Printed: 08/12/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	07/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS CARE CENTER, WY 82633

(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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to notify the physician and/or responsible parties when one of 12 sample residents (#5) experienced changes in his/her condition. The findings included: Resident #5's medical record review revealed the	F 157	Preparation and execution of this response and plan of correction does not constitute an 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. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 42 C.F.R. Par 488.18 and section 7317A of the State Operations Manual. The facility will inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative/interested party when there is a change in resident's condition.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: _____ TITLE: Admin. (X6) DATE: 8/21/09

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 157	Continued From page 1 resident was admitted to the facility on 10/29/99 with diagnoses which included: CHF (congestive heart failure), heart disease, hypertension, dementia, osteoarthrosis, RA (rheumatoid arthritis), anxiety, and fractured femur. a. Review of the significant change MDS (Minimum Data Set) dated 6/3/09 identified the resident as being total care. The MDS included: -Total dependence (full staff performance) with two staff persons physical assistance for bed mobility, transfers, and toilet use. -Total dependence with one staff person physical assistance for dressing, eating, and personal hygiene. -Bowel and bladder incontinence of four (inadequate control with multiple episodes, all or almost all the time). b. Review of the "Physician's Orders" included orders dated 6/4/09 which identified an injury to the resident's left foot. The "Physician Orders" dated 6/4/09 included: 2) "I need a detailed explanation with supporting nurses notes for L (left) foot injury ASAP (as soon as possible). 3) Ice, elevation of L foot qid (four times per day) x 15 minutes, 4) Ortho referral for left foot trauma, 5) X-ray and lab done today before return to NH (nursing home)..." c. Review of the history and physical sheet dated 6/4/09 included the following notes signed by the physician:	F 157	Family and physician of resident #5 were notified of the resident's condition on 6/25/09. The facility will notify family and physician of changes for all residents of the facility. Facility will inservice nursing staff on appropriate notification and charting criteria for resident change in condition. Facility will audit resident charts weekly to determine compliance. Facility will report to CQI monthly for 1 year to ensure continued compliance.	8/28/09

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F 157	Continued From page 2 "17. L foot abrasion - scabbed - with no office notification of injury - in stages of healing - unsure what happened - Xray and ortho referral." "Skin... L foot with edema, erythema, abrasion to toes- scabbed over linear abrasion tender to touch." Diagram of foot also noted, "Scabbing eschar" to area of little toe and "Dorsum L foot area of edema ..." pointed at 2nd to 5th toes. d. Review of the "Licensed Nurses Notes" included: 6/4/09 "1300 (1:00 PM) Resident returned from apt. with MD, new orders received." "1500 (3:00 PM) Copies of RN (registered nurse) notes made for (___name physician)... Plan to have copies hand delivered to Dr. office by medical records staff. During conversation with Dr. office prior to resident coming back to facility, MD understandingly upset regarding resident's injury to L foot /toes." 6/5/09 "Daughter in to visit. Showed res (resident) toes L foot. Dr. (__name) had phoned family and spoke of concerns for res-foot. Expressed our concerns and assured family we would follow up and monitor." e. Review of the "Record of Physician's Visit" sheet dated 6/8/09 stated, "L foot scabbing, redness on 2nd-5th toes. Redness >(increased) 2nd-3rd toes. No trauma reported at nursing home; May have happened while pt. was being bathed. May have been [sign for about] 2 weeks ago. Daughter thinks it looks slightly more red today 2nd toe. Low grade fever in past for UTI/pyelonephritis, being tx (treated)." f. Review of the "Incident Report" for Resident #5	F 157		

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F 157	Continued From page 3 listed date of occurrence 6/4/09. The type of injury was circled as scrape/abrasion left toe. A written note stated, "Abrasion rug burns." The areas for physician notification and family notifiacation were both marked as "NO". g. Interview with the DONon 7/23/09 confirmed that the notification of the physician and family was not done. The facility failed to inform the resident's physician and the resident's family of an accident involving this resident which resulted in an injury.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	Staff will adhere to facility abuse policies. All staff will be in serviced on facility abuse policies, investigation and reporting requirements. A report of the 6/5/09 allegation to resident #5 will be submitted to the state survey agency. All allegations of abuse will be immediately reported to the nursing supervisor, the director of nursing services and administrator. The administrator will be responsible to report the allegation to the state survey agency as required. Investigations will be completed and submitted to the state survey agency within 5 working days of the event and if the alleged violation is verified, corrective action will be taken.	

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F 225	Continued From page 4 investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to investigate and/or report neglect involving one of 12 sample residents (#5). Additionally, the facility failed to implement their current abuse policies and procedures. The findings included: Resident #5's medical record review revealed the resident was admitted to the facility on 10/29/99 with diagnoses which included: CHF (congestive heart failure), heart disease, hypertension, dementia, osteoarthrosis, RA (rheumatoid arthritis), anxiety and fractured femur. a. Review of the significant change MDS (Minimum Data Set) dated 6/3/09 identified the resident as being total care and two staff persons physical assistance for bed mobility, transfers, and toilet use, b. Review of the "Physician's Orders" included orders dated 6/4/09 identified an injury to the resident's left foot. The "Physician Orders" dated 6/4/09 included: 2) "I need a detailed explanation with supporting nurses notes for L (left) foot injury ASAP (as soon	F 225	Investigation audits will be completed weekly to determine compliance. Facility will report to QI monthly for 1 year to ensure continued compliance.	8/28/09

