POC accepted 3/14/08 at 0830 with day of compliance for federal tags 3/4/08 per telephone call with Donna Schultz

DEPARTMENT OF HEALTH AND HUM. SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
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
	535034	A. BUILDING _____ B. WING _____	01/31/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

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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, staff interview and medical record review, the facility failed to ensure dignity was maintained for three (#4, #20, #53) of 13 sample residents. The findings were: 1. Observation on 1/29/08 at 9:55 AM revealed certified nurse aide (CNA) #1 placed resident #53 into bed. Continued observation revealed the CNA left the resident's slacks down around his/her ankles. Periodic observation from 9:55 until noon revealed the slacks remained down around the resident's ankles until s/he was gotten up for lunch. Review of the 11/29/07 significant change Minimum Data Set (MDS) assessment revealed the resident was unable to communicate verbally. However, based on the reasonable person, having slacks placed around the ankles for an extended period of time was not dignified. During an interview with the director of nursing (DON) on 1/31/08 at 8:15 AM, she confirmed slacks should not be left around the ankles. 2. Observation on 1/29/08 at 10 AM revealed CNA #6 entered the room of residents #4 and #20 without knocking or announcing herself. During an interview with the DON on 1/31/08 at 11:15 AM, she stated staff should knock prior to entering resident rooms.	F 241	Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged or that any regulatory violations occurred. **F241:** 1 Resident #53 will have the slacks removed entirely or pulled back up while in bed for a nap. Residents who require assistance with ADLs will be put in bed with appropriate placement of clothing. 2. Nursing staff was inserviced on 2-14-08 by the Director of Nursing on the appropriate garment placement on residents while in bed; and on knocking on doors before entering a resident's room 3. Residents that require assistance with ADLs will be randomly observed weekly by IDT members to ensure that residents are appropriately laid down in bed and garments are appropriately placed on the residents for comfort. Random weekly observations will be made by IDT members of staff knocking on doors and asking resident for permission	3/04/08
F 280	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Schultz — TITLE: Admin Asst — (X6) DATE: 2/25/08

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.

FEB 26 2008

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F 280 SS=D	Continued From page 1 CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to update the written plan of care for 3 (#14, #52, #53) of 13 open sample residents. The findings were: 1. Observation on 1/28/08 at 5:25 PM and on 1/30/08 at 8:25 AM revealed resident #52 drank thin (regular) liquids. A 10/24/07 physician order showed the resident's diet order was changed to include regular liquids. Review of a discharge summary from the speech therapist dated 11/11/07 showed the resident was able to drink regular liquids. However, review of the current	F 280	to enter. Deviation from standards will be corrected immediately 4. Results of random weekly audits will be reviewed by the Quality Assurance Committee for recommendation and continued compliance. Audits will be reviewed for 3 months and then re-evaluated. **F280** 1. The care plan for resident #52 has been updated to reflect the correct liquid consistency to be given. The care plan for #53 has been developed for interventions for contractures. Care plan for resident #14 has been updated to reflect the discontinuation of the catheter. 2. A complete review of resident's care plans will be done to ensure the care plan reflects the resident's current condition in the following areas: use of thickened liquids, catheter use, All mechanical lifts, and contractures. Care plans will be revised if issues are found. in any areas of plan of care	3/04/08

