originally approved 1/6/09 Reapproved 1/12/09 as corrected form Karla Hobbs

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

PRINTED: 12/24/2008
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
	535036	A. BUILDING _____ B. WING _____	C 12/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WY HEALTHCARE &	542 16TH STREET RAWLINS, WY 82301

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F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and medical record review, the facility failed to ensure 1 (#31) of 11 sample residents and 1 (#14) non-sample residents who self-administered medications were evaluated by the interdisciplinary team as safe to do so. The findings were: 1. Observation on 12/9/08 at 6:25 AM revealed resident #31 required limited assistance with activities of daily living (ADLs). On the resident's bedside table there was a bottle of eye drops. Interview with the resident on 12/10/08 at 3:45 PM revealed s/he administered the eye drops once a day. Medical record review showed there was not any evaluation as to whether the resident was considered safe to administer medications without staff assistance. Interview with the director of nursing (DON) on 12/11/08 at 8:30 AM confirmed there had been no assessment that evaluated resident #31's ability to self administer medications. 2. Interview on 12/10/08 at 3:40 PM with the DON revealed there was only one resident in the facility that self-medicated (resident #14). The DON stated the resident did his/her own nebulizer treatment. However, review of the medical record for resident #14 showed the assessment for self administration of medication had not been	F 176	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F- 176 Self Administration of Meds** **Corrective Action for Identified Residents** Eye drops have been removed from resident #31 after asking the resident. The family had brought the eye drops to the resident with out the knowledge of the staff. Family and resident have been educated and it has been documented. It was determined the resident did not desire to have the eye drops and they have been removed from the center. Center has updated the Self-Medication Assessment on resident #14 with the Interdisciplinary Team. The evaluation has been completed and signed by Interdisciplinary team. **Identification of Residents with Potential to be Affected** Facility resident room audit has been completed to look for medications at bedside. Any newly identified concerns have been addressed in accordance with the center Policy and Procedures for Self Administration of Medications.	Completion Date: Jan 12 2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	EXECUTIVE DIR	1/5/09

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

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F 176	Continued From page 1 completed. The area for the interdisciplinary team recommendation was blank, and there was no date.	F 176	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of the facility policy on restraints, the facility failed to perform an evaluation to ensure the use of physical restraints was required to treat medical symptoms for one (#44) of two sample residents who was physically restrained. The findings were: Observation on 12/8/08 at 4:20 PM revealed resident #44 had a seatbelt on while in his/her wheelchair. Periodic observations from 12/9/08 through 12/11/08 revealed each time the resident was in the wheelchair, the seatbelt was used. Review of the physician's orders revealed an order for physical restraints was written on 11/18/08. Review of the medical record revealed there was no evaluation performed to determine the medical necessity for the physical restraint. There was also no evidence that less restrictive alternatives had been attempted prior to utilizing the physical restraint. Interview with registered nurse (RN) #7 on 12/10/08 at 3:15 PM revealed she was unaware of an evaluation having been done for the physical restraints but stated the resident had experienced falls out of the wheelchair.	F 221	**Corrective Action to Prevent Recurrence** The Nursing Staff will be inserviced by Staff Development Coordinator (or designee) on the center Policy and Procedures regarding self-administration of meds and leaving medications at bedside. **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will do random weekly audits for 6 weeks to monitor compliance with Policies and Procedures on Self Administration. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance Committee: Director of Nursing, Utilization Coordinator, Social Services and Activities Director.) The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** **Correction date:** January 12 2009	

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F 221	Continued From page 2 Review of the facility's policy on restraints, dated 4/28/06, revealed the following instructions: a. Before the use of a restraint, the interdisciplinary team assesses the resident to determine the presence of a specific medical symptom that would require the use of restraints. b. Determine how the use of restraints would treat the medical symptom and protect the resident's safety. c. The least restrictive device is to be used. d. Documentation in the resident's medical record shows evaluation of the effectiveness of least restrictive method of restraint. Interview with the district director of clinical operations (DDCO) on 12/10/08 at 3:30 PM revealed an evaluation was completed on 12/10/08, 22 days after the initiation of the physical restraint.	F 221	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F -Tag 221 Physical Restraints** **Corrective Action for Identified Residents** Interdisciplinary team completed evaluations and assessments on Resident #44 for use of a self-releasing belt on 12/09/2008. Care plan was updated on 12/10/2008 to include the use of a self-releasing belt when in the wheelchair. Attempts are in process to notify the family regarding the updates on the changes in the care plan. **Identification of Residents with potential to be affected** A baseline audit has been completed to identify residents with physical restraints. Corrections have been made for newly identified issues. **Corrective Action to Prevent Recurrence** The Licensed Nursing staff as well as the C.N.As will be inserviced by Staff Development Coordinator (or designee) on Policies and Procedures the use of restraints.	Jan 12 2009
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, family interview, and medical record review, the facility failed to ensure dignity was maintained for one (#44) of 11 sample residents. The findings were: Review of the 12/8/08 quarterly Minimum Data Set (MDS) assessment revealed resident #44 required extensive staff assistance for dressing. Interview with a family member on 12/8/08 at 7	F 241		

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F 241	Continued From page 3 PM revealed the resident liked to wear pajamas to bed each night. Further interview revealed the family washed and provided the pajamas for the resident. Review of the 9/23/08 timed from 6 AM to 6 PM nursing notes revealed the resident preferred to wear pajamas brought from home to bed at night. Observation on 12/9/08 at 8:15 AM revealed the resident was in bed wearing a dress shirt (observed on the resident at 5 PM on the evening before) and incontinence briefs. Interview with certified nurse aide (CNA) #8 at that time revealed she was unsure why the resident was not wearing his/her pajamas.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will complete audit charting, assessments, and evaluations related to physical restraints to validate accurate and appropriate documentation is in place. This auditing will be completed weekly for four weeks, then monthly or as directed by the Performance Improvement Committee. At the completion of the audits the Director of Nursing will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** The Director of Nursing will be responsible for continued compliance. **Correction Date** **January 12 2009**	
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed for 1 (#44) of 1 sample resident who should have had a	F 274		

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F 274	Continued From page 4 significant change assessment. The findings were: According to the Centers for Medicare and Medicaid Services revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, Revised May 2005, page 2-7, "If a significant change in status is identified in the process of completing a Quarterly assessment, code the assessment as a SCSA [significant change in status assessment] and complete a comprehensive assessment. Do not code it as a Quarterly assessment." Examples of a significant change included any decline in a resident's incontinence pattern from 0 or 1 to a 3 or 4. Also included in the examples was a weight loss problem (5% change in 30 days....). Review of the 9/15/08 initial and the 12/8/08 quarterly MDS assessments for resident #44 revealed the following concerns: a. Review of the 9/15/08 initial MDS assessment for the resident revealed s/he was continent of bowel and bladder (coded as 0). Review of the quarterly 12/8/08 MDS assessment revealed the resident was incontinent (all or almost all of the time) of bowel and bladder (coded as a 4). Observation on 12/9/08 at 8:30 AM revealed the resident was incontinent of urine. Interview with CNA #8 at the time of the observation revealed the resident was almost always incontinent. b. Review revealed the resident experienced a weight loss of greater than 5% in 30 days. Review of the nutrition notes dated 12/4/08 revealed the resident experienced a weight loss of 6% in 30 days. Interview with the MDS coordinator on 12/10/08 at	F 274	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law* **F-241 Dignity** **Corrective Action for Identified Residents** The Staff Development Coordinator or designee has inserviced the nursing staff on resident #44's desire to wear pajamas to bed each night (per family request). The inservice includes charting when the resident refuses to wear his own pajamas on the back of the ADL Flow Sheet. The care plan for Resident #44 has been updated to reflect the resident's preference for wearing pajamas at night-time to bed. The care plan also reflects the resident's intermittent refusal to change into pajamas for bedtime. The family will be updated regarding trends in refusals to wear pajamas at bedtime during care conferences. The resident #44 will be monitored on the ADL Flow Sheet for wearing pajamas to bed. **Identification of Residents with Potential to be Affected** All residents have the potential to be	Jan 12 2009