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F 225	Continued From page 5 as possible)." c. Review of the "Incident Report" for Resident #5 listed date of occurrence 6/4/09. At the top of the sheet a written note stated, "6/25/09 late entry for 6/4/09 incident". The type of injury was circled as scrape/abrasion left toe. A written note stated, "Abrasion rug burns." The areas for physician notification and family notification were both marked as "NO". The area for "State Agency Notified" was also marked as "NO". Refer to F157. The area to describe what was observed was dated 6/25/09. This was 21 (twenty one) days after the physician notified the family and asked the facility for an explanation regarding injuries to the left foot. There was no evidence that an incident report was done and an investigation completed on 6/4/09 with the physician's inquiry. The facility failed to investigate this injury of unknown source timely. The note on the incident report dated 6/25/09 1700 (5:00 PM) identified that a CNA verified that the injury was reported to the LPN (Licensed Practical Nurse) at the time of the incident but the LPN failed to notify the physician, family, and do an assessment. The note also stated that the LPN terminated on 6/7/09. The report did not indicate the termination was related to the incident. The notes also addressed that in interviewing the family a concern that "the CNA maybe was afraid to report because of the repercutions {spelling}". d. The facility's policies on abuse were reviewed and included: 1) "Abuse Policy" not dated and 2) "Abuse Prevention Program" not dated. The "Abuse Prevention Program" included the	F 225		

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F 225	Continued From page 6 procedure for "Accidents and Incidents-Investigating and Reporting". It included: "1. Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor as soon as accident/incident is discovered or when information of such accident/incident is learned...." "4. Investigative Actions: a. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident. b. The following data as it may apply must be included on the Report of Incident/Accident form." It then listed 14 items to include in the report. c. "A completed Report of Incident/Accident form must be submitted to the Director of Nursing Services no later than 12 hours after the occurrence of the accident or incident." There was no evidence that the facility followed it's "Abuse Prevention Program" for timely reporting and investigation of resident #5's injury of unknown source to the left foot either when the incident actually occurred or when the physician made the facility aware of the injury on 6/4/09. [NOTE: "Injuries of unknown source" - An injury should be classified as an "injury of unknown source" when both of the following conditions are met: - The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and - The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the	F 225		

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F 225	Continued From page 7 injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. "Immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter state time frame requirement.] e. Observation with care 7/21/09 at 8:55 AM identified the resident to have scabbed areas to the toes on the resident's left foot. f. Interviews with the DON and Nurse F confirmed the injury of unknown origin was not investigated timely. The facility failed to ensure injuries of unknown origin were investigated timely.	F 225		
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 and staff interview, it was determined that the facility failed to provide care for one of 12 sample residents (#11) and seven supplemental residents (#23, #30, #31, #37, #38, #15, and #32) in a manner which enhanced the residents' self worth and individuality while they were eating their meals in the dining room, using the bathroom located in their rooms, or discussing their medical condition. The findings included: 1. On 7/20/09 during facility initial tour an	F 241	The facility will promote care for residents in a manner and in an environment that maintains or enhances each residents dignity & respect in full recognition of his or her individuality.	

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F 241	Continued From page 8 interview with resident #37 revealed that the bathroom door did not close properly. The resident stated "it is embarrassing when visitors were in the room and his her roommate was using the bathroom." Observation of the bathroom door verified that door did not fit the door frame properly and would not close. 2. On 7/21/09 at 9:38 AM, during a medication pass observation of nurse (D) with nurse (C) assisting, nurse (D) prepared and administered a medication to resident #11. The medication was a Fentanyl patch. While nurse (D) applied the patch, the resident stated that he/she had not received his/her morning insulin. The nurses (C and D) explained that the resident's Lantus insulin was held because his/her blood sugar was below 100 (was 93). The resident told the nurses that 93 was not low for him/her and that the insulin had not been held before. The nurses insisted on the resident having another finger stick blood sugar done before he/she could receive the insulin injection. The resident's blood sugar was 136. After the insulin was prepared, nurse (D) administered the insulin. During this observation the two nurses argued with resident who indicated that he/she knew how his/her diabetes worked. They continued to tell the resident that insulin was always held for a blood sugar of 100. The resident's individuality and knowledge of his/her condition was not respected. 3. On 7/22/09 at 12:03 PM, in an interview with a dietary staff member (X), the staff member was asked about how the order of the meal service was determined. Staff (X) stated that the nursing staff make that determination based on who is ready to eat. 4. Observations during the 7/21/09 evening meal	F 241	The bathroom door for resident #37 closes properly. Resident #11 is respected for his individuality and knowledge of his condition. Residents sitting at one table will served meals as closely together as reasonable. New clothing protectors will be in place. Staff will assist residents in the dining room with serving equipment such as thermos and water pitchers. All staff will be in serviced on promoting resident dignity and culture change approaches to the delivery and care and services. Staff and residents will be observed on daily rounds to determine compliance. Results of daily rounds audits will be submitted to CQI monthly for 1 year to determine continued compliance.	9/28/09