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F 280	Continued From page 2 care plan dated 12/18/07 showed the resident was to have nectar thick liquids. During an interview on 1/30/08 at 4:43 PM the registered dietitian stated the resident was on regular liquids and the care plan should have been changed. 2. Periodic observations on 1/28/08 from 4:25 PM through 1/30/08 at 6 PM revealed resident #53 had contractures of both hands. Review of the 10/30/07 care plan revealed the resident's contractures were not addressed. Interview with the director of nursing on 1/31/08 at 8:15 AM revealed contractures should be included in the resident's care plan. 3. Review of the 12/4/07 care plan for resident #14 revealed s/he had an indwelling catheter and required transfer with a gait belt and a 1-2 person assist. However, observation on 1/29/08 at 8:20 AM revealed the resident required the use of a mechanical lift for transfers. In addition, observation showed the resident did not have a catheter. Review of a physician's order dated 12/21/07 showed the urinary catheter was discontinued. Interview with the director of nursing on 1/30/08 at 10:07 AM confirmed the care plan did not reflect the current status of the resident and needed to be updated.	F 280	3. The Interdisciplinary Team will receive further inservice on the care plan process to include initiating and revising care plans. Random weekly reviews of care plans will be done by the risk team to assure that care plans are reflecting the resident's current condition and needs in regards to thickened liquids, catheter use, mechanical lifts and contractures. Any deviations from standard will be corrected immediately. 4. Results of random weekly care plan reviews to assure care plans reflect the residents current needs for thickened liquids, catheters, mechanical lifts and contractures will be reviewed by the QA committee for recommendation and continued compliance. Results will be reviewed for three months and reevaluated.	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure standards of practice were followed regarding following physician's orders, assessment, and	F 281	**F281** 1. For resident #27, blood sugar checks and catheter care will be documented as ordered by the physician. Resident #53 will receive	3/04/08

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F 281	Continued From page 3 follow up response for three (#7, #27, #53) of 13 sample residents. The findings were: 1. Review of the 1/08 physician orders recapitulation for resident #27 revealed s/he had diagnoses including diabetes. Review of the 1/6/08 physician's order revealed an order for blood sugar checks twice daily at varied times. Review of the 1/08 medication administration record revealed only one, instead of two, blood sugar checks were performed on 7 of 29 days and no blood sugar checks were performed on 1/14/08. Interview with the director of nursing (DON) on 1/31/08 at 10 AM revealed there was no evidence the blood sugar checks were performed as noted above. Review of the 12/20/07 physician's orders revealed an order to provide catheter care every shift. Review of the 1/08 treatment administration record revealed catheter care was not provided 19 of 29 times on the day shift and 18 of 29 times on the evening shift. Interview with the DON on 1/31/08 at 10 AM revealed there was no evidence the catheter care was provided on the above noted dates and times. 2. Review of the 10/22/07 quarterly and the 11/29/07 significant change Minimum Data Set (MDS) assessments for resident #53 revealed s/he was totally dependent on staff for all activities of daily living and was unable to verbally communicate. Review of these documents also revealed the resident had severe cognitive impairment. Review of the nursing notes revealed the following concerns: a. The nursing entry for 4/27/07 timed 11:20 PM revealed the resident had bruises to both posterior hands. Review of the nursing notes revealed there was no evidence an assessment	F 281	a head to toe skin assessment to assure if any bruising found is investigated. Resident #7 was seen by the Physician on 2-11-08, problems and medication regime was reviewed at that time and no changes were made. 2. A complete audit of physician faxes and orders will be done to assure that all have been responded to timely. Records will be audited for accuracy of documenting blood sugar checks and catheter care, and an audit of occurrence reports and progress notes will be done to identify any bruises that have not been fully investigated. Issues identified will be corrected immediately. 3. The D.O.N. has inserviced the licensed nurses on 2-14-08 on the process for faxing physicians and receiving a timely response; on accurate documentation of blood sugar checks and catheter care; and	

