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

PRINTED: 08/26/20(
FORM APPROVE
OMB NO. 0938-03(

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 08/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BROGER AVE PINEDALE, WY 82941

(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 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy and procedure review, staff interview, and review of personnel files, the facility failed to develop written policies and procedures that address mistreatment, neglect, and misappropriation of resident property. The facility also failed to implement their written procedure for pre-employment screening for 4 (#1, #2, #3, #4) of 5 sampled employees. In addition, the facility failed to check the nurse aide registry prior to employing 1 (#2) of 1 sampled certified nurse aide (CNA). The findings were: 1. Review of facility policies and procedures titled "Resident Abuse Prevention," "Abuse Procedure Policy," and "Elder Abuse Reporting," revealed the policies and procedures only addressed abuse; none of the policies mentioned mistreatment, neglect or misappropriation of resident property. Interview with the administrator on 8/12/09 at 5 PM confirmed the written policies and procedures addressed only abuse. At that time, the administrator also verified the facility had no other written policies for mistreatment, neglect, or misappropriation of resident property. 2. Review of the policy titled "Resident Abuse Prevention" revealed the following procedure: "1. Screening- All new hires will have DFS [Department of Family Services] background checks completed and all appropriate licensure	F 226	The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. The Administrator will expand facility Policies and Procedures entitled "Resident Abuse Prevention", "Abuse Procedure Policy", and "Elder Abuse Reporting" to address mistreatment, neglect, or misappropriation of resident property. 2. The Administrator will conduct an in-service for all Department Managers on procedure for obtaining and documenting DFS background checks, references, and, when applicable, licensure status for all new hires. The Administrator shall monitor compliance with these procedures via audit of personnel files, and present the outcomes at the quarterly QAA meeting with appropriate follow-up. 3. Prior to employment, the DON shall check the nurse aide registry to verify that a CNA has no findings of abuse, neglect, mistreatment or misappropriation of resident property. The Administrator shall monitor compliance via audit of CNA personnel files, and present the outcomes at the quarterly QAA meeting with appropriate follow-up.	09/08/2009 09/22/2009 09/08/2009

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

Heather McKee | Administrator | 9-15-09

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.

PoC approved with changes on 9/21/09 at 3:30 PM
T telephone conversation T Heather McKee, administrator

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F 226	Continued From page 1 boards will be contacted. References will be called and the results documented." The following concern was identified: Review of the applications for employees #1, #2, #3, #4 showed no evidence any of the listed references were contacted prior to employment. During interviews with the certified dietary manager on 8/12/09 at 2:26 PM, and the director of nursing (DON) on 8/13/09 at 9:20 AM, both stated they never contact the references listed on the applications. 3. Review of the personnel file for employee #2, hired on 6/19/09, revealed she was certified as a nurse aide by the Wyoming State Board of Nursing. Further review showed no evidence the facility checked the nurse aide registry to verify the CNA had no findings of abuse, neglect, mistreatment, or misappropriation of resident property. Interview with the DON on 8/13/09 at 9:35 AM confirmed the facility was not checking the nurse aide registry prior to employing CNAs.	F 226		
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.)	F 274		

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F 274	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to perform a significant change Minimum Data Set (MDS) assessment in a timely manner for 1 (#16) of 4 sample residents who experienced a significant change in condition. The findings were: According to the Centers for Medicare and Medicaid Services', Revised Long Term Care Facility Resident Assessment Instrument User's Manual, revised December 2008, page 2-8 and 2-9, a significant change in resident status is a decline in 2 or more areas with areas that include: "Resident's decision-making changes ...; Emergence of sad or anxious mood pattern as a problem that is not easily altered ...; Resident's incontinence pattern changes...; Emergence of a pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher...; Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision-making)..." Record review showed resident #16 was admitted on 1/27/09 with diagnoses of depressive disorder, Alzheimer's disease, diabetes mellitus, esophageal reflux, chronic airway obstruction, and nutritional deficiency. Review of the 2/9/09 admission MDS assessment documented the following: a. The resident had modified independence in cognitive skills for daily decision making. b. The resident was easily altered from a sad or anxious mood pattern. c. The resident was continent of bowel and	F 274	The facility will ensure that resident #16 and any other resident with change of condition, for improvement or for decline, will be identified by the interdisciplinary care plan team as evidenced by: The care plan team meets weekly and will discuss any residents with noted changes. A log will be kept of residents discussed at this meeting. A significant change of condition MDS will be done within 14 days of the determination to document that a significant change has occurred in the resident's condition. This process will be monitored by DON and MDS coordinator. An inservice with the interdisciplinary team will be conducted on September 3, 2009 A report will be given at the quarterly QAA meeting with appropriate follow-up.	09/03/2009

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usually continent of bladder.

d. The resident had no pressure sores.

e. The resident had no change in care needs.