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F 274	Continued From page 5 12:15 PM revealed she did not consider the resident to have had a significant change in condition.	F 274	*This Plan of Correction is the center's credible allegation of compliance.*	
F 278 SS=E	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to timely complete the resident assessment protocol (RAP) summaries	F 278	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law;* affected. **Corrective Action to Prevent Recurrence** Staff Development Coordinator (SDC) or designee will inservice all staff on dignity, including adhering to resident personal preferences regarding cares. **Monitoring/Quality Assurance** The Director of Nursing or designee will do random weekly audits for 6 weeks to monitor that resident #44 is being offered to wear pajamas at night. The Director of Nursing or designee will report trends to the Performance Improvement Committee (Quality Assurance) for review and recommendations. **Director of Nursing will be responsible for continued compliance.** **Correction date:** January 12 2009	

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F 278	Continued From page 6 for 9 (#4, #8, #13, #21, #31, #35, #41, #42, #44) of 11 sample residents. The findings were: Review of the Centers for Medicare and Medicaid Services (CMS) RAI User's Manual, version 2.0, page 3-238 revealed VB2, "...Date that the RN coordinating the Resident Assessment Protocol (RAP) assessment process certifies that the RAPs have been completed." The following concerns were identified: 1. Review of the 4/23/08 admission Resident Assessment Instrument (RAI) for resident #21 showed the registered nurse (RN) coordinator signed (at VB2) that all Resident Assessment Protocols (RAPs) were complete on 4/23/08. However, the RAPs for psychosocial, mood, and activities were dated as having been completed on 4/27/08. 2. Review of the 6/5/08 annual RAI for resident #35 showed the RN assessment coordinator signed that all RAPs were completed on 6/5/08. However, the RAP summary for psychosocial well-being was dated as being completed on 6/11/08 and the RAP summary for mood state was dated as completed on 6/19/08. 3. Review of the 4/10/08 initial RAI for resident #41 showed the RN coordinator signed that all RAPs were completed as of 4/10/08. However, the RAP summaries for psychosocial well-being and mood state were dated as completed on 4/15/08. 4. Review of the 11/5/08 annual RAI for resident #42 showed the RN coordinator signed that all RAPs were completed as of of 11/5/08. However, the RAP summaries for psychosocial well-being, mood state, and behavioral problems were not	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-274 Significant Change** **Corrective Action for Identified Residents** A significant change MDS was completed on resident #44 on 12/12/2008. The care plan has been updated related to the Significant change MDS. The family will be updated with the care plan changes during care conferences or when there has been a significant change in condition. The District Director of Clinical Operations has inserviced the Case Manager on completion of updated MDS with significant changes in condition. **Identification of Residents with Potential to be Affected** All residents who have a significant change have the potential to be affected. **Corrective Action to Prevent Recurrence** The Case Manager or designee will inservice nurses and Interdisciplinary team on	Jan 12 2009

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F 278	Continued From page 7 dated as completed until dated 11/12/08. 5. Review of the 9/15/08 initial RAI for resident #44 showed the RN coordinator signed that all RAPs were completed as of 9/15/08. However, all RAP summaries were actually dated as completed 9/16/08, with the exception of psychosocial well-being, which was dated on 9/17/08. 6. Review of the initial MDS assessment dated 11/30/08 for resident #31 showed the VB2 date was 11/30/08, indicating the RAP assessment was completed. However review of the individual RAP summaries including: cognitive loss, communication, ADL function, psychosocial well-being, activities, falls, nutritional status, and pressure ulcers showed they were all dated after 11/30/08. All were dated 12/3/08, except cognitive loss, which was dated 12/2/08. 7. Review of the RAI for resident #4 revealed the RN assessment coordinator signed that all RAPs were completed on 8/12/08. However, the psychosocial well being and mood RAP summaries were signed as having been completed on 8/15/08. 8. Review of the RAI for resident #8 revealed the RN coordinator signed that all RAP summaries were completed on 10/22/08. However, the cognition, activities of daily living (ADL), falls, nutrition, dehydration, and pressure ulcers RAP summaries were all signed as completed on 10/29/08. 9. Review of the RAI for resident #13 showed the RN coordinator signed that all RAPs were complete on 11/18/08. However, the mood, psychosocial well being, and delirium RAP summaries were signed as completed on	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* significant changes and significant change in status assessments. The Case Manager or designee will run a comparison report on MDSs before completing MDS to assure that a significant change is not missed. **Monitoring/Quality Assurance** The Director of Nursing or designee will do random weekly audits for 6 weeks to monitor MDSs for significant changes. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** Correction date: **January 12 2009**	

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F 278	Continued From page 8 11/19/08 and the cognition, vision, ADL, activities, nutrition, urinary incontinence, dehydration, and pressure ulcers RAP summaries were signed as completed on 11/24/08. 10. Interview on 12/10/08 at 2:10 PM revealed the MDS coordinator was aware the RN coordinator was not supposed to sign off at the VB2 Section until all RAP summaries were done.	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 279 SS=D	483.20(d), 483.20(k)(1) 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 medical record review and staff interview, the facility failed to develop comprehensive care plans for 3 (#4, #8, #13) of	F 279	**F-278 Resident Assessment** **Corrective Action for Identified Residents** The District Director of Clinical Operations has educated the MDS Coordinator and the DNS on the appropriate process for completing, signing and dating the RAPs. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** The District Director of Clinical Operations will educate those members of the Interdisciplinary Team who complete RAPS on the proper dating of R2b/Vb2 dates. Social Service Director or designee will be educated once she returns from FMLA. The Case Manager or designee will print out the RAPS without dates to allow the Interdisciplinary Team has 7 days to complete the RAPS after the completion of the MDS. **Monitoring/Quality Assurance**	Jan 12 2009