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F 281	Continued From page 4 to determine the cause and severity of the bruises was performed. b. The nursing entry for 9/5/07 timed 3 AM revealed the resident had a three inch bruise on the right forearm. Review of the nursing notes revealed there was no evidence an assessment to determine the cause and severity of the bruise was performed. c. The nursing entry for 10/31/07 timed at 5 AM revealed there was an aging bruise observed under the resident's chin. Review of previous nursing notes revealed no earlier entry regarding a bruise. In addition, review of the following nursing notes revealed there was no evidence there was an assessment to determine the cause or severity of the bruise. d. Interview with the DON on 1/31/08 at 10 AM revealed there was no evidence an assessment of the bruises was performed. According to Clinical Nursing Skills by Smith, Duell, and Martin, sixth edition, 2004, page 4 "The responsibilities of the professional nurse involve a level of performance for a defined range of healthcare services. These services include assessment..." 3. Review of physician orders showed resident #7 received Aspirin 325 milligrams (mg) and Plavix [antiplatelet drug] 75 mg every day. Further review of the medical record revealed a fax communication form from nursing to the physician dated 12/27/07. The nurse wrote that the resident received 325 mg of Aspirin and was having increased bruising at insulin injection sites and on the arms. The nurse asked if the Aspirin dose should be decreased to 81 mg. A nursing note dated 12/28/07 showed the physician was	F 281	on follow-up and comprehensive investigation of bruises. Faxes will be reviewed in the IDT morning meeting to assure that they are being responded to timely. Random weekly reviews of Medical records will be completed by the risk team to assure documentation of blood sugar checks and catheter care. Bruises and investigations will be reviewed in the IDT morning meeting to assure they are timely and comprehensive. 4. Results of faxes being responded to timely, treatments signed off timely and bruises investigated will be reviewed by the QA committee for recommendation and continued compliance. Results will be reviewed for three months and reevaluated.	

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F 281	Continued From page 5 sent a fax about the bruising and the Aspirin dose, but there was no response back yet. Observation on 1/30/08 at 2:30 PM revealed the resident had two bruises on the left leg, one on the right leg, one on the abdomen, four on the right arm, and five on the left arm. Further review of the medical record on 1/30/08 (a month after the communication form was filled out) showed no response from the physician. In addition, there lacked evidence that nursing staff followed up with the physician regarding this issue. During an interview on 1/30/08 at 4:15 PM, the MDS coordinator stated the facility called the physician's office and they had no record of receiving the fax. According to "Nursing and the Law, Trends and Issues", Kammie Monarch, RN, MS, JD, copyright 2002, page 60, "...nurses are in the best position to promptly detect changes in a patient's condition. Detection, however is only the first step. Nurses are required to promptly communicate troublesome patient findings."	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed the care plan for two (#14, #53) of 13 sample residents. The findings were:	F 282	**F282** 1. The heels of residents #53 and #14 are being floated while in bed. 2. An audit of care plans will be completed by IDT members to identify residents who need to have heels floated. Interventions will be implemented as needed.	3/05/08

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F 282	Continued From page 6 1. Review of the 11/29/07 Braden scale pressure ulcer assessment for resident #53 revealed s/he was at risk for skin breakdown. Review of the 10/31/07 care plan revealed the resident had impaired skin integrity due to the resident's immobility and required his/her heels floated to prevent pressure ulcers. Periodic observations from 1/28/08 at 4:25 PM until 1/30/08 at 6 PM revealed the resident's heels were not floated. Interview with the director of nursing on 1/31/08 at 8:15 AM revealed the resident should have had his/her heels floated to prevent skin breakdown. 2. Review of the 11/27/07 admission Minimum Data Set assessment for resident #14 revealed s/he triggered for pressure ulcers. Review of the 12/7/07 care plan revealed the resident had impaired skin integrity due to the resident's immobility and required his/her heels floated to prevent pressure ulcers while in bed. Observation on 1/28/08 at 7:20 AM and again at 9:35 AM revealed the resident's heels were not floated while s/he was in bed. Interview with the director of nursing on 1/31/08 at 8:15 AM revealed the resident should have had his/her heels floated to prevent skin breakdown.	F 282	3. The D.O.N. has inserviced the nursing staff on 2-14-08 on following care plan interventions. A list of residents needing heels floated will be compiled by the D.O.N. and a random weekly observation to assure resident's heels are being floated will be completed by IDT members. Issues identified will be corrected immediately. 4. Results of weekly observational reviews to assure that resident's heels are being floated according to the care plan will be reviewed by the QA committee for recommendation and continued compliance. Results will be reviewed for three months and reevaluated.	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure	F 312	**F312** 1. Resident #53 is receiving pericare which includes all skin which may have been in contact with urine.	3/03/08

