace it with new tubing. Review of the facility procedure titled "Use of Oxygen" dated 5/21/2004 showed "...The following guidelines will be observed in oxygen administration...The O2 cannula...change it when soiled or dirty. Keep the tubing off the floor..."

In regards to hand washing:

1. Observation on 1/5/15 at 4:05 PM showed CNA #1 and CNA #2 provided perineal care to resident #2 in his/her room. After the resident was assisted, the CNAs removed their gloves, but did not perform hand hygiene, and assisted the resident with dressing and transferring into the wheelchair, and then to the toilet. The CNAs then washed their hands. Next, CNA #1 performed

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F 441	Continued From page 31 pericare with gloved hands, assisted the resident to the wheelchair without removing her gloves, handed the resident his/her water mug, and then she removed her gloves and performed hand hygiene. 2. Observation on 1/5/15 at 4:35 PM showed CNA #2 provided pericare to resident #20 in his/her room. The aide removed the resident's wet and soiled brief, used a wipe to clean the resident's perineum from front to back, then turned the visible soiled wipe over and used the other side to clean the resident's perineum from front to back again. The CNA then used the same glove to retrieve another wipe from the container and wipe front to back again, applied barrier cream to the resident's perineum, and then removed her soiled gloves. Interview at that time with the CNA revealed this was her usual way of providing personal care. Interview on 1/8/15 at 9:45 AM with the ADON revealed the facility expectation was for staff members to change gloves when soiled, and to perform hand washing or use sanitizer between glove changes. 3. Review of the facility procedure titled "Hand Washing" dated 8/13/14 revealed "...Hand washing/hygiene should be performed: Before and after resident contact, Before and after a procedure, when hands visibly soiled...On completion of pericare discard gloves and wash hands before touching resident, clean pad, linens, or personal items..."	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	F520 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	02/20/15

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F 520	Continued From page 32 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of medication errors policy and procedures, the facility failed to ensure the quality assurance (QA) program effectively identified, tracked and created an action plan related to medication errors and omissions. During the survey, 4 of 24 sample residents (#6, #40, #42, #74) and 1 non-sample resident (#78) were identified with medication errors of omission. The findings were: Interview with the administrator and DON on 1/8/15 at 1 PM revealed the last QA meeting was	F 520	A) Weekly audits of all residents' MARS to identify omissions initiated 1/7/15. Medication Error/Omission Report to be completed with each omission starting on 1/29/15. Director of Nursing has in-serviced contracted pharmacy on 01/13/15 regarding the importance of medications being available timely. Director of Nursing and in-house physicians ordered an expanded emergency kit on 01/20/15 B) Director of Nursing or designee will conduct random audits of residents' MARS to ensure omissions have Medication Error Report completed and is reported to the Quality Assurance Committee the following month. C) The Director of Nursing or designee will conduct an in-service on or before 02/20/15 with nursing staff regarding completion of Medication Error/Omission Report for omitted medications. The Executive Director or designee will conduct an in-service with the Quality Assurance Committee on or before 02/20/15 to ensure the quality assurance program effectively identifies, tracks, and creates an action plan for identified medication errors and omissions. D) A Performance Improvement tool will be utilized to conduct random audits. Any problems identified will result in immediate education and/or corrective action. The audits will be conducted by the Director of Nursing or designee.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530033	A. BUILDING _____ B. WING _____	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 33 held on 12/17/14 and the facility was aware of problems with obtaining medications from the pharmacy in a timely manner. The two further verified the consultant pharmacist participated in the quality meetings and provided monthly reports. In regards to medications, the DON stated formal audits of resident MARs hadn't been completed for the last couple of months; however, they were visually inspected. Additionally, the DON stated medication errors were reported and tracked. Review of the information provided for monthly medication errors showed from July 2014 to December 2014 there were monthly medication errors which ranged from 4 per month to 12 errors per month. Interview with the DON on 1/8/15 at 2:25 PM verified these monthly totals did not include errors of omitted medications for residents. Review of the policy and procedure for medication errors dated 10/2010 showed "A Medication Error/Omission Report is completed on all medication administration errors." This policy and procedure did not define mediation errors or omissions however it did outline process for review of medication errors and omissions through the quality assurance program: "...9. The quality assurance coordinator completes a tool for assessing severity of medication errors on each error using the information on the Medication/Omission,...10. The quality assurance coordinator completes a monthly summation of medication errors/omissions, and this information is reported to the Pharmacy & Therapeutics Committee and Nursing Quality Assurance Council for review and follow-up."	F 520	E) The Director of Nursing will report the result of audits and a summary of Medication Error/Omission Reports at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting of audits will occur for no less than three months or until ongoing compliance has been achieved. A summary of Medication Error/Omission Reports will be submitted monthly until ongoing compliance has been achieved.	