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F 241	Continued From page 9 and 7/22/09 noon meal services evidenced that the tray cards were placed outside of the kitchen serving window. The staff serving the meals to the residents' tables were selecting the tray cards for dietary to prepare. 5. On 7/21/09 during the evening meal, there were four other residents (#23, #30, #31, and #32) seated at the same table as resident #28. Resident #28 was served his/her meal at 5:12 PM. The other residents, three of whom were at the table when resident #28 was served his/her meal, were served between 5:23 PM and 5:26 PM (11 to 14 minutes after resident #28 was served his/her meal). 6. On 7/21/09 during the evening meal service resident #38 was observed seated in dining room. The resident waited and watched the meal being served to other residents. At 5:30 PM the first tray was served to the more independent residents. The resident observed his/her entire table served. As the next tray was served to the next table, the resident waved at staff asking about his/her tray. The resident was clearly distraught. The resident was told it would be along shortly. The next table was served completely and room tray deliveries were started. At 5:47 PM, the resident again waved and ask the same staff member about his/her food. The staff member stated "Oh (resident name) didn't you get your tray?" The resident received his/her tray at 5:49PM. 7. On 7/22/09 during the noon meal observations (12:00 PM - 1:10 PM) revealed that the tray service was slow. Initially there were several staff assisting with the delivery of trays to residents. As the higher level of care residents were served the staff providing feeding assistance would stop	F 241		

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F 241	Continued From page 10	F 241		

serving and begin individual assistance. The more independent residents were served, last. Resident #15 was seated in the dining room at his/her usual place. At 12:59 PM resident #15 had not received his/her tray. All residents in the dining room had been served and the delivery of room trays began. The resident quickly left the table and went to the kitchen service area, spoke with kitchen staff, and left the dining room. At 1:15 PM an interview with resident #15 in his/her room revealed, the resident to be visibly upset he/she stated, "This is the third time that I have been passed over in the dining room."

8. On 7/21/09 and 7/22/09, during meal services all residents were provided clothing protectors during meal service. The clothing protectors were observed to be well worn causing the Velcro attachments not to work properly. Many residents were observed throughout the meals adjusting and re-applying the clothing protectors, as they would frequently slip off.

9. On 7/22/09, during the noon meal service resident #39 was observed trying to pour coffee from a thermos. The thermos was large, awkward and too heavy for the resident to lift and handle. The resident gave up trying again a few moments later. Another resident sitting next to resident #39 struggled to assist. The lid to the thermos was unscrewed and a very small amount of coffee (approximately one swallow) was poured into a cup. The resident continued trying to pour more coffee, eventually removing the thermos lid entirely, exposing the hot coffee. This surveyor requested immediate assistance from staff. Several residents at other tables were observed to have similar issues with the coffee thermos or the water pitcher.

F 246	483.15(e)(1) ACCOMMODATION OF NEEDS	F 246		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	07/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS CARE CENTER, WY 82633

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F 246 SS=E	Continued From page 11 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This Requirement is not met as evidenced by: Based on observation and resident and family interview, it was determined that the facility failed to accommodate the individual positioning needs of three supplemental residents (#28, #27, and #32) when seating these residents at tables which were too high for them and failed to answer call lights in order to meet the needs of the residents. The findings included: 1. On 7/21/09 during observation of the evening meal, residents #28 and #27 were seated at tables where the residents had to reach up and onto the tables to access their food. The table height was equal with their upper chest. Resident #28 consumed approximately 15 % of his/her food and a small amount of liquids. 2. On 7/22/09 during observation of the noon meal, resident #27 and #32 were positioned at tables where they had to reach up and onto the tables to access their food. Resident #32 was also observed to lean backward in his/her wheelchair, making it difficult to reach the food on the table. 3. On 7/21/09 at 3:50 PM, during the Resident Group interview it was revealed that the response to call lights can take a "pretty long time",	F 246	The facility will accommodate individual positioning needs for residents seated in the dining room and answer call lights in order to meet the residents' needs. Residents #28 and #27 are seated at tables appropriate to their reach. Resident #32 is positioned in his wheelchair so he can access his food. The occupational therapy department will observe a resident meal to determine if additional residents have positioning needs. Call lights will be audited once a week on all three shifts to determine compliance. Call light audits will be reported to CQI monthly for 60 days to determine continued compliance.	8/28/09

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F 246	Continued From page 12 "Sometimes an hour." Five of six residents attending the interview agreed that response to call lights is slow. 4. On 7/21/09 at 9:30 AM, an interview with a family member for a resident revealed that the family frequently visits with the resident and that on several occasions they have observed that call lights are not answered in a timely basis. The interview further revealed that on one occasion the call light was observed by another family member to have gone unanswered for more than one hour.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide maintenance/housekeeping services to ensure a comfortable, orderly, and cleanable environment for the residents. The findings included: 1. On 7/20/09 at 3:00 PM during the facility initial tour and during the environmental during on 7/22/09 the following observations were made: a. Resident rooms 5, 8, and 14 were observed to have yellow stains in the bathroom at the edge of the floor tiles and surrounding the base of the toilet. b. Several resident rooms 1, 2, 4, and 5, were observed to have furnishings (bedside tables, nightstands, and common tables) that were worn and had non-cleanable surfaces.	F 253	The facility will provide maintenance and housekeeping services for clean and comfortable environment. Rooms for residents #5, 8 and 14 will have the bathroom floors stripped and waxed. All resident bathrooms will be observed to determine additional floors needing stripping and waxing. Room furnishing (table tops) has been cleaning, reglued or covered with a cleanable surface. Bathroom doors for resident #4 and #14 have been adjusted for proper operation. Bathroom doors for all residents have been looked at and adjustment made if necessary.	