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F 312	Continued From page 7 staff provided appropriate perineal care during three of four observations of perineal care. The findings were: 1. Review of the 11/29/07 bowel and bladder assessment for resident #53 revealed s/he was incontinent of bowel and bladder. Review of the 11/29/07 significant change Minimum Data Set (MDS) assessment revealed the resident required total dependence on staff for personal hygiene. Observation on 1/29/08 at 8 AM revealed certified nurse aide (CNA) #1 provided perineal care after s/he removed the resident's incontinence brief which was wet with urine. Observation revealed the CNA did not cleanse the anterior pubic and perineal areas nor the buttocks, all of which were in contact with the wet incontinence brief. Observation on 1/29/08 at 9:55 AM revealed CNA #1 provided perineal care for the resident after removing a wet incontinence brief. Continued observation revealed the CNA did not cleanse the anterior pubic and perineal areas not the buttocks, all of which were in contact with the wet incontinence brief. Interview with the CNA on 1/29/08 at 11:10 AM revealed s/he was aware all areas of the body in contact with the wet incontinence brief should be cleansed and stated s/he just forgot to complete the full perineal care process. 2. Observation on 1/29/08 at 11:30 AM revealed resident #52 was incontinent of urine and feces. Observation revealed while CNA #2 provided perineal care, s/he used an area of the wipe which was smeared with feces to cleanse the areas of both buttocks where feces were not present. In addition, observation revealed the CNA used a wipe soiled with feces to cleanse the perineal area and inner thighs four times.	F 312	The resident is free of sign and symptoms of urinary tract infection. Resident #52 is receiving pericare using multiple wipes so non-soiled areas of skin do not become soiled. The resident is free of signs and symptoms of urinary tract infection and the skin is in good condition. 2. Nursing staff will receive additional inservice on proper incontinent care and technique, to include a return demonstration on technique and supplies to be used. 3. Random weekly observation of staff performing pericare will be completed by the D.O.N. or designee to assure that staff is following proper procedure. Immediate retraining will be done if there is a deviation from standard. 4. Results of random weekly observations to assure that pericare is being performed according to policy will be reviewed by the QA	

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F 312	Continued From page 8 3. Interview with the director of nursing/infection control representative on 1/31/08 at 8:15 AM revealed a soiled wipe should not be used more than once and that all areas of the body that were in contact with the wet or soiled incontinence brief should be cleansed.	F 312	committee for recommendation and continued compliance. Results will be reviewed for 3 months and reevaluated	
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 provide care to prevent a urinary tract infection for one (#27) resident and failed to provide timely treatment for signs and symptoms of a urinary tract infection for another resident (#4), out of a sample of six residents with urinary catheters. The findings were: 1. Review of the recapitulation of January 2008 physician's orders showed resident #4 had a diagnosis of urinary retention and bladder spasms. In addition, these orders showed a standing order related to urinary tract infections (UTIs). The physician was to be contacted if there were signs and symptoms of a UTI for residents	F 315	**F315** 1. Resident #4 has resolved signs and symptoms of urinary tract infection, the skin is intact. Resident #27 will receive one-to-one training on the proper techniques of doing personal care hygiene correctly. There are no signs and symptom of UTI. 2. Residents who are independent with pericare will be identified for repeat urinary tract infections and training on personal hygiene technique will be provided by the D.O.N. or designee. A review of lab results will be done to assure that lab results have been addressed timely for treatment. Progress notes will be reviewed to	3/04/08