Review of a 4/12/09 nurse's note showed the resident needed two staff for transfers, had a sharp decline in ability to assist in activities in daily living, and required increased physical assistance. Review of a 4/13/09 MDS assessment coordinator progress note showed the resident was "...very drowsy & drooling. Seems unable to open eyes." Review of the resident's treatment administration record (TAR) showed the resident had a blister on the right heel on 4/13/09, and a blister on the left heel on 4/27/09. Review of a 4/28/09 MDS assessment coordinator's progress note showed both heels were assessed at a stage IV. Further record review of a 5/11/09 quarterly MDS assessment showed the following significant decline in the resident's condition:

a. The resident was severely impaired in cognitive skills for daily decision making.

b. The resident was not easily altered from a sad or anxious mood pattern.

c. The resident was frequently incontinent of bowel and bladder.

d. The resident had two stage II pressure sores.

e. The resident had a deterioration that increased care needs.

During an interview with the MDS assessment coordinator on 8/17/09 at 4:10 PM, it was confirmed that she was aware of the changes in the resident's condition prior to completing the 5/11/09 quarterly MDS assessment. However, the significant change MDS assessment was not completed until 5/25/09 (42 days after the significant change was initially identified and 27 days after the resident was assessed with two

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F 274	Continued From page 4 stage IV pressure ulcers). According to the Centers for Medicare and Medicaid Services', Revised Long Term Care Facility Resident Assessment Instrument User's Manual, revised December 2008, page 2-7, "If the condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the resident, but in no case later than 14 days after the determination was made that a significant change occurred."	F 274		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	The facility will ensure that resident #16, and all residents, will have an initial, reviewed, or updated comprehensive care plan within 7 days of a completed comprehensive assessment as evidence by: A comprehensive assessment is conducted in conjunction with the admissions assessment, the annual assessment, and any significant change assessment. Comprehensive care plans will be reviewed and revised at weekly interdisciplinary care plan meetings, or more frequently if required. Residents and their families will be invited to take part in the care planning process. All identified changes in resident needs will be addressed and implemented, and documented in the care plan. This process will be monitored by the DON, MDS Coordinator, and Social Services. A report will be given at quarterly QAA meetings with appropriate follow-up. An inservice with the interdisciplinary team will be conducted on September 3, 2009.	09/03/2009

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F 280	Continued From page 5 Based on medical record review and staff interview, the facility failed to ensure the care plan was revised for 1 (#16) of 10 sample residents. The findings were: Refer to F314 regarding the facility's failure to update the care plan for resident #16 in regard to a significant decline in functional status, increased risk for pressure ulcers, and subsequent pressure ulcer development.	F 280		
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: Based on medical record review and staff interview, the facility failed to ensure professional standards of practice were maintained related to assessments. Nursing assessments for 4 (#4, #16, #25, #26) of 10 sample residents were completed by a licensed practical nurse (LPN). In addition, nutritional assessments for 8 (#2, #4, #8, #13, #17, #25, #26, #28) of 10 sample residents were completed by a certified dietary manager (CDM). The findings were: 1. According to Chapter 3 of the June 2009, Wyoming Board of Nursing Rules and Regulations, Section 3. Standards of Nursing Practice for the Licensed Practical Nurse (a) Standards related to the licensed practical nurse's contribution to the nursing process. (i) The licensed practical nurse shall: (A) Contribute to the nursing assessment by: (I) Collecting, reporting and recording	F 281	1. The facility will ensure Nursing Assessments will be completed per professional standards of practice as evidenced by: All nursing assessments such as those on residents #4, #16 #25, #26 will be completed by a RN (Registered Nurse). The DON made a new Assessment Schedule on 08/13/2009 listing only RN's to complete the quarterly assessments as well as skin assessment and initial nursing admission assessments. A meeting is to be held on 09/16/2009 to instruct nursing staff of the changes. The DON will monitor all assessments to ensure they are completed by the proper staff monthly and will report at the quarterly QAA meeting with appropriate follow up.	09/16/2009