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F 253	Continued From page 13 c. Resident rooms 4 and 14 were identified by residents and confirmed through observation to have a bathroom doors that did not fit inside the door jam causing the door not to close completely. d. Resident room 5 was observed to have curtains unhooked and hanging down from the curtain rod. e. Several Resident room 5, 7, 11, 18, 19, 24, and 25 were observed to have oxygen concentrator filters that were dirty. The filters contained large amounts of fine powdered dust. Dust was observed to come off the filter when removed by Staff (F). f. Resident room 11A was observed to have bed sheets that were stained brown and a recliner was stained brown in the front. g. Resident rooms 4, 14, and 15 were observed to have damaged window blinds. h. Resident room 9 was observed to have a broken handicap toilet seat. i. Resident room 7 was observed to have a freestanding fan with a protective cage that was covered with dust. j. Several Resident rooms 5, 9, 11 and 22 were observed to have a large area above the light switch at that were missing wallpaper and wallboard. k. The hallway carpet near the Women's Lounge and building exit was observed to be stained.	F 253	Curtain and curtain rod in resident #5's room has been fixed. The curtains in all rooms have been reviewed and fixed as necessary. The oxygen company has agreed to a weekly schedule for replacing filters on the concentrators. Window blinds for resident rooms #4, #14 and #15 have been replaced. Housekeeping will monitor the condition of blinds during daily cleaning and notify maintenance for needed replacement. Resident #9 toilet seat have been fixed. Rooms for residents #5, 9, 11 and 22 were textured and painted. The recliner is resident #11's room have been cleaned and the bed sheets are cleaned. All carpets have been shampooed on a bi- weekly basis with a check off sheet to document completion. Carpets will be professionally cleaned at least annually. All free standing fans have been cleaned. A deep cleaning scheduled for fans has been developed.	

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F 253	Continued From page 14 i. Resident room 16 had very dirty carpet, the vanity area was soiled and there was food laying on the vanity. m. At the rear exterior of the building an open cable box was observed to have a rodent's nest. An interview with the (CMC) Corporate Maintenance Consultant revealed that the cable box contained a squirrel's nest. An interview during the intial tour with the Acting Administrator revealed the facility had suffered a power loss due to squirrels biting the electrical wiring. n. The entrance to the facility was observed to have worn carpet that was loose and pulling away from the carpet tacking causing a potential trip hazard. o. The call light for Resident room 19 was observed to be on frequently and would often light up at the same time as other resident room call lights. CNAs at the nurses' station expressed confusion as to whether the resident was actually needing assistance or was the light faulty. 2. During the environmental tour on 7/22/09 from 2:50 PM to 4:00 PM with the CMC, Housekeeping Supervisor, and Acting Administrator present, observations revealed the following issues: a. Room 5 had two windows. Under each window there was wall damage noted. The wall board was loose and cracked from the base of the window to the baseboard heating unit on the floor. The CMC checked the areas and described it as water damage from the windows. The area was dry however it did create a potential area for build up of mildew or mold. b. A check of the beauty shop found the	F 253	The exterior cable box area has been cleaned and the box screwed shut. Exterior carpet will be replaced at the entrance to the building. The call light for resident #19 is fixed. The damaged areas under the windows in resident #5's room has been removed, replaced, taped and painted. The beauty shop has been cleaned. This area has been added to the daily housekeeping check list. The ventilation duct in the west hall has been cleaned. The window wells have been cleaned.	8/28/09

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F 253	Continued From page 15 baseboard heat vents had a build-up of hair dust and debris and were in need of cleaning. c. The housekeeping closet on the west hall was noted to have a corner floor sink. The wall on the left when entering the room, by the floor sink was damaged. The baseboard was pulled away from the wall (approximate 2 foot area) with cracked dry wall visible behind the loose baseboard. The flooring was also chipped, gouged, and worn away leaving an uncleanable surface. d. The ventilation duct identified on the ceiling in the west hall was in need of cleaning. The vent was identified as being from the swamp cooler bringing in cool air. The vent was discolored with dust hanging on portions of the vent and surrounding ceiling. e. During a check of the outside of the building window wells were noted to have grated covers. However, the window wells were noted to have a build-up of leaves and debris and were in need of cleaning. The CMC reported that the cleaning of the window wells was on the routine maintenance list and needed to be done.	F 253	All staff will be in serviced on completion of maintenance work requests when need repairs are spotted by staff. Housekeeping will maintain daily check off sheets to document completed tasks. Daily walking rounds will be completed to determine compliance with housekeeping and maintenance issues. Results of rounds will be reviewed monthly at QA to determine continued compliance.	8/28/09
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE 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;	F 272	The facility will complete comprehensive assessments that are accurate, complete and signed in accordance with federal guidelines. Care plans will be completed within 7 days of the resident assessment. RAP summaries will be completed with location of information used to complete the resident assessment.	