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F 315	Continued From page 9 with catheters. Observation on 1/29/08 at 4:15 PM showed the resident continued to utilize a urinary catheter; and according to the 1/8/08 quarterly Minimum Data Set assessment, the resident had a UTI in the past 30 days. The following concerns related to timely treatment of the UTI were noted: a. Review of a nursing note dated 11/22/07 at 9:35 PM showed the resident's catheter was changed and the nurse noted, "urine cloudy with some blood". b. Review of the medical record showed the physician was not contacted about the urine. However, on 11/28/07 a nursing note timed 12:30 PM revealed a nurse contacted the physician regarding the complete blood count (CBC) lab results. The note showed there were elevated white and red blood cell values. On 11/28/07 at 4:50 PM the physician responded back to the nursing home with a order to repeat the CBC in a month. There were no other orders noted. c. On 12/6/07 a communication form was sent to the physician that showed the resident was complaining of abdominal pain. Further record review showed a urinalysis was performed that day, and was positive for a UTI. d. On 12/7/07, 15 days after noting the cloudy, bloody urine, new orders were received from the physician for Cipro 250 mg twice daily to treat the UTI. e. Interview with the director of nursing on 1/30/08 at 5:22 PM confirmed signs and symptoms were present on 11/22/07 and treatment should have been provided sooner. 2. Review of the 11/16/07 quarterly and the 1/14/08 significant change Minimum Data Set (MDS) assessment for resident #27 revealed s/he had an indwelling catheter. Observation on	F 315	assure that residents identified with signs and symptoms of urinary tract infection have received appropriate follow-up and treatment. 3. Nursing staff will be inserviced on providing prompting and cueing for those residents who perform their own personal hygiene to use the correct techniques. Licensed nurses will receive additional training on the process for timely follow up on identified signs and symptoms of urinary tract infection to include: assessment, notification of the physician, timely treatment and documentation. Monthly reviews of residents who do self care, and tracking and trending of urinary tract infections will be done by the Staff Development Coordinator. Random weekly reviews of labs will be done by the IDT members to	

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F 315	Continued From page 10 1/29/08 at 9:20 AM revealed the resident had a bowel movement on the way to the bathroom. Observation revealed the resident cleansed his/herself in the bathroom while certified nurse aide (CNA) #3 provided oversight. Continued observation revealed the resident did not use front to back technique and did not follow the process of using a wipe only once after it was soiled with feces. Observation revealed the resident used the same soiled wipe multiple times while s/he cleanse the perineal area and catheter. The following concerns were identified: a. Observation revealed the CNA did not assist or cue the resident when s/he did not use the proper cleansing technique to prevent infection. b. Review of the 1/14/08 timed at 6:15 PM nursing noted revealed the resident was readmitted from the hospital after having Escherichia coli (E.coli) sepsis pyelonephritis. According to Mosby's Diagnostic and Laboratory Test Reference, 6th edition, 2003, page 828, E. coli is a bacteria that is commonly found in the bowel. The organism is associated with infection resulting from fecal contamination following improper perineal hygiene.	F 315	assure that labs are followed up timely and treatment is provided. 4. Results of weekly lab reviews and infection tracking and trending will be reviewed monthly by the QA committee for recommendation and continued compliance. **F329** 1. For resident #43 the dosage of Tranxene was changed to match the Physician's order found in the physician's progress note. A sleep assessment will be done on resident #25.	
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	2. Physician progress notes will be audited to assure that all physician's orders have been captured and implemented. The records of residents receiving antipsychotic and hypnotic medications will be	3/04/08

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F 329	Continued From page 11 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the drug regimen was free from unnecessary drugs for 2 (#25, #43) of 15 sample residents. The findings were: 1. Review of physician orders showed resident #43 received Tranxene [antianxiety; benzodiazepine] 7.5 milligrams (mg) twice per day since 1/18/07. Review of the "Antipsychotic Medication Quarterly Evaluation" in the medical record dated 1/17/08 showed the resident received Tranxene 7.5 mg twice per day. The assessment showed the resident did not exhibit behavioral episodes (anxiousness, danger to self) and the last dose reduction was 1/18/07. However, review of a physician progress note dated 3/20/07 showed "...no further anxiety now. We will decrease Tranxene to 7.5 q hs [at bedtime]." However, the progress note was not noted by a nurse, and there lacked evidence the physician wrote an order to decrease the	F 329	audited by IDT members for presence of dosage reduction attempts per guidelines, issues identified will be addressed by the risk team and consulting Pharmacist. 3. Licensed Nurses were inserviced by the consulting Pharmacist on 2-19-08 on the utilization of antipsychotic and hypnotic medication and the need for assessment and dosage reduction attempts. This included behavior monitoring and sleep assessment. Random weekly audits of physician's progress notes will be done by the risk team to assure that new orders have been noted and transcribed timely to the physician's orders. A pharmacy review committee has been developed made up of DON, IDT and pharmacy consultant to review residents monthly who receive antipsychotic or hypnotic medication. This team will review	