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F 279	Continued From page 9 12 sample residents. The findings were: 1. Medical record review for resident #4 revealed section V (psychosocial well-being) of the RAI dated 8/12/08, would be addressed in the care plan. Review of the care plan, however, revealed the problem of psychosocial well-being was not addressed. Interview on 12/11/08 at 9 AM with the Minimum Data Set (MDS) coordinator confirmed this problem should have been addressed in the resident's plan of care. 2. Review of the RAI, for resident #8 dated 10/22/08, revealed psychosocial well-being and cognition triggered as problems that would be addressed in the resident's care plan. Review of the care plan, however, revealed these areas were not addressed. Interview on 12/10/08 at 2:10 PM with the MDS coordinator confirmed these problems should have been addressed on the resident's plan of care. 3. Review of the RAI for resident #13, dated 11/18/08, indicated problems related to vision, activities of daily living, and delirium. However, review of the resident's care plan showed these areas were not addressed. Interview on 12/11/08 at 9 AM with the MDS coordinator confirmed vision, activities of daily living, and delirium should have been addressed on this resident's care plan, but had not been done because the comprehensive assessments were not completed for these areas. Review of CMS RAI User's manual, page 3-238, states that the VB4 date is the date the care planning decisions are completed and is done after the care plans. Review of the section V of the resident's RAP summary revealed a VB4 date of 11/18/08.	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Case Manager or designee will do random weekly audits for 6 weeks to validate the dating of RAPS are completed correctly. At the completion of the audits the Case manager or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Case Manger will be responsible for continued compliance.** **Correction date:** January 12 2009 **F-279 Comprehensive Care Plans** **Corrective Action for Identified Residents** The Care Plan for resident # 4 has been updated to address section V(psychosocial well-being) of the RAI. The Care Plan for resident #8 has been updated to address psychosocial well being and cognition.	Jan 12 2009
F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS	F 281		

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F 281 SS=D	Continued From page 10 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 and resident interviews, the facility failed to ensure professional standards were followed in regard to physicians' orders for 2 (#35, #42) of 11 sample residents. The findings were: 1. Review of the December 2008 physician's orders for resident #35 revealed an order dated 9/29/08 for oxygen at 2-3 liters per nasal cannula continuously because of chronic airway obstructive disease. Periodic observations on 12/8/08 through 12/11/08 revealed the resident did not have oxygen in use. Observation revealed there was a tank of oxygen on the back of the resident's wheelchair, but it was not turned on. Interview with RN #7 on 12/11/08 at 8:40 AM revealed the resident did not like to wear the oxygen, but said discontinuing or changing the order had not been discussed with the physician. 2. Interview with resident #42 on 12/8/08 at 5 PM revealed s/he had felt ill that morning with complaints of diarrhea and stomach ache. During an interview with RN #7 on 12/8/08 at 4:50 PM, she stated she would not administer the resident's regularly scheduled Colace (stool softener) that evening because the resident had experienced diarrhea earlier in the day. Interview with the resident on 12/9/08 at 7 AM revealed s/he continued to have complaints of stomachache and diarrhea. Review of the physician's orders revealed an order dated	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Care Plan for resident #13 has been updated to address vision, activities of daily living, and delirium. **Identification of Residents with Potential to be Affected** All residents who have items trigger on the RAI have the potential to be affected. **Corrective Action to Prevent Recurrence** The Case Manager or designee will review Care Plans to make sure areas that have triggered on the RAPS are addressed and care planned if needed. The Case Manager or designee will inservice those completing care plans for triggered items as needed. **Monitoring/Quality Assurance** An audit will be completed by Case Manager or designee to validate RAPS that trigger are addressed in the care plan as needed. The Case Manager or designee will do	

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F 281	Continued From page 11 10/23/07 for Lomotil (anti-diarrheal) after each loose stool as needed. However, review of the December 2008 medication administration record revealed no Lomotil was administered on the two days the resident was reported to have diarrheal episodes. 3. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* random weekly audits for 6 weeks to monitor RAPS and Care plans and then monthly for 2 months.	
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 and resident interview, and medical record review, the facility failed to ensure staff followed the care plan in a variety of areas for 2 (#2, #44) of 11 sample residents. The findings were: 1. Review of the December 2008 physician's order for resident #44 revealed s/he had diagnoses including chronic cystitis. Review of the 9/23/08 care plan revealed an intervention/approach for staff to monitor the resident's urine output for amount, color and odor. Review of the entire medical record revealed no evidence staff ever followed this intervention/approach. Interview with registered nurse (RN) #7 on 12/10/08 at 4:15 PM confirmed	F 282	Case Manager or designee will report trends to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Case Manager will be responsible for continued compliance.** **Correction date:** **January 12 2009** **F-281 Comprehensive Care Plans** Jan 12 2009 **Corrective Action for Identified Residents** Oxygen order on resident #35 has been changed to PRN per Doctor. Continuous order is D/cd. Resident #42 orders for Lomotil have been clarified by the MD on the parameters of dosage. Resident #42 will inform the nurse of having ~~loose stools. Lomotil will be given per MD~~	

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F 282	Continued From page 12 there was no evidence monitoring was completed, but verified that it should have been. In addition, review of the nutrition care plan revealed weight loss was identified as a problem for this resident. Further review of the care plan revealed an intervention added on 12/1/08 included ice cream twice daily with lunch and dinner. Observation of the evening meal on 12/8/08 and the lunch meal on 12/9/08 revealed the resident received no ice cream. Interview with the registered dietitian (RD) on 12/10/08 at 2:10 PM confirmed the resident should have had ice cream at lunch and dinner and stated it was an "oversight" the ice cream was not served. 2. Observation on 12/8/08 at 6:20 PM, 12/9/08 at 1:10 PM, and 12/10/08 at 3:30 PM revealed resident #2 was grinding his/her teeth. Medical record review showed the resident had a diagnosis of anxiety, and the facility had identified this behavior. According to the resident care plan, last updated on 8/4/08, staff were to monitor and chart behaviors, including repetitive physical movements. Interview with licensed practical nurse (LPN) #9 revealed she had noticed the teeth grinding during the past couple of days. She stated it was a long standing behavior for the resident and occurred almost constantly. However, review of the behavior monitoring sheet from 12/1/08 to 12/10/08 revealed there had been no episodes of repetitive physical movements documented.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* orders and documentation will be provided in medical record. **Identification of Residents with Potential to be Affected** A baseline audit has been completed for residents having an order for Lomotil. Any newly identified issues have been addressed. A baseline audit has been completed for residents with orders for oxygen to determine utilization in accordance with physician orders. Newly identified issues have been corrected. **Corrective Action to Prevent Recurrence** Staff Development Coordinator (SDC) or designee will inservice Licensed staff on Policies and Procedures related to Oxygen Therapy and on the importance of obtaining parameters for administering Lomotil. Staff Development Coordinator or designee will inservice licensed staff on following physician orders and documentation in the medical records when a resident has a change in condition.	
F 323 SS=J	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff provided safety supervision for 1 (#44) of 11 sample residents. The resident was left alone in an at-risk position for falling, which resulted in immediate jeopardy. The findings were: Observation of resident #44 on 12/9/08 from 8:28 AM until 8:40 AM revealed CNA #8 raised the resident's bed from the low position, provided incontinence care, and dressed the resident. Next, the CNA attempted to transfer the resident from the bed to the wheelchair with the bed still in a raised position. Observation revealed the CNA was unable to transfer the resident on her own so she left the resident on the edge of the raised bed, and exited the room. The resident was leaning toward the foot of the bed, partly supported by his/her right elbow. The resident's legs were hanging partway off the bed, with one hip completely off. The wheelchair had been placed parallel to the foot of the bed. The wheelchair's position was such that, in the event of a fall, the resident's face would likely come in contact with the foot pedals of the wheelchair. Because it appeared the resident was likely to fall given his/her position on the bed, the surveyor, without leaving the room, motioned for licensed practical nurse (LPN) #10 to come into the room. When the LPN entered the room the surveyor asked her to stay with the resident to prevent him/her from falling. The LPN walked over to the resident, placed her hand on his/her shoulder	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Monitoring/Quality Assurance** The Director of Nursing or designee will do random weekly audits for 6 weeks to monitor Medication Administration Records to validate parameters are in place and are being followed for Lotomil orders are being followed correctly. The Director of Nursing or designee will do random weekly audits for 6 weeks to monitor those residents who are being weaned off of oxygen. Documentation will be reviewed to validate accuracy. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** **Correction date:** **January 12 2009**	

