POC accepted 8/14/10 Janelle Cook, ONE

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 _____	07/09/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	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, review of resident council meeting minutes, and staff, resident, and family interview, the facility failed to provide an orderly and dignified dining service during 2 of 3 observed meals. The findings were: 1. Two of three meals (dinner 7/6/09 and breakfast 7/7/09) observed during the survey were served late and in piecemeal fashion. Meal production was disorganized, resulting in some food items being served late or not prepared in sufficient quantities for the number of residents in the facility. The following concerns were noted: a. Observation on 7/6/09, from 5:30 to 8:15 PM, showed the evening meal (hot dogs, baked beans, and watermelon) was served up to 90 minutes late to some residents. The established time for dinner was 5:30 to 6:30 PM and these hours were posted in the main dining room. (1). Residents were served watermelon beginning at 5:40 PM because the main course was not ready. Five non-sample residents were observed to leave the main dining room at 6:05 PM after eating water melon. One resident (#16) stated s/he "was tired of waiting for dinner." (2). The first resident was served the main course at 6:07 and at 6:28 PM staff began serving only hot dogs to the remaining residents while additional beans were heated; the initial quantity of beans prepared was only sufficient for	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-241 Dignity** **Corrective Measures for Identified Residents:** Resident #46, #40, #20, #2, and #6 will be served, assisted and offered fluids in a timely and dignified manner. Education will be conducted with CNAs and nurses to address the expectations that residents be assisted fully and in a dignified manner. **Identification of other residents:** Residents being served and assisted in the dining rooms have the potential to be affected. **Measures/Systemic Changes:** Training of staff including kitchen staff will be conducted by the SDC/ Designee by August 23, 2009 regarding timely meal service, assistance until meals are fully consumed as desired by the resident, and providing a dignified dining experience for residents. This will include correct terminology such as "clothing protectors" versus "bibs". JC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Joanne Taylor — Executive Director — Aug 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. Changes made per phone call c Joanne Taylor, ED on 8/14/09 @ 11 Am.

Janelle Cook, ONE

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F 241	Continued From page 1 26 of the 54 residents in the facility. Piecemeal service continued for 22 minutes. Four more non-sample residents were observed to leave the dining room before receiving their full dinner portions. (3). Resident #46 requested to eat in his/her room and did not receive a room tray until 7:09 PM. The resident was lying in bed at that time and certified nurse assistant (CNA) #4 left the food tray on a bedside table. The director of nursing (DON) checked the resident at 7:47 PM, discovered the hot dogs were cold, and reheated them. The resident received rewarmed food at 8:02 PM. 2. Observation of the evening meal in the assisted dining room on 7/6/09 from 5:45 PM until 7:40 PM revealed the following concerns: a. At 5:45 PM, observation showed certified nurse aide (CNA) #2 was seated at a table waiting to assist resident #40 with the evening meal, which had not yet been served. The CNA called from across the room to registered nurse (RN) #1 seated at another table stating, "I need to leave to go do my time sheet." The RN shook her head no and said you cannot leave now. The CNA then assisted the resident with his/her gelatin that was served at 6:10 PM. As plates of food were served to other residents, the resident yelled out "Hey, hey," and held up his/her arms toward the plate of food. The CNA made the comment, "Your food is coming [resident's name]. You're hungry aren't you?" The resident's meal, which consisted of a pureed hot dog, bun, and baked beans, was finally served at 7:02 PM. During the observation the CNA fed the resident four or five bites of the pureed hot dog. At 7:05 PM the CNA again called across the room to RN #1 stating she really needed to go home to feed	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.* A dining room hostess program will be implemented by 8/23/09 to assist in timely meal service, oversight of the dining room, providing complete assistance throughout the meal and confirmation that residents are treated in a dignified manner. Training for managers participating in the hostess program will be completed prior to implementation. Resident Council members will be queried monthly regarding the timeliness of meal service and if they are experiencing dignified dining service. Identified concerns will be handled through the facilities grievance program. **Monitoring:** The ED/Designee will monitor meal service 3 x weekly, will compile daily meal service evaluations written by the host/hostess and report findings to the Performance Improvement Committee for review and recommendations monthly x 6 months. **Date of compliance: August 23, 2009**	Aug. 23, 09