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F 281	Continued From page 6 objective and subjective data in an accurate and timely manner. Data collection includes observations about the condition or change in condition of the patient. The following concerns were identified with nursing assessments: a. Record review for resident #4 showed an LPN completed the following assessments: elopement risk, fall risk, pressure ulcer risk, bowel and bladder retraining, hydration risk, and pain on 6/18/09. In addition, an LPN completed the resident's pain assessments on 12/9/08 and 3/21/09. b. Record review for resident #16 showed an LPN completed the following assessments: pressure ulcer risk, bowel and bladder retraining, hydration risk, and pain on 1/28/09. Further review showed an LPN also completed a pressure ulcer risk, hydration risk, and pain assessment on 6/23/09. c. Record review for resident #25 showed an LPN completed the following assessments: the admission assessment on 2/16/09 as well as elopement risk, fall risk, and hydration risk assessments on 2/18/09 and 6/5/09. Further review showed an LPN also completed a bowel and bladder retraining and pain assessments on 2/18/09. d. Record review for resident #26 showed an LPN completed the following assessments on 11/10/08: elopement risk, fall risk, pain, pressure ulcer risk, hydration risk, and bowel and bladder retraining. During an interview with the director of nursing on 8/13/09 at 8:45 AM she stated she was unaware LPNs could not complete assessments after the initial assessment was completed by a registered nurse.	F 281	2. The facility will ensure nutritional assessments will be completed per professional standards of practice as evidenced by: The RD (Registered Dietician) will assign certain tasks to the CDM for obtaining the data needed for the nutritional care process as to provide the RD with needed information (e.g. screens, gathering of data and other information) to communicate with the CDM and educating patients. This process will allow the CDM to gather information needed for the RD in the Nutritional Care Process ending with the RAP Rationale such as with residents #2, #4, #8, #13, #17, #25, #26, #28 and all residents. The CDM met with the RD on 08/19/09 and discussed the new assessment schedule as assigned in a timely manner for the CDM to help acquire accurate and relevant data and information for the RD to identify nutritional-related problems, following and completing the nutritional care process for the RAP Rationale and Nutritional Assessments. The CDM will report at the quarterly QAA meeting with appropriate follow up.	08/19/2009

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2. According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals ...for nutrition risk factors. ..It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients."

The following concerns were identified with nutritional assessments:

a. Record review for resident #2 revealed the initial nutritional history/assessment was completed by the facility CDM on 7/31/08. In addition, review of the 3/17/09 and 6/15/09 quarterly dietary assessments revealed they were completed by the CDM.

b. Record review for resident #4 showed a CDM completed the nutritional resident assessment protocol (RAP) on 7/13/09, and dietary assessments on 4/14/09 and 7/13/09.

c. Record review for resident #8 showed a CDM completed the initial nutritional history/assessment on 1/28/09 and nutrition care