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F 323	Continued From page 14 (without attempting to assist the resident), and stated, "I can't transfer [him/her] by myself because I have a bad shoulder." The LPN then dropped her hand from the resident's shoulder and stepped away. She walked toward the door, stating she needed to go get some assistance. The surveyor stated that the CNA had already gone for help, and somebody needed to stay with the resident to prevent a fall. The LPN responded that "it wouldn't be the first time." Neither the CNA nor the LPN attempted to use the call light to request assistance during this observation. During an interview with the CNA (#8) on 12/9/08 at 1:50 PM, it was revealed she saw nothing wrong with leaving the resident "leaning" on the edge of the bed. The CNA stated "Oh [s/he] won't fall, [s/he] leans like that all the time." Review of the medical record revealed this resident had a history of falls that had occurred on 10/6/08, 10/20/08, 10/24/08,10/27/08, 11/10/08, 11/11/08, and 11/15/08. Review of the 11/15/08 timed at 4:45 PM revealed the resident had been found on the floor next to the bed. Interview with the director of nursing services on 12/9/08 at 12:15 PM revealed that fall was unwitnessed. On 12/9/08 at 11:50 AM the administrator was notified of the immediate jeopardy. On 12/10/08 at 4:50 PM the immediate jeopardy was removed on-site by the following actions: a. The resident received one-to-one supervision. b. A physical therapy evaluation was completed for safety and transfers. c. Immediate in-service education regarding falls and safety was provided to nursing staff. Staff received education prior to beginning their shift.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-282 Comprehensive Care Plans** **Corrective Action for Identified Residents** The Director of Nursing has updated the behavior monitoring sheet for Resident # 2 to reflect teeth grinding. The care plan for resident #44 has been updated to reflect monitoring output for urine color and odor has been appropriately removed from care plan. Nursing staff and dietary will be in-serviced on following care plans and resident #44's preference to get ice-cream with lunch and dinner. If the ice cream is not on the tray they are to ask the dietary staff to provide him ice cream. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected.	Jan 12 2009

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F 323	Continued From page 15 d. Competencies were completed for staff with regards to transfers. e. The CNA involved received in-service education and the LPN involved received in-service education and was suspended for possible neglect. The facility will submit the results of the investigation to the survey agency. f. The facility identified other residents at risk, and therapy screens were completed on those residents. Care plans were updated regarding transfer status.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Corrective Action to Prevent Recurrence**	
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to provide interventions as planned to maintain weight for one (#44) of four sample residents who had experience a weight loss. The findings were: Review of the 9/15/08 quarterly Minimum Data Set assessment for resident #44 revealed s/he had experienced a 6% weight loss in 30 days. Review of the nutrition care plan revealed weight loss was identified as a problem for this resident.	F 325	Staff Development Coordinator (SDC) or designee will inservice nursing staff on the policies and procedures on following care plans. Care plans will be reviewed per the RAI process. Nursing staff will chart the offering of ice cream during lunch and dinner. **Monitoring/Quality Assurance** The Case Manager or designee will do random weekly audits for 6 weeks to monitor care plans for evidence of accuracy. The Director of Nursing or designee will do random weekly audits for 6 weeks to make sure behavior monitoring sheets are completed per care plan. At the completion of the audits the Case Manager, Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports.	

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F 325	Continued From page 16 Further review of the care plan showed an intervention added on 12/1/08, which included ice cream twice daily with lunch and dinner. However, observation of the evening meal on 12/8/08 and the lunch meal on 12/9/08 revealed the resident did not receive ice cream. Interview with the RD on 12/10/08 at 4:15 PM confirmed the resident should have had ice cream at lunch and dinner. The RD stated the failure to serve the ice cream in accordance with the resident's care plan was an "oversight."	F 325	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Director of Nursing will be responsible for continued compliance.** **Correction date: January 12 2009**	
F 364 SS=D	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff provided a palatable meal for one (#44) of eleven sample residents. The findings were: Observation on 12/9/08 revealed CNA #8 placed a breakfast tray for resident #44 on the over-the-bed table in the resident's room and removed the cover at 8:15 AM. The meal consisted of an egg, oatmeal, and muffin. Continued observation in the resident's room revealed the CNA replaced the cover on the plate at 8:28 AM. At 8:49 AM the CNA stated she would take the tray to the kitchen and request a fresh one since it would be cold. However, observation on 12/9/08 at 8:55 AM revealed CNA #8 actually placed the resident's tray on the table where the	F 364	**<u>F-323 Accidents and Supervision</u>** **Corrective Action for Identified Residents** Resident #44 received one-to-one supervision on 12/09/2008 until resident was evaluated by therapy for recommendations regarding safety and transfers. A physical therapy evaluation was completed for safety and transfers for resident #44 on 12/09/08. The C.N.A involved received in-service education and was counseled. The LPN involved received in-service education and was suspended for possible neglect. Investigation for neglect by the LPN was substantiated and the LPN was terminated. The results of the investigation were sent to the state survey agency.	Jan 12 2009

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F 364	Continued From page 17 resident dined and left it there. Continued observation revealed there was no fresh tray provided for the resident, and the food on the tray was not reheated. Observation also revealed the resident was positioned at the dining table and assisted with the meal at 8:55 AM (40 minutes after the meal was first delivered). Interview with the cook on 12/9/08 at 9:15 AM and with the dietary aide at 9:20 AM verified that they did not prepare a fresh tray for the resident, nor did they re-heat the meal. Review of the 12/8/08 quarterly Minimum Data Set assessment for resident #44 revealed s/he had moderate cognitive impairment. While the resident was unable to express whether the temperature of his/her breakfast was warm, a reasonable person would assume a 40 minute wait would result in food that was cold and unpalatable.	F 364	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Identification of Residents with Potential to be Affected** All residents who are fall risks have the potential to be affected. **Corrective Action to Prevent Recurrence** An in-service education regarding falls and safety was provided to nursing staff on 12/10/2008. Staff received education prior to beginning of their shift. Facility identified other residents at risk, and therapy screens were completed on those residents. Care plans were updated regarding transfer status. **Monitoring/Quality Assurance** The Staff Development Coordinator or designee will do random weekly audits for 6 weeks to monitor that residents are being transferred appropriately according to care plans. At the completion of the audits the Staff Development Coordinator or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then	
F 371 SS=K	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility documentation, the facility failed to ensure food was stored, prepared, and served under sanitary conditions. Raw and ready-to-eat meats were stored in a manner that allowed the ready to eat meat to become contaminated.	F 371		