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F 241	Continued From page 2 her horses. "I don't want to feed them in the dark....They [horses] usually get fed at 5 PM." The RN stated the CNA could leave, which she did. Continued observation revealed no other staff member assisted resident #40 with the remainder of his/her meal. At 7:20 PM the RN told CNA #3 that resident #40 was finished eating. CNA #3 then assisted the resident to his/her room. Review of the meal intake record revealed the resident ate 50 percent of the meal. Review of the 5/24/09 initial Minimum Data Set (MDS) assessment revealed the resident was totally dependent upon staff for eating and nourishment. b. Observation of the meal served in the assisted dining room revealed watermelon was served to residents at 5:55 PM. The next meal item served was gelatin which was served at 6:10 PM. By 6:25 PM, CNA #2 was heard to say, "I wonder where the rest of the food is at." Observation showed the first plate consisting of a hot dog, bun, and baked beans was served to a resident at 6:37 PM. At 6:46 PM, the DON was observed as she passed ice cream cups to residents who had not yet been served the main entree. At 6:57 PM another plate of food was served. Observation revealed resident #40 was seated at the dining room table for the evening meal from 5:45 until 7:25 PM (1 hour 35 minutes) waiting for his/her meal. c. Observation on 7/6/09 at 7:10 PM revealed resident #20 was not eating the meal. RN #1 asked the resident if s/he would like soup and the resident said "yes." Continued observation revealed the resident did not receive the requested soup until 7:35 PM (25 minutes later). e. Observation on 7/6/09 at 6:15 PM showed RN #1 asked CNA #1 to put a "bib" on resident #2.	F 241		

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F 241	Continued From page 3 3. Observation of resident #6 on 7/6/09 during the evening meal at 5:20 PM, revealed the resident sat in a wheelchair at the table in the assisted dining area drinking small sips of iced tea, juice, and a liquid supplement while waiting for his/her food to be served. Continued observation revealed staff did not assist or cue the resident from 5:20 to 6:48 PM. At 5:40 PM, the resident was served a bowl of sliced watermelon and at 6:40 PM the resident was served a hot dog, bun, and shredded cheese. At 6:48 PM, when the resident was served a bowl of beans, a CNA began to feed the resident. At 6:55 PM, the CNA stopped feeding the resident, and the resident left the dining room. At 7:05 PM, a second CNA wheeled the resident back to the dining room, gave him/her a spoonful of chocolate ice cream, instructed him/her to eat, and walked away. At 7:10 PM, the resident ate three additional spoonfuls of the ice cream, then the resident left the dining room in his/her wheelchair, having consumed less than 5% of his/her food while waiting more than an hour and 50 minutes in the assisted dining room. 4. Observation of the breakfast meal on 7/7/09 revealed the following concerns: a. Residents requesting fried eggs as an alternative to a cheese omelet were given hot cereal and toast while the cook caught up on orders; fried eggs were served piecemeal for the remainder of the breakfast meal. The cook stated in interview at 7:52 AM she knew some residents preferred fried eggs, but she was "just too busy getting everything else ready" to prepare alternative choices in a more timely manner. b. Pureed foods were not ready for residents in the assisted dining room until 8:32 AM, causing	F 241		