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F 281	Continued From page 8 plans on 6/12/09, 6/19/09, and 7/24/09. d. Record review for resident #13 showed the CDM completed an initial nutritional assessment on 1/27/09, the nutritional status RAP on 2/1/09, and a quarterly dietary assessments on 4/21/09 and 8/3/09. e. Record review for resident #17 revealed the 2/11/09 and the 8/11/09 quarterly dietary assessments were completed by the CDM. f. Record review for resident #25 revealed an initial nutritional assessment was performed by the CDM on 2/17/09. The CDM also conducted the nutritional status RAP on 2/27/09. g. Record review for resident #26 showed the CDM completed an initial nutritional assessment on 11/7/08, the nutritional status RAP on 11/18/09, and a quarterly dietary assessment on 2/16/09. h. Review of the 6/8/09 quarterly dietary assessment for resident #28 revealed it was completed by the CDM. Interview with the CDM on 8/12/09 at 4:45 PM she confirmed she completed nutritional assessments and was unaware an RD should complete them.	F 281		
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of policy and procedures, and staff interview, the facility failed to monitor, assess, and implement preventive skin measures in a timely manner for 1 (#16) of 1 sample resident who experienced a significant decline in health status while in the facility. This resulted in harm as shown by the development of two avoidable pressure ulcers. The findings were: Review of the medical record showed resident #16 was admitted on 1/27/09 with diagnoses of depressive disorder, Alzheimer's disease, diabetes mellitus, esophageal reflux, chronic airway obstruction, and nutritional deficiency. According to the 1/27/09 physician's admission orders, staff were required to complete weekly skin assessments. Review of a 1/28/09 pressure ulcer risk assessment showed the resident was assessed at a level of moderate risk. According to the 2/9/09 admission Minimum Data Set (MDS) assessment, the resident had no pressure sores and required one person for assistance with transfers. Review of the 2/9/09 resident assessment protocol (RAP) for pressure ulcers showed the resident triggered for increased pressure ulcer risk due to chronic obstructive pulmonary disease, Alzheimer's dementia, depression, and diabetes. The RAP further showed the resident needed to be repositioned every two hours, and as needed. The RAP also documented the resident's skin needed to be monitored daily during routine care. Review of the resident's care plan showed a problem with a potential for impaired skin integrity was identified on 2/9/09 related to diabetes and occasional incontinence. The care plan	F 314	The facility will ensure residents admitted without a pressure ulcer will not develop a pressure ulcer as evidenced by: a. The DON will monitor to ensure weekly (or more frequent if indicated) skin assessments are completed and documented in the treatment book by Mondays. By checking the treatment book on Monday for the previous weeks' skin assessments, the DON will ensure all residents had their skin checked. If a resident has not received a weekly skin assessment, one will be done immediately. The DON will report at the quarterly QAA meeting with appropriate follow-up.	~~9/20/2009~~

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F 314	Continued From page 10 documented staff were to turn and reposition the resident every two hours and observe and report signs of skin breakdown. Review of physician's orders showed a 3/30/09 order for Neurontin (Gabapentin) 600 milligrams (mg) orally at 7 AM and 2 PM, and 800 mg at 9 PM. Review of a 4/12/09 nurse's note showed the resident required two staff for transfers, had a sharp decline in ability to assist in activities of daily living, and required increased physical assistance. A 4/13/09 progress note by the MDS assessment coordinator documented the resident was "...very drowsy & drooling. Seems unable to open eyes." On that date, the physician visited the resident and lowered the dosage of Neurontin to 400 mg three times a day. On 5/15/09 the physician discontinued the Neurontin due to a continued decline in the residents neurological status. Review of the March 2009 treatment administration record (TAR) showed the resident's skin was intact. However, according to the April 2009 TAR, on 4/13/09 a right heel blister was identified and described as "mushy to touch." Further review of the TAR showed a left heel blister was identified on 4/27/09 and described as "fluid filled." The following concerns were identified: a. After the right heel blister was discovered on 4/13/09, there was no evidence the resident's skin was monitored and assessed until 4/20/09 (7 days later). On 4/20/09, a note on the April 2009 TAR documented the right heel blister measured 2.5 cm by 3.0 cm and described the heel as "mushy." Following the 4/20/09 assessment, there was no evidence the resident's skin was monitored and assessed until 4/27/09 (7 days later) when a blister on the left heel was identified. On 4/28/09 a nurse's note showed the right heel	F 314	b. The DON will monitor residents that have been identified to have had a decline, such as resident #16, to ensure proper interventions have been put in place to ensure residents do not have any breakdown, all Licensed nursing staff will notify the DON immediately if a resident has had a significant change in status. The DON will ensure proper interventions have been put in place to prevent any breakdown before it happens. All residents with a significant change of status will be identified at the weekly care plan conference. The DON will instruct nursing staff on 09/16/2009, when a resident has had a decline the licensed nursing staff should report the change to the DON immediately by communication form or verbally. Thereafter, the DON will ensure that proper interventions will be taken. The DON will report outcomes at the quarterly QAA meeting with appropriate follow-up.	~~9/03/2009~~

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PRINTED: 08/26/2009
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OMB NO. 0938-039