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F 371	Continued From page 18 Furthermore, this was the routine practice for thawing meats in the dietary department. The food preparation staff did not recognize the risk associated with this method of thawing of potentially hazardous foods, resulting in immediate jeopardy. In addition, commercial nutritional supplements were available for service after the expiration date; dietary staff handled food while wearing contaminated gloves; and water pitchers were badly damaged, preventing sanitation of those containers. The facility census was 45. Findings were: 1. Observation on 12/10/08 at 10:45 AM revealed a plastic tub in the the walk-in refrigerator containing a plastic bag of sliced raw bacon, a large plastic bag of raw chicken pieces, and a bag of diced meat. Pooled liquid that appeared to have dripped from the raw chicken had accumulated in the bottom of the tub and had contaminated the bags containing the bacon and diced meat. According to Food Code 2005, U.S. Public Health Service, 3-302.11: Packaged and Unpackaged Food-Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD,.. Interview on 12/10/08 at 10:55 AM with cook #2 verified the diced meat in the contaminated bag was ready to eat turkey that would be used in a sandwich the next day without any further cooking. She stated this was the normal procedure for thawing meats, because there was only enough room for one tub on the bottom shelf in the walk-in, and there was not enough room to separate all the items. The cook then asked if the facility's practice was "okay." The cook was	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** **Correction date:** **January 12 2009** **F-325-Nutrition** **Corrective Action for Identified Residents** Ice cream is being offered to resident #44 at lunch and at dinner according to care plan. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** Staff Development Coordinator (SDC) or designee will inservice dietary staff and nursing staff on following tray cards, filling special requests as noted on tray cards, and following care plans.	Jan 12 2009

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F 371	Continued From page 19 observed to remove the diced turkey from the tub and put it on a separate tray. The tray was placed on another shelf in the walk-in refrigerator. Observation in the walk-in refrigerator on 12/10/08 at 1 PM with the administrator and the RD resulted in all items from the tub (including the turkey) being discarded. The RD stated the observed thawing practices had been inappropriate. Further interview with the RD on 12/10/08 at 2:05 PM verified the diced turkey would not have received further cooking and was going to be served on 12/11/08 to residents on mechanical soft diets. She provided a list of twelve residents (#34, #41, #13, #15, #19, #22, #27, #32, #2, #6, #1, #21) who would have received the ready to eat turkey the next day. Review of the facility's in-service history detail, showed the dietary staff had food safety education on 9/26/08. Review of these written materials showed the education was titled "Keeping Food Safe-It Depends on You." Although many food safety issues were presented, the materials did not include education to prevent cross contamination of potentially hazardous foods. An in-service that specifically addressed cross-contamination had been provided in March 2008 according to review of the in-service attendance roster and was titled "Be Smart. Keep Foods Apart-Don't Cross Contaminate." On 12/10/08 at 2:44 PM, the administrator was notified of the immediate jeopardy. On 12/11/08 at 9:45 AM, the immediate jeopardy was removed on-site by the following actions: a. The contaminated foods were discarded. b. The facility provided in-service eduction to all dietary staff on the prevention of cross	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Nursing and Dietary will track that Resident #44 receives ice cream for lunch and dinner. **Monitoring/Quality Assurance** The Director of Nursing or designee will audit ice cream tracking tool weekly for 6 weeks to validate ice cream is being put on the tray and being offered to resident #44 at lunch and dinner. The Dietary Service Manager will complete random weekly Tray Card Accuracy Audits for 6 weeks. At the completion of the audits the Director of Nursing, Dietary Service Manager or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** **Correction date:** **January 12 2009**	

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F 371	Continued From page 20 contamination and food safety. c. Bins/tubs were purchased and placed in the walk-in refrigerator with labels instructing staff to store meats separately. d. The facility presented a written plan to ensure all areas of food storage would be reviewed by the RD in order to identify any other potential cross contamination problems. e. The RD planned to complete daily audits to ensure proper procedures were being followed for food storage. f. Information from the RD's audits were to be brought to stand-up meetings and to monthly performance improvement meetings. g. The RD has planned to work full-time (specified as 30 hours per week) until the dietary manager has completed the state-required certification course. 2. Observation on 12/8/08 at 3:20 PM revealed 27 thawed vanilla nutritional supplements in a box in the walk-in refrigerator. A date of 11/10/08 was written on the box. There was no indication as to what the date was for. Review of the information printed on the cartons revealed the product was good for fourteen days after being thawed. Interview with cook #1 at 3:20 PM revealed the date written on the box was the date the shakes had been thawed (29 days earlier). Further interview at 3:50 PM with cook #1 revealed she was not aware the shakes were expired, as she was not aware they were only good for fourteen days once thawed. Interview with the RD on 12/8/08 at 4:35 PM revealed the written date on the box was actually the date the shakes were received from the vendor and not the thaw date. She confirmed the dating system was unclear and that the staff would be re-educated. She stated the thaw date would be clearly indicated in the	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-364 Food** **Corrective Action for Identified Residents** Resident #44's meals will be monitored to make sure they are given at the appropriate temperature. **Identification of Residents with Potential to be Affected** All residents taking room trays have the potential to be affected. **Corrective Action to Prevent Recurrence** Registered Dietician or designee will inservice nursing staff and dietary staff on appropriate food temperatures and proper serving of room trays. **Monitoring/Quality Assurance** The Registered Dietitian or designee will do random weekly audits for 6 weeks to monitor the room tray temperatures and the timeliness of the tray being delivered. At the completion of the audits the ~~Registered Dietitian or designee will report~~	Jan 12 2009

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F 371	Continued From page 21 future so the shakes could be discarded when expired. 3. Observation on 12/10/08 from 11:33 AM to 11:40 AM revealed cook #2 was wearing disposable gloves while preparing to serve the noon meal. During the observation, the cook went into the walk-in refrigerator on three separate occasions handling the walk-in door with her gloved hands each time. On all three occasions the cook continued to wear the same pair of disposable gloves. The third time the cook came out of the walk-in with a bag of hamburger buns. She proceeded to open and handle each bun with her gloved hands. According to Food Code 2005, U.S. Public Health Service,3-304.15 Gloves, Use Limitation. (A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 4. Observation on 12/10/08 at 11:05 AM revealed the dietary aide was filling water pitchers for the noon meal. There were fourteen pitchers, and the aide stated they were used at each meal, and placed on the dining tables. The water pitchers were made of plastic, and had visible damage such as scratches and gouges on both the insides and outsides, including around the rims. Further interview with the aide and cook #2 confirmed the pitchers were not in good condition. Interview with the RD on 12/11/08 at 10:15 AM revealed new water pitchers were ordered in March 2008, they needed to be replaced again. According to Food Code 2005, U.S. Public Health Service, 4-202.11 Food-Contact Surfaces. (A) Multiuse FOOD-CONTACT SURFACES shall be:	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Registered Dietician will be responsible for continued compliance.** **Correction date:** January 12 2009 **F-Tag 371** **Sanitary Conditions – Food Prep & Service** **Corrective Action for Identified Residents** Bacon, chicken and diced pre-cooked meat was discarded at the time of the survey. Shakes with mislabeling were discarded at the time of the survey. New water pitchers have been ordered, received and old water carafes have been discarded. Vanilla nutritional supplements were thrown out. **Identification of Residents with potential to be affected**	Jan 12 2009