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F 329	Continued From page 12 Tranxene. The subsequent 5/17/07 physician progress note showed the resident "..is doing well on the lower dose of Tranxene...We will continue with Tranxene 7.5 q h.s." However, the Tranxene was never reduced, but remained at 7.5 mg twice per day. During an interview on 1/31/08 at 9:20 AM the director of nursing (DON) stated the resident remained on Tranxene 7.5 mg twice per day, and there had been no dose reduction since 1/18/07. The DON further stated nursing staff should have noted the hysician's progress note because "doctors don't always write orders when [they] mean to." 2. Review of the medical record face sheet showed resident #25 was re-admitted to the facility on 7/2/07 with diagnoses including insomnia. According to a 7/2/07 physician's order, the resident was prescribed temazepam (a hypnotic) 30 mg every night. Further review of the record showed there was no assessment or evaluation related to the resident's insomnia or use of the hypnotic medication. In addition, there was no evidence an attempted dose reduction was tried from 7/2/07 to when the medication was changed to another hypnotic on 12/18/07. Interview with the director of nursing on 1/30/08 at 3:30 PM confirmed a sleep assessment related to the insomnia was not done.	F 329	drug utilization and necessity, assessment, behavior monitoring and dose reduction activities. 4. Results of monthly restraint proper committee reviews and activities and the physican's progress notes audited will be reviewed by the QA committee for recommendation and continued compliance. **F441** 1. Resident #27 is being cued and assisted by nursing staff in performing pericare with the correct technique. Residents #27, #52 and #53 remain free from infection. 2. Staff was inserviced by the D.O.N. on 2-14-08 on correct pericare techniques, handling and disposal of pericare supplies, use of	3/04/08
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as	F 441		

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F 441	Continued From page 13 isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control records, the facility failed to ensure staff observed appropriate infection control practice when they assisted with perineal care during three of three observations of perineal care for sample residents, while they adjusted or replaced nasal cannulas during three of three observations, and during one of two meal observations. The findings were: 1. Review of the 11/16/08 quarterly and the 1/14/08 significant change Minimum Data Set (MDS) assessment for resident #27 revealed s/he had an indwelling catheter. Observation on 1/29/08 at 9:20 AM revealed the resident had a bowel movement on the way to the bathroom. Observation revealed the resident cleansed his/herself in the bathroom while certified nurse aide (CNA) #3 provided oversight. Continued observation revealed the resident wiped from back to front and also used the same soiled wipe multiple times while s/he cleansed the perineal area and catheter. The following concerns were identified: a. Observation revealed the CNA did not assist or cue the resident to use front to back strokes and to discard the wipes soiled with feces instead of re-using them to prevent a potential infection. b. Review of the 1/14/08 timed at 6:15 PM nursing notes revealed the resident was readmitted after a hospital stay with the diagnosis	F 441	gloves and hand washing, and the handling, storage and sanitizing of nasal cannulas. Random weekly audits will be done by the Staff Development Coordinator to observe pericare techniques, handling and disposal of pericare supplies, hand washing, glove use and cannula care. 4. Results of weekly observations to assure accurate staff practices will be reviewed by the QA committee for recommendation and continued compliance.	