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F 241	Continued From page 4 some residents to wait at their table for over an hour before being served. 5. Confidential resident interviews conducted during the survey revealed the following concerns about the food service: a. Food service was slow. b. Residents did not like to wait for their food while other residents at the same table were already eating their meals. c. "The food was served in pieces which isn't homelike." Residents were served one food item and had to wait for the next food item to be served. d. In the past, the residents talked about the problem during the resident council meetings, but nothing had been done about it. e. Some residents leave the dining room without eating because they get tired of waiting. f. Staff told the residents to arrive at the dining room a half hour before the meal then the residents had to sit for another half hour before the food was served. 6. Review of the resident council meeting minutes from four of the last six months (1/15, 2/19, 5/21 and 6/26/09), revealed the residents reported concerns about the lack of kitchen staff, food preferences not being honored, and waiting too long for meals to be served. 7. Interview with a family member on 7/9/09 at 7:50 AM, revealed the family member visited three to four times a week during the past four months and observed periodic incidents of slow food service and staff's failure to provide assistance to residents who needed assistance at mealtimes.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-272 Resident Assessment** **Corrective Measures for Identified residents:** RAPs for cited residents #21and #39 had addendum attachments written to include accurate and complete evaluation and analysis of the collected data as it relates to psychosocial well-being, psychotropic drug use, and mood state. **Identification of Other residents:** An audit will be conducted by the MDS Coordinator to determine if the Social Services RAPs contain documentation to support causes, contributing factors, and analysis of the data being collected. Incomplete RAP documentation will be revised with an addendum note written by the Social Services Director.	
F 272	483.20, 483.20(b) COMPREHENSIVE	F 272		

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F 272 SS=D	Continued From page 5 ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff performed a comprehensive assessment in the areas of psychosocial well-being, psychotropic drug use,	F 272	*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* **Measures/Systemic Changes:** The District Director of Case Management will train the Social Services Director on analysis of data and correct documentation on the RAP. **Monitoring:** Random audits will be conducted monthly by the MDS Coordinator to confirm that RAPs contain documentation to support causes, contributing factors, and analysis of the collected data. Findings will be reported to the PIC monthly x 3 months for review and recommendations. **Date of Compliance: August 23, 2009**	Aug. 23, 09

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F 272	Continued From page 6 and mood state for 2 of 12 sample residents (#21, #39). The findings were: 1. Review of the 5/27/09 annual Minimum Data Set (MDS) assessment for resident #21 revealed s/he triggered for comprehensive assessment in the areas of mood state, psychotropic drug use, and psychosocial well-being. Review of the Resident Assessment Protocol (RAP) for psychosocial well-being, dated 5/27/09, the RAP for psychotropic drug use, dated 5/28/09, and the RAP for mood state, dated 6/2/09, revealed, there were no causes or contributing factors identified for these potential problem areas. Nor were there any analyses of the collected data. 2. Review of the 5/13/09 annual MDS assessment for resident #39 revealed s/he triggered for comprehensive assessment of psychosocial well-being and psychotropic drug use. Review of the RAP for psychotropic drug use, dated 5/13/09, and the RAP for psychosocial well-being, dated 5/15/09 revealed there was data only. No analyses were done of the collected information. 3. During an interview with the social worker on 7/9/09 at 10:20 AM, she acknowledged assessments did not consist of data collection only, but required an evaluation of the data, as well.	F 272	*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-281 Professional Standards** **Corrective Action for Identified Residents:** The blood glucose monitor was re-tested and is functioning within normal range. Due to the lock-out quality control mechanism in the glucose monitor the nurse would have been unable to use the monitor until corrective action was taken. Therefore, it is reasonable to assume that action was taken prior to obtaining additional blood glucose values for residents #17, #19, #49, #50, #53, and #54. Identified expired reagents and supplies were discarded immediately on 7/8/09.	
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	**Identification of Other Residents:** Facility blood glucose monitors were re-tested and found to be within normal range. A thorough observation of utility rooms and nurses' station was completed. Outdated reagents and supplies were removed and replaced as appropriate.	