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F 272	Continued From page 16 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 record review and staff interview, it was determined that the facility failed to accurately complete the Resident Assessment Instrument (RAI) as specified and required for three of 12 sample residents (#4, #3, and #7). The findings included: 1. Review of resident #4's 5/6/09 significant change Minimum Data Set (MDS) assessment evidenced that the assessment was completed on 5/6/09. The care plan was not completed until 5/27/09 (21 days after the assessment). 2. Review of resident #3's 4/10/09 quarterly MDS assessment revealed that the Registered Nurse (RN) coordinator signed the assessment, indicating that it was complete. Review of this assessment evidenced that sections K (weight and height), M, P, and Q were not completed.	F 272	The Director of Nursing Services has in serviced the MDS Nurse on accurate/complete assessments including RAPS and RAP summaries. In serviced on timely care plans. Facility will complete and audit of all assessment and care plan due dates for all residents of the facility and ensure accurate and timely completion. Director of Nursing will complete audits for accurate signature dates of the assessments. Audits will be completed weekly to determine compliance and report to CQI monthly for 90 days to determine continued compliance, then quarterly for the year.	8/28/09

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F 272	Continued From page 17 Review of the resident's RAP Summary Report for the 10/15/08 initial MDS assessment evidenced that the specific location and/or date of the information used for the assessment was not listed on the form. 3. Review of resident #7's 2/22/09 annual MDS assessment revealed that the staff completing the assessment signed off on the assessment on 3/9/09 (15 days after the assessment was signed by the RN Coordinator as completed). Review of the resident's RAP Summary Report for the 4/21/09 significant change MDS assessment evidenced that the specific location and/or date of the information used for the assessment was not listed on the form. Additionally, there was no RAP Summary Report found for the 2/22/09 annual MDS assessment. On 7/22/09 at 3:27 PM, the MDS Coordinator verified that there was no Summary form (for the 2/09 assessment) in the resident's record. Review of the resident's 4/28/09 significant change MDS assessment evidenced that the assessment was completed on 4/28/09. The care plan was not completed until 5/20/09 (22 days after the assessment).	F 272		
F 278 SS=D	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.	F 278	MDS nurse has completed new full MDS assessments for residents #5 & #8 that is accurate and complete. Other MDS assessments will be complete and accurate at their next scheduled assessment.	

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F 278	Continued From page 18 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 observation, record review, and staff interview, it was determined that the facility failed to accurately assess two of 12 sample residents (#5 and #8). These residents' Minimum Data Set (MDS) assessments did not contain accurate information for the residents at the time the assessment was completed. The findings included: 1. Resident #5's medical record review revealed the resident was admitted to the facility on 10/29/99 with diagnoses which included: CHF (congestive heart failure), heart disease, hypertension, dementia, osteoarthrosis, RA (rheumatoid arthritis), anxiety and fractured femur.	F 278	Director of Nursing will in-service MDS nurse on importance of accurate assessments, checking for accuracy and completion after computer entry, and correct time frames for signatures. Director of Nursing will complete weekly audits to determine compliance. Audits will be reported to CQI monthly for 90 days and quarter thereafter to determine continued compliance.	8/28/09

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F 278	Continued From page 19 a. Review of the quarterly MDS assessment dated 10/18/08 the resident was identified as having limitations in ROM (range of motion). The section of G4 was coded as 2-1 (ROM limitation on both sides/voluntary movement partial loss) for arms, hands, legs, foot and other. b. Review of the annual MDS assessment dated 3/28/09 identified G4. as 1-1 (ROM Limitation on one side/partial loss). c. Review of the significant change MDS assessment dated 6/3/09 identified the resident as having no limitations in ROM. The significant change assessment was due to skin breakdown and decline in the resident's condition. The MDS assessment also identified the resident as having Tuberculosis. d. Interview with Nurse (F) on 7/21/09 confirmed that the resident's MDS assessment was not accurate. She reported the resident did have limitations in ROM, did not have Tuberculosis, and was recently treated with IV (intravenous) antibiotics for a resistant E coli UTI (urinary tract infection). 2. Resident #8's medical record review revealed the resident was admitted to the facility on 3/29/09 with diagnoses which included: Alzheimer's disease, hypertension, senile dementia, osteoporosis, arthritis, and anxiety. a. On 7/20/09 at 3:10 PM, on initial tour of the facility with Nurse (F), resident #8 was identified as being on Hospice Care and was observed to have leg contractures. Staff reported the resident had skin breakdown behind the right knee due to contractures.	F 278		

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F 278	Continued From page 20 b. Review of the MDS assessment dated 1/27/09 revealed the resident was assessed as having (G.4) Functional limitations in range of motion of 2-1 (ROM limitation on both sides/voluntary movement partial loss) for arms, hands, legs, foot and other. c. Review of the quarterly MDS assessment dated 4/20/09 did not accurately reflect the resident's status for G.4 Functional limitations in range of motion. All areas were marked as zero (meaning no limitation). d. Review of the significant change MDS assessment dated 6/3/09 identified the resident having 1-1 (ROM Limitation on one side/partial loss). However, the resident was observed to have severe leg contractures and limitations in ROM. f. Interview with Nurse (F) on 7/21/09 confirmed the MDS assessments for resident #8 was not accurate. Nurse (F) reported that problems with accuracy of the MDS assessments were identified by the facility and changes were made. Nurse F reported she was now the RN Assessment Coordinator and had started doing the assessments in June 2009. The facility failed to ensure that the resident's ROM was accurately assessed and documented in the resident's MDS assessment.	F 278		
F 280 SS=E	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.	F 280	The facility will have accurate care plans for residents that are updated as resident conditions change.	