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F 441	Continued From page 14 of Escherichia coli (E.coli) sepsis pyelonephritis. According to Mosby's Diagnostic and Laboratory Test Reference, 6th edition, 2003, page 828, E. coli is a bacteria that is commonly found in the bowel. The organism is associated with infection resulting from fecal contamination following improper perineal hygiene. c. Interview with the director of nursing on 1/31/08 at 8:15 AM revealed the CNA should have cued or assisted the resident to use the proper technique for cleansing. 2. Observation on 1/29/08 at 8 AM and again at 9:55 AM revealed the incontinence brief of resident #53 was wet with urine. Observation revealed CNA #1 placed a trash can liner on the resident's bed and placed several clean wipes on the surface. Further observation revealed after the CNA used each wipe to provide perineal care, s/he placed the soiled wipe on the same trash liner directly next to the clean wipes. Interview with the CNA at 11:10 AM on 1/29/08 revealed he was "told by infection control" to use the same trash liner for both clean and dirty. Interview with the director of nursing/infection control representative on 1/31/08 at 8:15 AM revealed facility practice was not to place clean and dirty wipes next to each other in the same container. 3. Observation on 1/29/08 at 11:30 AM revealed the incontinence brief of resident #52 was soiled with urine and feces. Observation revealed CNA #2 placed a trash can liner on the resident's bed and placed several clean wipes on the surface. Further observation revealed after the CNA used each wipe to provide perineal care, s/he placed the soiled wipe on the same trash liner directly next to the clean wipes. Interview with the director of nursing/infection control representative on	F 441		

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F 441	Continued From page 15 1/31/08 at 8:15 AM revealed facility practice was not to place clean and dirty wipes next to each other in the same container. 4. Observation on 1/29/08 at 9:55 AM revealed CNA #1 used his/her gloved hand to check inside the incontinence brief for wetness. Interview with the CNA at the time revealed the incontinence brief was wet. Observation revealed without removing the gloves used to check inside the incontinence brief, the CNA placed the resident's nasal cannula into the his/her nose. During an interview with the CNA at 11:10 AM on 1/2/9/08, he stated he did not remove the soiled gloves, wash his/her hands and put on a new pair because it took too much time and s/he was on a tight schedule. 5. Observation on 1/29/08 at 9:20 AM revealed resident #27 was seated on the toilet. At that time the resident stated s/he had diarrhea. Observation revealed the resident had placed his/her nasal cannula on the wheelchair cushion which was soiled with feces. Observation revealed CNA #3 removed the nasal cannula from the seat cushion and placed it over the back of the wheelchair but did not clean the cannula. Continued observation revealed the resident placed the nasal cannula back into his/her nose. Observation revealed the resident then transferred him/herself from the toilet to the wheelchair and self propelled him/herself back to the recliner. Observation revealed the nasal cannula was caught under the wheel of the wheelchair and was pulled off the resident's face and onto the floor when the resident transferred to the recliner. Observation revealed CNA # 4 picked the soiled nasal cannula up and without cleaning it, handed it back to the resident who	F 441		

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F 441	Continued From page 16 placed it into his/her nose. 6. Observation of the evening meal on 1/28/08 revealed CNA #5 adjusted the oxygen nasal cannula in the nose of resident #3, touching his/her skin. Continued observation revealed the CNA assisted the resident with eating and then turned to assist resident #53 without washing her hands. Interview with the director of nursing/infection control representative on 1/31/08 at 8:15 AM revealed the CNA should have washed her hands after touching the nasal cannula and prior to continuing to assist residents with eating. 7. Interview with the director of nursing/infection control representative on 1/31/08 at 8:15 AM revealed only sporadic monitoring of handwashing, perineal care, and infection control practices were done. She also stated it looked as though more education on infection control was needed.	F 441	**F444** 1. Staff was inserviced by the D.O.N on 2-14-08 on hand washing (and/or sanitizing) before and after each resident contact, after touching a resident or handling belongings, whenever hands are obviously soiled, after contact with body fluids and after handling contaminated items; on glove use and on handling of nasal cannulas.	3/09/08 Resident 53 + 34
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, and review of facility policies, the facility failed to ensure handwashing protocols were followed during two of three random observations. The findings were: 1. Observation on 1/29/08 at 9:55 AM revealed	F 444	2. Random weekly observations of glove use, hand washing, hand sanitizing, cannula storage and sanitizing will be done by the Staff Development Coordinator or Designee in resident's room and in the dining room to assure proper procedures are being followed. Any	