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F 281	Continued From page 7 Based on review of quality control log sheets for glucose testing and confirmed by staff interview, the facility failed to identify and correct 2 of 7 instances when quality control values were unacceptable. The facility further failed to remove from use 3 expired laboratory items. The findings were: 1. Review of laboratory testing records, reagents, and supplies disclosed the following deficiencies: a. Review of quality control log sheets for whole blood glucose testing on 7/9/09 at 3:25 PM showed seven instances in which quality control values exceeded the acceptable range established by the manufacturer of the control materials. Two (6/7/09 and 7/1/09) of the out-of-range events lacked evidence of corrective action prior to resident testing; the unacceptable values were noted for the "South" hallway glucometer, serial number L73215A00146. Review of glucose test results showed six residents (#17, #19, #49, #50, #53, and #54) were tested on the South hallway on each of the days control values were out-of-range. b. Inspection of a storage area on the South hallway on 7/7/09 at 10:50 AM showed three of five laboratory items stored in an overhead cabinet behind the nurses' station were expired: Hema-Chek color developer (lot no. 5901, expiration 02/2009, 2 bottles), sodium heparin green-top blood collection tubes (lot no. 715-8540, expiration 05/2009, 4 tubes), and culture collection and transport swabs (lot no. 010L10, expiration 03/2009, 9 kits). Registered nurse (RN) #2 stated in an interview on 7/7/09 at 11:30 AM these were the only laboratory supplies she knew about and, further, she would use them if needed for resident care. c. The staff development coordinator stated	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.* **Measures/Systemic Changes to Prevent Recurrence:** Nursing staff will be re-educated by the SDC by 8/23/09 regarding the needed follow-up and documentation to be done when glucometer control values are found to be out of the normal range. The meters have a built-in system that will not permit further use until corrective action is taken for abnormal results found during routine checks. Training will also include the timely removal and replacement of outdated reagents and supplies. **Monitoring:** The DNS/Designee will review glucose monitor test results 5 x weekly for 2 weeks, then weekly for 2 weeks, then monthly to confirm that corrective action has been documented when monitors are out of range. The DNS/Designee will observe utility rooms and nurses' stations for expired reagents and supplies weekly to validate their removal and replacement. Findings of observations and audits will be	

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F 281	Continued From page 8 in interview on 7/8/09 at 4:10 PM nursing personnel performing glucose testing were required to obtain acceptable quality control values before using a glucometer for resident testing. She stated nursing staff may have used a glucometer from another hallway, but confirmed a lack of evidence to clearly document the staff's actions. The coordinator added expired laboratory items were not to be used and, further, the expired supplies were discarded 7/8/09.	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.*	
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, and medical record review, the facility failed to ensure staff provided dining assistance to 4 (#6, #25, #37, #40) of 6 sample residents who required total or extensive assistance with eating. The findings were: 1. Observation of resident #37 on 7/6/09 at 6:58 PM showed s/he received a plate of baked beans, and a hot dog with a bun. The plate was placed uncovered on the table in front of the resident. Observation from 6:58 until 7:05 PM showed no staff member offered to assist the resident with his/her meal and did not cue the resident to eat. The resident was taken from the table at 7:05 PM without the opportunity to eat any of the main entree. Review of the 6/15/09 initial Minimum Data Set (MDS) assessment revealed this	F 312	reported monthly to the Performance Improvement Committee for review and recommendations for 3 months or as directed by the PIC. **Date of Compliance: August 23, 2009** **<u>F-312 Activities of Daily Living</u>** **Corrective Action for Identified Residents:** Resident #6 is deceased. Resident #25 was re-evaluated by the SLP on 7/14/09 and requires maximum assistance at meals. Resident #37 will be re-evaluated by the SLP by 7/30/09. Resident #40 was re-evaluated on 7/14/09 by the SLP and requires maximum assistance at meals. CNA's caring for cited residents were re-educated regarding dining assistance for these individuals.	Aug. 23 09