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F 280	Continued From page 21 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to update the care plans in a timely manner for seven of 12 sample residents (#4, #9, #3, #7, #5, #8, and #6) as their individual needs changed. The findings included: 1. Record review for resident #4 revealed that the resident was admitted 1/23/08 with diagnoses that included bipolar, manic depression, stroke, breast cancer, congestive heart failure, and pain. a. Review of the resident's 5/6/09 significant change Minimum Data Set (MDS) assessment evidenced that the resident was assessed to need extensive assistance with bed mobility, transfer, and eating and total assistance with toilet use and bathing. b. Review of the facility's weight tracking form evidenced that the following weights (in pounds) for this resident:	F 280	Resident #4 care plan is updated for nutrition. Resident #3 care plan is updated for drug resistance. Resident #7 has expired. Resident #5 care plan is updated for drug resistance and skin care. Resident #8 care plan is updated for drug resistance and skin care. Resident #6 has expired. Amedysis Hospice and their medical director has been notified of this deficiency and the need for their prompt participation in updating their care plan and ensuring that an integrated plan of care exists. IDT team has been in serviced on completion of accurate care plans. Audits will be completed weekly to determine compliance. Audits will be reported monthly to CQI for 1 year to determine continued compliance. ate: 8/28/09	

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11/08 - 141
12/08 - 133
1/09 - 132
2/09 - 130
3/09 - 129
4/09 - 127
5/09 - 125
6/09 - 125.1
7/09 - 121.4.

c. Review of the resident's meal (tray) card evidenced that the resident was to receive a regular diet with a texture of regular, ground, or pureed and fortified foods. He/she was to be given 8 ounces of fortified milk and hot chocolate at each meal.

d. Review of the resident's physician orders evidenced an order dated 5/28/09 for a supplement, Med Pass 60 cc (cubic centimeters) three times a day.

e. Review of the resident's care plan revealed that the plan for weight loss included Med pass 30 cc three times a day and pureed diet/thickened liquids. The care plan was not updated to show the resident's current supplement and current texture of food (per resident request).

f. Review of the resident's physician progress notes and licensed nurses notes dated 6/20/09 and 6/21/09 revealed that the resident experienced two falls on 6/20/09. The resident went to the hospital for pain in his/her left arm.

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DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS CARE CENTER, WY 82633

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F 280	Continued From page 23 The x-rays verified that there was a fracture. g. Review of the resident's care plan evidenced a problem of "potential for injury from falls, related to history of falls, diuretics, and coronary artery disease". This plan was last updated on 5/27/09, prior to the two falls on 6/20/09. There was no evidence that the care plan was changed or updated after the falls with the resident sustaining a fracture. 2. Record review for resident #9 revealed that the resident was re-admitted to the facility on 5/9/09 after a hospitalization with diagnoses that included fractured hip and fecal impaction/mega colon. a. Review of the resident's physician orders revealed an order dated 6/12/06 for a weekly weight. b. Review of the resident's care plan revealed a problem for wt loss/dehydration with an approach of weigh monthly and record. The facility failed to update the care plan for this resident who was facility assessed to be nutritionally at risk. Refer to F325 for details of nutritional risk. 3. Record review for resident #3 revealed that the resident was admitted with diagnoses that included congestive heart failure, stroke, chronic urinary tract infections, and low blood pressure. a. Review of the resident's 6/10/09 urine culture laboratory report evidenced that the resident had Escherichia coli (E. coli) which was drug resistant.	F 280		

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F 280	Continued From page 24	F 280		

b. Review of the resident's care plan revealed that a problem of "potential for infection" with approaches to prevent infection. This care plan was noted to have been updated on 7/22/09 but did not include evidence that the resident had had drug resistant E. Coli or any precautions that would have been instituted.

4. Record review for resident #7 revealed that the resident had diagnoses that included aphasia, congestive heart failure, heart attack, osteoporosis, urinary tract infections, depression, and stroke.

a. Review of the resident's 4/28/09 significant change MDS assessment evidenced that the resident was independent with all activities of daily living (ADLs) except bathing, for which the resident's required extensive assistance.

b. Review of the resident's physician orders revealed that the resident was to receive a regular diet consistency as tolerated, fortified diet. On 12/19/08 there was telephone order for the resident to receive a fortified diet and Med Pass or similar 90 ml (milliliters) three times a day for weight loss.

c. Review of the facility's weight tracking form evidenced that the following weights (in pounds) for this resident:

7/08 - 153
8/08 - 155
9/08 - 154
10/08 - 152
11/08 - 154
12/08 - 146
1/09 - 148
2/09 - 152