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F 314	Continued From page 11 blister had increased in size to 3.5 cm by 4.0 cm and both pressure ulcers were assessed as stage IV. b. Review of the care plan and medical record showed no additional interventions were planned or implemented to address the resident's immobility, development of the right heel ulcer, and increased risk for additional skin breakdown from 4/12/09 until 4/27/09. On 4/27/09 (15 days after the right heel ulcer was noted and the same day the right blister was identified) a note on the April 2009 TAR documented padded heel protectors would be used, and the resident's heels would be floated in bed. c. Interview with the DON on 8/13/09 at 10:25 AM confirmed the care plan was not revised to take into account the resident's significant decline on 4/12/09 and development of a right heel ulcer on 4/13/09. The DON was unsure why no additional interventions were implemented to address the resident's immobility and increased skin breakdown risk from the 4/12/09 significant decline through 4/27/09 when the second blister was identified. Interview with the MDS assessment coordinator on 8/17/09 at 4:10 PM, revealed the resident's significant decline was attributed to an adverse reaction to Neurontin. According to the "Drug Information Handbook for Nursing 2007," 8th edition, Neurontin "may cause central nervous system depression, which may impair physical or mental abilities." According to the facility policy titled, Pressure Ulcer Prevention: "The care process should include efforts to stabilize, reduce, and/or remove underlying risk factors. The nurse should monitor the impact of the interventions and should modify the interventions as appropriate."	F 314	c. The DON will in-service all licensed staff on interventions to prevent skin breakdown that should be put in place when a resident has been identified to have had a decline, as well signs a resident may have had a decline in his/her mobility or ADLs. The DON will also instruct the non-licensed staff as to when they should notify the licensed nursing staff of a decline. The DON will monitor nursing staff compliance and report outcomes at the quarterly QAA meeting with appropriate follow-up.	9/16/2009
F 323	483.25(h) ACCIDENTS AND SUPERVISION	F 323		

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F 323 SS=E	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment for residents in 2 of 2 bathing rooms. The findings were: Periodic observation from 8/10/09 through 8/13/09 revealed the following safety concerns: a. Observation of the support/stability bars attached to the toilets in the two main resident bathing rooms were unstable. Observation in the bathing room opposite the activities room showed the stability bar was loose and the attachment to the underside of the toilet seat was cracked. Observation in the bathing room opposite resident room #106 revealed the stability bar was only attached to the wall, not the floor. As a result, the bar was wobbly. b. Interview with the Minimum Data Set assessment coordinator on 8/13/09 at 8:30 AM confirmed the bars were unstable.	F 323	a. The facility repaired the unstable support/stability bars in the two main resident bathing rooms, and replaced the toilet seat attachment in the bathing room opposite the activities room. Staff have been instructed to inspect support/stability bars and fixtures in resident bathing rooms on a regular basis, and to report any malfunctioning equipment to the Maintenance Director for repair or replacement. In addition, the Maintenance Director will conduct monthly inspections of the facility to monitor compliance with CMS safety standards. Results of the inspections will be documented and outcomes presented at the quarterly QAA meeting with appropriate follow-up.	08/18/2009
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		

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F 329	Continued From page 13 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regime for 1 (#26) of 9 sample residents who received psychotropic medications was free of unnecessary drugs. The findings were: Review of the medical record face sheet showed resident #26 was admitted to the facility on 11/7/08 with diagnoses that included intracerebral hemorrhage, depressive disorder, and personal history of alcoholism. Review of the 11/7/08 admission orders revealed the resident was prescribed Zyprexa (an antipsychotic) 5 milligrams (mg) in the morning and 2.5 mg at bed time. The following concerns were identified:	F 329	The facility will ensure a gradual dose reduction for residents taking psychotropic drugs unless clinically contraindicated and documented by the resident's physician as evidenced by: a. The DON met with the Pharmacist Consultant on 08/31/2009 during her monthly drug review. The DON and Pharmacist Consultant will meet with the physicians that have admitting privileges and instruct them on the requirements for a gradual dose reduction, ~~such as with~~ resident #26, as per CMS guidelines. The DON will monitor the physician's documentation on a monthly basis after the Pharmacist Consultant has been in and made her Recommendations for gradual dose reduction. The DON will follow up with physicians and report at the quarterly QAA meeting with appropriate follow-up.	8/31/2009