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F 444	Continued From page 17 CNA #1 used his/her gloved hand to check inside the incontinence brief of resident #53 for wetness. Interview with the CNA at the time revealed the incontinence brief was wet. Observation revealed without removing the gloves used to check inside the incontinence brief, the CNA placed the resident's nasal cannula into the his/her nose. During an interview with the CNA at 11:10 AM on 1/2/9/08, s/he stated s/he did not remove the soiled gloves, wash his/her hands and put on a new pair because it took too much time and s/he was on a tight schedule. 2. Observation of the evening meal on 1/28/08 revealed CNA #5 adjusted the oxygen nasal cannula in the nose of resident #3. Continued observation revealed the CNA assisted the resident with eating and then turned to assist resident #53 without washing her hands. Interview with the director of nursing/infection control representative on 1/31/08 at 8:15 AM revealed the CNA should have washed her hands after touching the nasal cannula and prior to continuing to assist residents with eating. 3. Review of the facility policy and procedure for handwashing, dated 2/1/1981, revealed the following instructions: wash hands ..."before and after each resident contact, after touching a resident or handling his or her belongings, whenever hands are obviously soiled, after contact with any body fluids, and after handling any contaminated items (linens, soiled diapers, garbage, etc).:"	F 444	deviations from standard will be corrected immediately. Charge nurses will receive further training on being observant of staff who are performing cares and assisting in the dining room to immediately intervene with corrective action when deviations from standard are observed. 3. Results of weekly observations to assure staff is following infection control protocols will be reviewed by the QA committee for three months for recommendation and continued compliance.	
F 469 SS=D	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests	F 469	**F469** 1. The kitchen floor has been thoroughly cleaned and all ants have been destroyed. 2. All rooms of the facility have been inspected for the presence of insects. None were found.	3/04/08

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F 469	Continued From page 18 and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of a maintenance record, the facility failed to ensure the kitchen was free from pests. The findings were: Observation of the kitchen on 1/30/08 at 11:20 AM revealed an area on the floor between two cabinets where there was an accumulation of more than 30 ants. The ants were feeding on an area of spilled food that was on the floor. Interview with the dietary manager on 1/30/08 at 12 PM revealed maintenance was responsible to spray the kitchen for pests. She was unsure of the last time this was done or at what frequency it occurred. Interview with the director of maintenance on 1/31/08 at 8:26 AM revealed he was not aware of the current ant problem in the kitchen. He stated there was a log book where staff recorded things that needed the maintenance department to address. When pests were brought to his attention he would spray the area and then follow-up with Terminex (a pest control company). Review of the maintenance record book located at the nursing station on 1/31/08 revealed there was no entry related to the ants in the kitchen.	F 469	Dietary staff has been inserviced on the need to thoroughly sweep and mop all areas of the floor including between and under equipment. The maintenance department will be notified if any insects are spotted so that extermination of insects can be done immediately. 3. Random weekly inspections of kitchen floor cleanliness and presence/absence of pest will be done by the Dietary Manager and/or the maintenance Supervisor. 4. Audits of floor cleanliness and the presence of insects will be reviewed by the QA assurance committee for recommendation and continued compliance.	
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.	F 502	**F502** 1. Resident #27 had a CBC in January and is back on schedule to have a CBC done in April, July and	3/04/08

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F 502	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory tests were performed as ordered for one (#27) of 13 sample residents. The findings were: Review of the 1/08 physician's order recapitulation for resident #27 revealed an order dated 10/1/04 for a complete blood count every three months (January, April, July, October). Review of the medical record revealed there was no evidence a CBC laboratory test was completed in 10/07. During an interview on 2/5/08 at 9:30 AM, the director of nursing confirmed the test was not completed as ordered.	F 502	October as ordered by the physician. 2. A complete review of lab orders will be done by the IDT members to assure that labs have been completed and results are back timely. If any labs have been missed, the physician will be notified for further instruction. Licensed nurses have been inserviced by the D.O.N. on 2-14-08 on the process for labs, including: receiving lab order, having labs done and follow up on the return of the lab results. 3. Random weekly reviews of lab orders and results will be done by the risk team. 4. Results of the weekly review of labs to assure that labs have been done as ordered will be reviewed by the QA committee for recommendation and continued compliance.	