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F 312	Continued From page 9 resident was totally dependent upon staff for eating. 2. Observation on 7/6/09 showed CNA #2 assisted resident #40 with his/her gelatin which was served at 6:10 PM. As plates of food were served to other residents, the resident yelled out "Hey, hey," and held up his/her arms toward the plate of food. The CNA made the comment, "you must be really hungry." The resident's meal, which consisted of a pureed hot dog, a bun, and baked beans, was served at 7:02 PM. The CNA fed the resident five bites of the pureed hot dog, then, at 7:05 PM that CNA left the facility. Continued observation revealed no other staff member replaced CNA #2 to assist resident #40 with the remainder of his/her meal. At 7:20 PM the RN told CNA #3 that # 40 was finished eating. CNA #3 assisted the resident out of the dining room. Interview with the CNA at the time of the observation revealed the resident required total assistance of staff for eating. Review of the meal intake record revealed the resident had eaten 50 percent of the meal. Review of the 5/24/09 Initial MDS assessment revealed the resident was totally dependent on staff for eating and nourishment. Review of the undated CNA care plan showed the resident required feeding of his/her meals. Observation on 7/8/09 at 11:32 AM showed resident #40 received lunch, which consisted of pureed green beans and ham. The resident was not assisted with the meal until 12:01 PM (29 minutes later). Observation also showed the resident's meal had been left u uncovered during that time and no attempt was made to test the temperature of the food or reheat it prior to assisting the resident with the meal.	F 312	*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 Other Residents:** Residents will be screened by therapies for dining assistance needs by 7/30/09 to identify residents who require additional assistance and/or cueing. **Measures/Systemic Changes:** Staff will be trained by therapies on the proper techniques for cueing and assistance at meals. The Restorative Nurse will create a list, with guidance from therapies, of residents requiring additional assistance at meals. This list will be maintained at the nursing stations for reference by staff. **Monitoring:** The (ED/DNS/ Designee) will randomly monitor meals 3 x weekly for 3 months to confirm that residents receive the necessary assistance during meals. The SLP and/or Rehab Program Manager will monitor meal service 1-3 x weekly and assist and train as appropriate.	

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	535036	A. BUILDING _____ B. WING _____	07/09/2009

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F 312	Continued From page 10 3. Observation in the dining room on 7/8/09 at 11:32 AM showed resident #25 was served green beans and ham. Observation revealed the resident was not assisted with the meal for 29 minutes (12:01 PM). Two CNA's were seated at the table with this resident, but both were exclusively assisting the other two residents at the table. Observation showed the resident was not offered even a drink while awaiting his/her meal. Also, observation showed the resident's meal was not covered with a lid to keep the food warm and was not reheated. Review of the meal intake record revealed the resident ate only ten percent of the meal. Review of the 4/20/09 quarterly MDS assessment revealed s/he required extensive assistance with eating and nourishment. Review of the undated CNA care plan for the resident showed the resident required feeding of his/her meals. 4. Refer to F 241 regarding inadequate feeding assistance provided for resident #6 on 7/6/09. 5. Refer to F 241 regarding an interview with a family member who had observed, on more than one occasion, staff's failure to provide assistance at meals to dependant residents.	F 312	*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.* Findings of observations and corrective measures will be reported by the ED/Designee to the Performance Improvement Committee monthly for 3 months or as directed by the PIC. **Date of Compliance: August 23, 2009**	Aug. 23, 09
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 387	**F-387 Frequency of Physician Visits** **Corrective Action for Identified Residents:** The physicians for residents #21 and #54 have been notified and residents will be seen by August 23, 2009. **Identification of Other Residents:** The Health Information Manager (HIM) will complete an audit of the records of facility residents to identify other physicians who are out of compliance with visits. The physicians have been notified in writing and per phone.	

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F 387	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure physician visits were made every sixty days as required for 2 of 14 sample residents (#21, #54). The findings were: 1. Review of the physicians' notes for resident #21 revealed the resident was last seen by his/her physician on 1/23/09. Interview with the DON on 7/9/09 at 9:45 AM revealed there was no evidence the physician had seen the resident since his January visit. 2. Review of the physicians' notes for resident #54 revealed the resident was last seen by his/her physician on 3/25/09. Interview with the DON on 7/9/09 at 9:45 AM revealed she was unsure why the physician had not seen the resident since 3/25/09.	F 387	*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.* **Measures/Systemic Changes:** The ED will send a letter to all attending physicians to re-educate them on the visitation and documentation requirements by August 23, 2009. The Health Information Manager will audit records monthly for compliance and notify physicians in writing of any pending required visits.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	**Monitoring:** The HIM will conduct monthly record audits to validate compliance with visitation and documentation requirements. Findings will be reported to the PIC monthly for review and recommendations. **Date of Compliance: August 23, 2009**	Aug. 23, 09
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the physician received and			