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F 329	Continued From page 14 a. Review of the medical record, and additional documentation provided by the physician on 8/14/09 and 8/19/09, showed no evidence a gradual dose reduction (GDR) for the Zyprexa had been attempted since the resident's admission on 11/7/08, nine months before. In addition, there was no documentation of the continued necessity of the dose, or the clinical rationale that the benefits of the dose outweigh the risks. Further review of the 8/19/09 physician's documentation revealed the resident "functions well at the current dose [of all medications]." b. During an interview on 8/18/09 at 2:15 PM the pharmacist confirmed she had not recommended a GDR, nor had a GDR been attempted. The pharmacist further stated she should have recommended a GDR after the resident received the Zyprexa for a period of four months.	F 329	b. The DON will ensure the Pharmacist Consultant recommends gradual dose reduction, unless clinically contraindicated, for those residents receiving psychotropic drugs on a monthly basis after the Pharmacist Consultant has her monthly visit by monitoring the drug print out sheets the Pharmacist Consultant gives to the physicians after her review. If a resident has been placed on a psychotropic drug, such as resident #26, and there has been no recommendation for a gradual dose reduction has been made, the DON will consult with the Pharmacist Consultant and make the suggestion to the physician. The DON will report at the quarterly QAA meeting with appropriate follow-up.	8/31/2009
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 medical record review and staff interview, the facility failed to ensure the pharmacist recommended a gradual dose	F 428	The facility will ensure a gradual dose reduction will be requested as evidenced by: The DON will ensure the Pharmacist Consultant requests a gradual dose reduction ~~on~~ residents that have been given a psychotropic drug per CMS guidelines. for resident #26 and all The DON will review the drug comment sheet given to the physician by the Pharmacist Consultant prior to the drug comment sheet being given to the physician. If there was a new psychotropic drug administered and no gradual dose reduction requested, per CMS guidelines, the DON	8/31/2009

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F 428	Continued From page 15 reduction (GDR) for 1 (#6) of 1 sample resident who received an antipsychotic medication. The findings were: Refer to F 329 in regard to the lack of a recommendation by the pharmacist to gradually reduce the dose of Zyprexa for resident #26.	F 428	will contact the Pharmacist Consultant to confirm the that gradual dose reduction is needed and will then ask the physician for the gradual dose reduction. The DON will report at the quarterly QAA meeting with appropriate follow-up.	
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1of 5 facility doors and 2 of 3 alarm systems were maintained in a functional manner. The findings were: Observation on 8/12/09 at 3:48 PM revealed the east entrance/exit door to the facility was not completely closed. As a result, the electronic metallic door alarm circuit contact points on the door and the door frame were separated. Further observation at that time revealed the door alarm system was not notifying the nurses' station the door was open. Interview with the director of nursing at that time revealed the door alarm system should sound at the nurses' station if the door was not closed. The DON further stated she needed to contact the maintenance department to fix the alarm system. Interview with maintenance staff on 8/13/09 at 8:45 AM revealed the east door was out of alignment and the alarm system was malfunctioning.	F 465	a. The facility re-aligned the east entrance/exit door to ensure proper closure and to reset metallic door alarm circuit contact points. Staff have been instructed to report malfunctions of the door alarm system to the Maintenance Director for immediate repair. The Maintenance Director will monitor on a monthly basis all doors with alarms, document, and report on the function of the door alarm system at the quarterly QAA meeting with appropriate follow-up. b. The facility replaced the batteries for the motion detector alarm at the east entrance/exit door. The Maintenance Director will check the batteries in all alarms once a month, and will replace as needed. The Maintenance Director will document these inspections and report the outcomes at the quarterly QAA meeting with appropriate follow up.	08/13/2009

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F 465	Continued From page 16 Observation on 8/12/09 at 3:48 PM revealed the motion detector at the east entrance/exit door to the facility did not signal an alarm when staff passed through the door. Interview with Minimum Data Set assessment coordinator at that time revealed the motion detector was not working, and the maintenance department needed to be notified. Interview with maintenance manager on 8/13/09 at 8:30 AM revealed the batteries for the motion detector were weak and had to be replaced.	F 465		