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F 280	Continued From page 25 3/09 - 151 4/09 - 152 5/09 - 145 6/09 - 144 7/09 - 142.5. d. Review of the resident's care plan evidenced that the 5/21/09 problem of "potential for further weight loss R/T (related to) decline in condition" included approaches of fortified food program, Med pass 30 cc three times a day, and monitor and record weight every month. The facility failed to update the care plan for this resident who was facility assessed to be nutritionally at risk. Refer to F325 for details of nutritional risk. 5. During the review of the infection control program and review of residents' medical records, residents were identified as having infections which included MDRO (multiple drug resistant organisms). However, review of residents' plans of care revealed there was no evidence those infections were addressed. The care plans did not identify the history of MDROs or interventions for staff to use in the provision of care for residents having active infections. Examples included: a. Resident #5 was identified with ongoing UTIs (urinary tract infections) which were identified as Resistant E.coli (Escherichia coli) infections. The resident had a UA (urinalysis)done 5/21/09 which confirmed E.coli. The "Monthly Summary" sheet dated 6/809 identified the resident was started on IV antibiotics for the UTI. Review of the care plan dated 6/10/09 revealed it was not updated to address the resident's	F 280		

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F 280	Continued From page 26 infection or history of Resistant E.coli to ensure interventions were addressed. b. Resident #8 was identified with ongoing UTIs (urinary tract infections) which were identified as Resistant E.coli (Escherichia coli) infections. Review of the care plan dated 4/29/09 revealed it did not address the resident's history with Resistant E.coli infections. Review of resident #8's "Comprehensive Plan of Care" dated 5/27/09 did not address this resident's resistant E.coli infection. c. Resident #6 medical record review revealed the resident had a urinalysis completed with culture and sensitivity on 5/28/09 which identified E.coli with resistance and Proteus mirabilis. On 5/29/09 the physician called and reported the resident being "Resistant" to most medications and ordered Ancef 1 gram to be given IM (intramuscular) BID (two times a day) for three days. Review of the resident's care plan dated 5/6/09 revealed it was not updated to address the resident's infection or history of Resistant E.coli to ensure interventions were addressed. d. Interview with the Director Of Nursing, on 7/23/09 at 2:50 PM, confirmed the residents with problems of infections specially those with MDRO such as E.coli, C-Diff (Clostridium difficile), and MRSA were not getting care planned. [Multidrug-resistant organisms (MDROs), have important infection control implications. MDROs are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents.]	F 280		

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F 280	Continued From page 27 Escherichia coli (abbreviated as E. coli) are a large and diverse group of bacteria. Although most strains of E. coli are harmless, others can make you sick. Some kinds of E. coli can cause diarrhea, while others cause urinary tract infections, respiratory illness and pneumonia, and other illnesses.] MRSA (Methicillin Resistant Staphylococcus aureus) are the most commonly encountered multidrug-resistant organisms in patients residing in non-hospital healthcare facilities. Non-hospital healthcare facilities can safely care for and manage these patients by following appropriate infection control practices. Clostridium difficile (C-diff) is a spore-forming, gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It is a common cause of antibiotic-associated diarrhea (AAD).] 6. Observation and record review for Residents #5 and #8 identified with skin breakdown and pressure ulcers did not have updated plans of care to meet the residents' skin care needs. Examples included: a. Review of resident #5's "Comprehensive Plan of Care" identified a problem of "Abrasion to top of toes left foot and blister to left heel". The date for this care problem appeared to be 6/16/09 and was written over to be 6/10/09 which included, "Heels off bed and chair". However there was no evidence the plan of care was updated on 6/1/09 when the blister to the heel was identified. The care plan did not identify the open area on the buttocks, skin tears to both upper arms, use of foam arm protectors, use of pressure reducing surfaces for bed and chair, or turning and	F 280		

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F 280	Continued From page 28 repositioning for this dependent resident. b. Review of resident #8's "Comprehensive Plan of Care" identified a problem dated 5/27/09 as: "Impaired skin integrity Stage IV right popliteal area". The goal stated, "will be healed next 90 days". The approaches addressed monitoring of the wound, dressing changes and Med pass 60 cc three times a day. The plan of care did not address interventions examples not limited to: the use of an air mattress with the appropriate setting to met the resident's need, pressure relieving device for the Geri chair, turning and repositioning and the sheepskin use to splint the flexion contracture of the right leg. Review of the "Hospice Visit Note and Care Plan" sheets from 6/29/09 to 7/22/09 for resident #8 did not address the use of an air mattress and the appropriate setting to met the resident's need, pressure relieving device for the Geri chair, turning and repositioning and the sheepskin use to splint the flexion contracture of the right leg. The facility failed to ensure that an integrated plan of care was developed and updated to meet the needs of the resident. (Cross refer to F314)	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 record review, observation, and staff interviews, it was determined that the facility failed to follow professional standards and facility policies when administering medications and failed to ensure that physician orders were followed for two of 12 sample residents (#9 and	F 281	Facility nursing staff will follow standards for administration of medications. All nursing staff will be in serviced on; following physician orders, documentation of narcotic use in the narcotic book and in the medication administration record; accountability of narcotics from shift to shift, accurate documentation of medications	