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F 371	Continued From page 22 (1) SMOOTH; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections;	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control surveillance records and policies and procedures, the facility failed to ensure staff followed appropriate infection control practices when assisting three residents with dining, washing their hands, personal care, and dressing. The census was 46. The findings were: 1. Observation on 12/9/08 at 8:30 AM revealed certified nurse aide (CNA) #8 provided perineal care for resident #44 who was incontinent of urine. Observation revealed the CNA threw the soiled linen on the floor beneath the wheelchair. After completion of the perineal care, the CNA icked up the soiled linen and moved it closer to door of the resident's room. The CNA then oved her gloves and washed her hands. ever, after washing her hands, she picked up lled laundry with her bare hands, holding	F 441	Any resident has the potential to be affected. **Corrective Action to Prevent Recurrence** The Dietary Manager or designee have inserviced dietary staff on the prevention of cross-contamination and proper storage of foods. The Dietary Manager or designee has inserviced dietary staff on hand washing and the proper use of gloves. The Dietary Manager or designee has inserviced dietary staff on the proper labeling and thawing of nutritional supplements. The Dietary Manager or designee will inspect glasses and water carafes and discard ones that are worn out and old. **Monitoring/Quality Assurance** The Dietary Manager or designee will do daily and monthly quick rounds to monitor compliance of sanitation and cross contamination. At the completion of the audits the Dietary Manager will report compliance to the Performance Improvement	

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F 441	Continued From page 23 the soiled laundry next to her body and left the room. After placing the soiled laundry in the soiled utility room, the CNA assisted resident #43 to the physical therapy department then back into the dining room. The following concerns were identified: a. During the entire observation of providing perineal care, dressing the resident, and handling soiled linen next to her body, the CNA was wearing her dietary apron. Continued observation revealed the CNA hung her dietary apron on a hook in the assisted dining area at 8:50 AM. b. Interview with the RD on 12/10/08 at 11:58 AM revealed dietary aprons were not supposed to be worn during resident cares, only for dining assistance. c. Interview with the infection control coordinator on 12/10/08 at 10:30 AM revealed dietary aprons were only used for serving and assisting residents with meals. She further stated the aprons were not to be worn during personal care or transporting soiled linen. In addition, the infection control coordinator stated soiled linen should be bagged and not just placed on the floor. Finally, she stated soiled aprons should not be hung on the hangers for further use but should be placed in the soiled laundry hamper. d. During an interview with CNA #8 on 12/9/08 at 9:10 AM, she stated she placed the soiled apron in the dirty laundry hamper, however, observation revealed she hung the apron up with the other aprons that would be used for the next two meals that day. 2. Observation on 12/9/08 from 8:55 AM revealed CNA #11 assisted resident #44 with the breakfast meal. Observation revealed at 8:58 AM this CNA coughed and sneezed into a napkin then placed the napkin on the table where the resident was	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. The Dietary Manager or designee will do random weekly audits of the kitchen's water pitchers for 6 weeks to monitor compliance. At the completion of the audits the Dietary Manager will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. The Dietary Manager or designee will do random weekly audits of the labeling and thawing of the health shakes for 6 weeks to monitor compliance. At the completion of the audits the Dietary Manager will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for any further audits/reports. The Dietary Manager or designee will do random weekly audits to monitor dietary staff for the proper use of gloves and hand washing for 6 weeks to monitor compliance. At the completion of the audits the Dietary Manager will report compliance to the Performance Improvement Committee	

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F 441	Continued From page 24 eating. Without washing her hands, the CNA then touched each of the dishes on the resident's tray and continued to assist him/her with eating. Continued observation revealed at 9:05 AM the CNA again coughed into the napkin, placed the napkin on the table, then resumed assisting the resident without washing her hands. 3. Observation on 12/9/08 at 9 AM revealed a nursing student (#12) was in the room of resident #21 to take the resident's vital signs. The resident came out of the bathroom in his/her room with urine soaked pants. The resident refused to go back into the bathroom, so the nursing student asked the resident to sit at the bottom of the bed (on top of the blanket), so she could take the resident's vital signs. The resident sat on the bed. Then the resident stood up, and the nursing student assisted the resident to the bathroom, where she changed the resident's clothing. When the resident came out of the bathroom with clean pants on, the nursing student asked the resident to sit at the bottom of the bed (in the same location the resident sat earlier with wet pants) so she could finish taking the vital signs. The resident sat on the bed. After all cares were provided, the nursing student made the bed, with the same blanket the resident had sat on with wet pants. During an interview on 12/10/08 at 10:45 AM, the nursing student (#12) stated she didn't notice that the resident sat on the bed with wet pants. 4. Observation on 12/9/08 at 6:42 AM revealed a nursing student (#12) put toothpaste on the toothbrush for non-sample resident #20. The resident's toothbrush touched the opening of the tube of toothpaste. Later that same morning at 9 AM, the same nursing student (#12) used the	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* (Quality Assurance). The Committee will then determine the need for any further audits/reports. **Responsible Party** **The Registered Dietician will be responsible for future compliance.** **Correction Date** January 12 2009 **F-441** **Corrective Action for Identified Residents** The C.N.A. mentioned in the 2567 has been counseled and educated regarding handwashing, provision of personal care, and transporting of dirty linens and the proper procedure for wearing aprons. Aprons were removed and taken to the laundry. New aprons have been ordered so that there will be enough to have clean aprons at each meal. Toothpaste has been provided for both resident #20 and #21. The Director of Nursing has validated resident #21 has clean, dry linens on her bed. ~~The Executive Director has sent a letter to~~	Jan 12 2009

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F 441	Continued From page 25 same tube of toothpaste when assisting resident #21 with oral hygiene. Resident #21's toothbrush also touched the opening of the tube of toothpaste. During an interview on 12/10/08 at 10:45 AM, the nursing student (#12) stated she used the same tube of toothpaste, but the resident's normally each had their own. 5. Observation on 12/11/08 at 9:55 AM revealed resident #13 had a pressure sore on his/her left upper back area. Licensed practical nurse (LPN) #9 washed her hands, put gloves on, and removed the soiled dressing that covered the area. Then, without removing the contaminated gloves, washing her hands, and applying clean gloves, the LPN proceeded to clean the area with saline, apply ointment, and cover the area with a clean dressing.	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* the nursing school informing the instructor of the need to educate nursing students in proper provision of cares and handling of linen.	
F 444 SS=E	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 and staff interview the facility failed to ensure the staff washed their hands after direct resident contact during two random observations. The findings were: 1. Observation on 12/9/08 at 8:55 AM revealed CNA #11 assisted resident #44 with the breakfast meal. Refer to F441 for details related to this CNAs failure to wash her hands when indicated while assisting this resident with the meal.	F 444	**Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** Staff Development Coordinator or designee will inservice nursing staff on appropriate hand washing and linen handling. Staff Development Coordinator or designee will inservice nurses on appropriate hand washing during dressing changes. Staff Development Coordinator or designee will in- service nursing staff on assisting with eating. Student nursing instructor will be notified of nursing student using the same tube of toothpaste and not changing linens after the resident sat on them with urine soaked pants. Student nursing instructor will be asked to	