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F 387	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure physician visits were made every sixty days as required for 2 of 14 sample residents (#21, #54). The findings were: 1. Review of the physicians' notes for resident #21 revealed the resident was last seen by his/her physician on 1/23/09. Interview with the DON on 7/9/09 at 9:45 AM revealed there was no evidence the physician had seen the resident since his January visit. 2. Review of the physicians' notes for resident #54 revealed the resident was last seen by his/her physician on 3/25/09. Interview with the DON on 7/9/09 at 9:45 AM revealed she was unsure why the physician had not seen the resident since 3/25/09.	F 387	*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-428 Pharmacy Drug Regimen Review** **Corrective Measures for Identified Residents:** The physician for resident #36 was notified for follow-up of the Pharmacist recommendation and a reply was obtained. **Identification of Other Residents:** On 7/13/09 the Pharmacy Consultant performed a record review for facility residents to confirm that Drug Regimen Review (DRR) follow-up was achieved on residents. A list of findings was provided to the DNS for follow-up. **Measures/Systemic Changes:** The Consolidated Pharmacy Report, left with the DNS immediately following each DRR visit, will be utilized by the DNS/Designee to document follow-through. This tool will be used to confirm that DRR recommendations are sent to the physicians and follow-through is achieved.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the physician received and	F 428		

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F 428	Continued From page 12 responded to medication irregularities identified by the pharmacist for 1 (#36) of 12 sample residents. Review of the monthly pharmacy reviews dated 1/29/09, 3/25/09, and 4/15/09 for resident #36 revealed the pharmacist recommended the physician discontinue the daily dose of Benadryl for this resident. Review of the 5/6/09 pharmacy review revealed a recommendation to decrease the daily dose of Benadryl. Review of the medical record revealed staff did not obtain a response from the physician and no changes were made to the medication order. Interview on 7/9/09 at 9:50 AM with the DON revealed the facility did not get a response from the physician because the nursing staff had "overlooked" the repeated recommendations by the pharmacist.	F 428	*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:** The Pharmacy Consultant will review records monthly and will notify the facility in writing of individualized and graphed follow-through analysis. The DNS will utilize the pharmacy reports and the Consolidated Pharmacy Report to confirm timely follow-up has been achieved.	
F 441 SS=D	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 staff interview, and review of medical records, and infection control policies and procedures, it was determined the facility failed to identify 1 of 1 resident (#46) with an	F 441	Identified trends will be presented by the DNS/Designee to the PIC monthly for review and recommendations. **Date of Compliance: August 23, 2009** **F-441 Infection Control Program** **Corrective Measures for Identified residents:** The culture and sensitivity report for resident #46 was reviewed with the physician on 7/14/09. The physician declined to give a corroborating diagnosis. The culture results were logged. No further testing will be done at this time.	Aug. 23, 09