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F 444	Continued From page 26 2. Observation on 12/11/08 at 9:55 AM revealed resident #13 had a pressure ulcer on his/her left upper back area. LPN #9 washed her hands, applied gloves, and removed the dressing that covered the area. Then, without removing the soiled gloves, washing her hands, or applying clean gloves, the LPN proceeded to clean the wound with saline, apply ointment, and cover the area with a clean dressing.	F 444	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law*	
F 445 SS=E	483.65(c) INFECTION CONTROL - 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 and staff interview, the facility failed to ensures staff handled and transported soiled linen in a manner to prevent cross contamination during observation of care for 1 (#44) of 4 sample residents. The findings were: Observation on 12/9/08 at 8:30 AM revealed certified nurse aide CNA #8 provided perineal care for resident #44 who was incontinent of urine. Observation revealed the CNA threw the soiled linen on the floor beneath the wheelchair. After completion of the perineal care, the CNA picked up the soiled linen and moved it closer to the door of the resident's room. The CNA then removed her gloves and washed her hands. However, after washing her hands, she picked up the soiled laundry with her bare hands, holding the soiled laundry next to her clothing and left the room. After placing the laundry in the soiled utility room, the CNA assisted resident #43 to the	F 445	in-service her students on proper oral care and linen and incontinence care. Before the next clinicals, the Staff Development coordinator or designee will re-in-service students on proper oral care and incontinence care and linen care. Each resident will be provided his or her own tube of toothpaste. The Staff Development Coordinator or designee will complete competencies for LNs and CNAs on hand washing and oral care. **Monitoring/Quality Assurance** The Director of Nursing or designee will do random weekly audits for 6 weeks to validate that resident's linens are changed correctly. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. ~~The Director of Nursing or designee will do~~	

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F 445	Continued From page 27 physical therapy department then back into the dining room. The following concerns were identified: a. During the entire observation of providing perineal care, dressing the resident, and handling soiled linen, the CNA was wearing a dietary apron. Continued observation revealed the CNA hung her dietary apron on a hook in the assisted dining area at 8:50 AM. b. Interview with the RD on 12/10/08 at 11:58 AM revealed dietary aprons were not to be worn during resident care, only for dining assistance. c. Interview with the infection control coordinator on 12/10/08 at 10:30 AM verified dietary aprons were only used for serving and assisting residents with meals. She further stated the aprons were not to be worn during personal care or while transporting soiled linen. In addition, the infection control coordinator stated soiled linen should be bagged and not just placed on the floor. Finally, she stated soiled aprons should not be hung on the hangers for further use, but should be placed in the soiled laundry hamper. d. During an interview with CNA #8 on 12/10/08 at 12:28 PM, she stated she placed the soiled apron in the dirty laundry hamper, however, observation revealed she had actually hung the apron on the peg for aprons which would be used for the next two meals that day.	F 445	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* random weekly audits for 6 weeks to validate appropriate technique during dressing changes. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. The Director of Nursing or designee will do random weekly audits for 6 weeks to validate that proper hand washing is performed during dining assistance. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports.	
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by:	F 502	The Director of Nursing or designee will do random weekly audits for 6 weeks to validate that serving aprons are put in the laundry after each meal. At the completion of the audits the Director of Nursing or designee will report	

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	535036	A. BUILDING _____ B. WING _____	C 12/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 502	Continued From page 28 Based on medical record review and staff interview, the facility failed to ensure laboratory services were provided in accordance with physician orders for 2 (#18, #44) of 11 open sample residents. The findings were: 1. Review of physician orders for resident #18 showed that on 9/26/08 the physician's ordered weekly PT [Prothrombin Time] and INR [International Normalized Ratio] labs. Review of the medical record showed lab reports dated 10/6/08 and 10/20/08, but no other lab reports between those dates. On 12/11/08 at 8:35 AM the DON provided the surveyor some lab reports, but none were dated between 10/6/08 and 10/20/08. On 12/11/08 at 10:10 AM, the DON stated "I don't know what happened." 2. Review of the 10/2/08 physician's orders for resident #44 revealed an order for a urinalysis with culture and sensitivity for signs and symptoms of a urinary tract infection (UTI). Review of the medical record revealed the urinalysis was performed and the resident was diagnosed with a UTI. The resident was treated with Levaquin (antibiotic), however, the culture and sensitivity was not performed so it was uncertain if the Levaquin was the appropriate antibiotic. Interview with the DON on 12/11/08 at 10:45 AM revealed the order for culture and sensitivity was not performed because it was not properly marked by nursing staff on the laboratory request form.	F 502	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. The Director of Nursing or designee will do random weekly audits for 6 weeks to validate that oral care is performed correctly. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** Correction date: **January 12 2009**	
F 520 SS=E	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520	**F-444 Preventing Spread of Infection** **Corrective Action for Identified Residents** Nursing staff will follow proper hand ~~washing procedure when assisting resident~~	Jan 12 2009

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F 520	Continued From page 29 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 staff interview, medical record review, and review of facility documents, the facility failed to ensure the performance improvement (PI) program was effective in resolving problems in the facility. The findings were: 1. Review of the medical record for resident #44 revealed s/he experienced falls on 10/6/08, 10/20/08, 10/24/08,10/27/08, 11/10/08, 11/11/08, and 11/15/08. Review of the performance improvement action plan for 11/11/08 revealed falls were identified as a problem in the facility. Review also revealed resident #44 was specifically identified as a high fall risk. The following concerns were identified with the PI action plan and oversight related to falls:	F 520	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* #44 with eating. Licensed nurses will follow proper hand washing procedure while performing dressing changes for resident #13. **Identification of Residents with Potential to be Affected** All residents who need assistance with eating and who need dressing changes have the potential to be affected. **Corrective Action to Prevent Recurrence** Staff Development Coordinator or designee will in-service nursing staff on appropriate hand washing. Staff Development Coordinator or designee will in-service nurses on appropriate hand washing during dressing changes Staff Development Coordinator or designee will in service nursing staff on assisting with eating. **Monitoring/Quality Assurance** The Director of Nursing or designee will do ~~random weekly audits for 6 weeks to~~	

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F 520	Continued From page 30 a. Review of the action plan revealed items listed to address this resident's falls included monitoring tabs alarms for residents who were independent with mobility by answering alarms as soon as possible. However, review of the 12/8/08 quarterly Minimum Data Set assessment for this resident revealed s/he was no longer independently mobile. Review of the 11/11/08 performance improvement action plan regarding falls revealed there was no evidence staff implemented the action plan and the resident experienced another fall after the implementation target date of 11/10/08. b. No further action items were established except to have the licensed nurse attend the morning meetings from Monday through Friday and for the director of nursing service to improve data entry so percentages of falls would be more accurate. c. Review of the medical record, the event reports, and the post fall reports revealed there was no assessment to determine the cause of falls. Review of the care plan revealed it was not updated regarding falls until 12/9/08 and review of the medical record revealed the resident was not re-assessed for risk of falls until 12/10/08 after immediate jeopardy was called. Refer to F323 for details regarding the immediate jeopardy. 2. Review of the previous survey findings dated 11/28/07 revealed the facility was cited for not following the care plan for residents (F282). In addition, the facility was cited for this tag during the 2004 and 2006 surveys. Review of the 11/28/07 survey plan of correction revealed the DON would perform weekly audits for six weeks and report back to the performance improvement committee for further determination of actions.	F 520	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* validate that dressing changes are done correctly. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. The Director of Nursing or designee will do random weekly audits for 6 weeks to validate that proper hand washing is performed during dining assistance. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** Correction date: **January, 12 2009** **F-445**	Jan 12 2009