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F 441	Continued From page 13 epidemiologically-significant infection. The findings were: Review of the medical record for resident #46 on 7/7/09 showed a laboratory report dated 6/14/09. The report showed the resident had a positive blood culture, confirming the presence of Staphylococcus aureus. The laboratory further reported the bacteria was resistant to the antibiotic oxacillin. According to the Centers for Disease Control & Prevention (CDC) guideline on multidrug-resistant organisms (released November 2006) oxacillin-resistance is synonymous with methicillin-resistance. This same information was contained in the facility's infection control policy for MRSA (Antibiotic Resistance Review, POL 628-01, 4/28/07). The resident's culture report was not recognized by facility staff as methicillin-resistant Staphylococcus aureus (MRSA). Review of the facility's infection control policies and procedures on 7/7/09 showed specific requirements for residents with MRSA positive cultures. The infection control nurse acknowledged in interview on 7/8/09 at 9:40 AM the facility failed to recognize the resident's MRSA culture results and she was not aware the resident was culture-confirmed for MRSA in June 2009.	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.* **Identification of Other residents:** The Infection Control nurse will review culture and sensitivity reports for other facility residents, dating from the last 90 days, to identify any other residents who have a Multi-Drug Resistant Organism (MDRO). The IC nurse will review any abnormal findings with the resident's physician for further direction. **Measures/Systemic Changes:** The IC nurse will identify and track MDROs on the infection control log. Training with nurses will be conducted by the SDC/Designee to educate them on the recognition and identification of MDROs and the significance of these organisms. **Monitoring:**	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	The Infection Control nurse will maintain logs of infections and MDROs and report findings to the PIC each month for their review and recommendations. **Date of Compliance: August 23, 2009**	Aug. 23, 09

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F 441	Continued From page 13 epidemiologically-significant infection. The findings were: Review of the medical record for resident #46 on 7/7/09 showed a laboratory report dated 6/14/09. The report showed the resident had a positive blood culture, confirming the presence of Staphylococcus aureus. The laboratory further reported the bacteria was resistant to the antibiotic oxacillin. According to the Centers for Disease Control & Prevention (CDC) guideline on multidrug-resistant organisms (released November 2006) oxacillin-resistance is synonymous with methicillin-resistance. This same information was contained in the facility's infection control policy for MRSA (Antibiotic Resistance Review, POL 628-01, 4/28/07). The resident's culture report was not recognized by facility staff as methicillin-resistant Staphylococcus aureus (MRSA). Review of the facility's infection control policies and procedures on 7/7/09 showed specific requirements for residents with MRSA positive cultures. The infection control nurse acknowledged in interview on 7/8/09 at 9:40 AM the facility failed to recognize the resident's MRSA culture results and she was not aware the resident was culture-confirmed for MRSA in June 2009.	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.* **F-514 Administration: Clinical Records** **Corrective Measure for identified residents:** The DNS removed the lab and care plan from resident #26 record and placed them in the correct resident record. Resident #6 is no longer in the facility. **Identification of Other Residents:** The Health Information Manager (HIM)/Designee will audit records of facility residents to validate the correct resident's information is posted/filed in their medical record by 7/30/09. Information incorrectly filed will be immediately returned to the correct record. **Measures/Systemic Changes:**	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	The SDC/Designee will train the staff on the correct method for filing/posting health information in the medical record to maintain confidentiality of the records by August 23, 2009.	

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F 514	Continued From page 14 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on review of medical records and confirmed by staff interview, the facility failed to maintain accurate clinical records for 3 (#6, #26, #46) of 10 sample residents. The findings were: 1. Review of the medical record for resident #46 on 7/7/09 and again on 7/8/09 showed care plan information and laboratory culture results from another resident (#26) were misfiled in his/her record. The misplaced information included an interim care plan for isolation during an infectious event and a positive culture report from a urine sample. 2. The infection control nurse acknowledged in interview on 7/8/09 at 10:30 AM the information from resident #26 was misfiled. She attributed the error to similar last names for the residents, stating "...that happens sometimes." 3. Review of the medical record for resident #6 revealed the 6/3/09 physician's order to discontinue one of the resident's medications was missing. Interview with the director of nursing (DON) on 7/9/09 at 9:50 AM revealed the staff were aware of the missing page, but couldn't find it. The DON also said the facility needed to implement a better system for putting information	F 514	*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:** The HIM will audit records each month with emphasis on accurate filing of documents. Discrepancies will be forwarded to the DNS for review. The HIM will report findings to the PIC monthly for 3 months or as indicated by the committee. **Date of Compliance: August 23, 2009**	Aug. 23, 09

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F 514	Continued From page 15 In the resident records to prevent misfiling and lost pages.	F 514		