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F 520	Continued From page 31 However, review of the 11/11/08 performance improvement action plan revealed care plan implementation and follow through was not being monitored and improvement was not sustained as evidenced by repeated deficient practice related to care plan implementation.	F 520	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Corrective Action for Identified Residents** Soiled linens will be handled appropriately. Aprons have been removed and taken to the laundry. New aprons have been ordered so that there will be enough to have clean aprons at each meal. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** Staff Development Coordinator or designee will in-service nursing staff on appropriate hand washing and linen handling. Staff Development Coordinator or designee will in-service all staff on the appropriate use of serving aprons and how they are to be put in the laundry after each meal. **Monitoring/Quality Assurance** The Director of Nursing or designee will do random weekly audits for 6 weeks to validate that residents' linens are changed	

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F 445	Continued From page 27 physical therapy department then back into the dining room. The following concerns were identified: a. During the entire observation of providing perineal care, dressing the resident, and handling soiled linen, the CNA was wearing a dietary apron. Continued observation revealed the CNA hung her dietary apron on a hook in the assisted dining area at 8:50 AM. b. Interview with the RD on 12/10/08 at 11:58 AM revealed dietary aprons were not to be worn during resident care, only for dining assistance. c. Interview with the infection control coordinator on 12/10/08 at 10:30 AM verified dietary aprons were only used for serving and assisting residents with meals. She further stated the aprons were not to be worn during personal care or while transporting soiled linen. In addition, the infection control coordinator stated soiled linen should be bagged and not just placed on the floor. Finally, she stated soiled aprons should not be hung on the hangers for further use, but should be placed in the soiled laundry hamper. d. During an interview with CNA #8 on 12/10/08 at 12:28 PM, she stated she placed the soiled apron in the dirty laundry hamper, however, observation revealed she had actually hung the apron on the peg for aprons which would be used for the next two meals that day.	F 445	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* correctly and soiled linens are handled properly. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. The Director of Nursing or designee will do random weekly audits for 6 weeks to validate that serving aprons are put in the laundry after each meal.	
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by:	F 502	At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. **Director of Nursing will be responsible for continued compliance.** Correction date: **January 12 2009**	

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F 502	Continued From page 28 Based on medical record review and staff interview, the facility failed to ensure laboratory services were provided in accordance with physician orders for 2 (#18, #44) of 11 open sample residents. The findings were: 1. Review of physician orders for resident #18 showed that on 9/26/08 the physician's ordered weekly PT [Prothrombin Time] and INR [International Normalized Ratio] labs. Review of the medical record showed lab reports dated 10/6/08 and 10/20/08, but no other lab reports between those dates. On 12/11/08 at 8:35 AM the DON provided the surveyor some lab reports, but none were dated between 10/6/08 and 10/20/08. On 12/11/08 at 10:10 AM, the DON stated "I don't know what happened." 2. Review of the 10/2/08 physician's orders for resident #44 revealed an order for a urinalysis with culture and sensitivity for signs and symptoms of a urinary tract infection (UTI). Review of the medical record revealed the urinalysis was performed and the resident was diagnosed with a UTI. The resident was treated with Levaquin (antibiotic), however, the culture and sensitivity was not performed so it was uncertain if the Levaquin was the appropriate antibiotic. Interview with the DON on 12/11/08 at 10:45 AM revealed the order for culture and sensitivity was not performed because it was not properly marked by nursing staff on the laboratory request form.	F 502	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-Tag 502 Laboratory Services** Jan 12 2009 **Corrective Action for Identified Resident** Resident #18's physician has been informed of the missing lab. Labs on Resident #18 will be monitored to validate orders are completed per physician orders. The physician for resident #44 was aware that a culture and sensitivity was not completed with the urinalysis. **Identification of Residents with potential to be affected** All residents with orders for labs have the potential to be affected. **Corrective Action to Prevent Recurrence** The system for tracking the completion of lab orders has been revised. Staff Development Coordinator or designee will review the lab order systems and make changes to validate all labs are completed per physician orders. The Staff Development Coordinator or	
F 520 SS=E	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		

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F 520	Continued From page 29 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 committees 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 staff interview, medical record review, and review of facility documents, the facility failed to ensure the performance improvement (PI) program was effective in resolving problems in the facility. The findings were: 1. Review of the medical record for resident #44 revealed s/he experienced falls on 10/6/08, 10/20/08, 10/24/08,10/27/08, 11/10/08, 11/11/08, and 11/15/08. Review of the performance improvement action plan for 11/11/08 revealed falls were identified as a problem in the facility. Review also revealed resident #44 was specifically identified as a high fall risk. The following concerns were identified with the PI action plan and oversight related to falls:	F 520	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* designee will in-service the licensed nurses on the correct way to write and follow lab orders. The Staff Development Coordinator will in-service the nursing staff in all changes of the lab monitoring system. **Monitoring/Quality Assurance** The Director of Nursing or designee will complete random audits for 6 weeks to validate labs are completed per physician orders. Reports will be given to the Performance Improvement Committee (Quality Assurance) and further monitoring will be determined by the Performance Improvement Committee (Quality Assurance). **Responsible Party** **Director of Nursing or Designee** **Correction Date** **January 12, 2009**	

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F 520	Continued From page 30 a. Review of the action plan revealed items listed to address this resident's falls included monitoring tabs alarms for residents who were independent with mobility by answering alarms as soon as possible. However, review of the 12/8/08 quarterly Minimum Data Set assessment for this resident revealed s/he was no longer independently mobile. Review of the 11/11/08 performance improvement action plan regarding falls revealed there was no evidence staff implemented the action plan and the resident experienced another fall after the implementation target date of 11/10/08. b. No further action items were established except to have the licensed nurse attend the morning meetings from Monday through Friday and for the director of nursing service to improve data entry so percentages of falls would be more accurate. c. Review of the medical record, the event reports, and the post fall reports revealed there was no assessment to determine the cause of falls. Review of the care plan revealed it was not updated regarding falls until 12/9/08 and review of the medical record revealed the resident was not re-assessed for risk of falls until 12/10/08 after immediate jeopardy was called. Refer to F323 for details regarding the immediate jeopardy. 2. Review of the previous survey findings dated 11/28/07 revealed the facility was cited for not following the care plan for residents (F282). In addition, the facility was cited for this tag during the 2004 and 2006 surveys. Review of the 11/28/07 survey plan of correction revealed the DON would perform weekly audits for six weeks and report back to the performance improvement committee for further determination of actions.	F 520	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-Tag 520 Quality Assessment and Assurance** **Corrective Action for Identified Residents** (See F-323) **Identification of Residents with potential to be affected** All residents have the potential to be affected. **Corrective Action to Prevent Recurrence** Members of the Performance Improvement Committee will be in-serviced on the writing, implementation, and follow-up of Performance Improvement Action plans as well as the purpose of Performance Improvement. Action plans will be reviewed at each monthly performance improvement meeting until committee has decided that improvement has been made. If improvement is not made, the action plan will be modified.	Jan 12 2009

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