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F 281	Continued From page 29 #4) and two supplemental residents (#14 and #24). The facility failed to have policies/procedures which were in accordance with current professional standards for the provision of nursing services and care. The findings included: 1. On 7/21/09 at 8:23 AM, during the observation of a medication pass, nurse (B) was observed to apply resident #14's Fentanyl patch, placing the patch on the resident's back. The nurse failed to wear gloves during the application of this patch and did not wash her hands following the procedure. The nurse did not sign the patch out on the narcotic record at the time she removed it from the medication cart or at any time during this medication observation. 2. On 7/21/09 at 8:38 AM, during the observation of a medication pass, nurse (D) prepare medications for resident #9 with nurse (C) assisting her. Nurse (D) poured oral medications and got out a Fentanyl patch in preparation. Nurse (D) picked up the medications and started down the hallway to a room. When nurse (C) questioned nurse (D) about who was to receive the medications, nurse (D) answered with another resident's name. Nurse (C) re-directed nurse (D) to resident #9's room. When nurse (D) went to apply the Fentanyl patch, she questioned whether or not gloves should be worn. The nurses discussed that they did not know the facility's policy but thought that it was a safer choice to wear gloves and check on the policy later. Nurse (D) was unable to locate the old patch in order to remove it. She applied the new patch and both nurses checked the resident's back for the old patch. Nurse (C) looked in the resident's bed. No patch was found. Later they reported that the nurse aides had not found a patch either. The	F 281	given in the medication administration record, infection control for medication administration (glove use), updating the medication of administration record as physician orders change and reconciliation of medication administration records at month end. Facility will have policies and procedures for administration of medication and use hot packs by therapy staff. Weekly medication pass audits will be completed to determine compliance. Audits will be reported to CQI monthly for 1 year. Completion date: 8/28/09	

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F 281	Continued From page 30 nurse did not sign the patch out on the narcotic record at the time she removed it or at any time during this medication observation. At the time of the survey exit, there was no evidence that the facility had investigated the loss of the resident's Fentanyl patch. The staff verified that no incident report had been completed. 3. Record review for resident #9 evidenced the following physician orders for pain management: Fentanyl Patch 25 mcg Change every 72 hours dated 5/28/09. Review of the resident's 5/09 and 6/09 MARs revealed the following: Fentanyl 25 mcg was not charted as given on 5/27 or 6/29/09. There was no evidence to show that the resident was medicated as physician ordered. 4. On 7/21/09 at 9:30 AM, during a medication pass observation with nurse (D) with nurse (C) assisting, nurse (D) prepared and administered a medication to resident #24. The medication was Pulmocort Flexhaler. Nurse (D) along with nurse (C) entered the resident's room to administer the inhaler. Nurse (D) was not aware that the medication dial on the bottom needed to be turned to prepare the medication for administration. Nurse (C) instructed nurse (D) on how to do this. The inhaler was given to the resident, who used the inhaler and gave it back to nurse (D). After returning to the medication cart, the surveyor questioned if two puffs were just administered or if the dial would have to be turned in order to get two puffs. Nurse (C) said that the	F 281		

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F 281	Continued From page 31 dial would need to be turned a second time. The resident's 7/09 MAR was reviewed and the dose was listed as two puffs so nurse (D) returned to the resident's room and gave him/her another puff. Review of the physician's orders evidenced that the order was actually one puff two times a day. It was not clear how or when the MAR was changed to give two puffs. Additionally, there was no evidence to show whether or not the resident had been receiving one or two puffs with each administration of the medication. The nurses charted that two puffs were given. This transcription error created the potential for multiple medication errors to be made by the nursing staff. 5. Record review for resident #4 evidenced the following physician orders for pain management: Morphine Sulfate Solution 0.25 mg (milligrams) every four hours Fentanyl 100 mcg (micrograms) every 72 hours (increased from 50 mcg to 75 mcg on 6/10/09 and from 75 mcg to 100 mcg on 6/25/09) Lortab 5/500 or 2 teaspoons liquid as needed. a. Review of the resident's 6/09 and 7/09 MARs revealed the following: Fentanyl 75 mcg was charted as given on 6/18, 6/20 (in emergency room), 6/22, 6/24, 6/26, and 6/28/09. Fentanyl 100 mcg was charted as given on 6/25 and 6/28/09.	F 281		

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F 281	Continued From page 32 Fentanyl 100 mcg was not charted as given on 7/10/09. Morphine Sulfate Solution was not charted as given on 6/25 at 4:00 PM and 6/26 at 8:00 AM and 4:00 PM. Morphine Sulfate Solution was not charted as given on 7/1 at midnight, 4:00 AM, and 4:00 PM and 7/2/09 at 4:00 PM. On 7/23/09 at 2:15 PM, in an interview, the DON and nurse (H) verified that the 7/1 and 7/2 4:00 PM doses of Morphine were not charted as given and were not signed out on the Control Drug Record. b. Review of the resident's Individual Control Drug Records evidenced the following: Fentanyl 75 mcg was signed out on 6/18, 6/22, 6/24, and 6/28/09. Fentanyl 100 mcg was signed out on 7/10, 7/13, 7/16, 7/19, and 7/22/09. The Director of Nursing (DON) stated that she was not able to find the resident's Control Drug Record for this dosage for dates 6/25, 6/28, 7/1, 7/4, and 7/7/09. Morphine Sulfate was not signed out on 6/25 or 6/26 at 4:00 PM. The Fentanyl 75 mcg and 100 mcg doses as charted overlapped (6/26 and 6/25, respectively). There was no evidence to clarify that the resident was medicated as physician ordered or that the resident's narcotic medications were correctly accounted for. FACILITY POLICIES AND PROCEDURES	F 281		

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F 281	Continued From page 33 1. On 7/22/09 at 3:00 PM, in an interview with a therapy staff member (BB), she revealed that the facility used hot packs (similar to bean packs) which were heated in the microwave for four minutes. Staff (BB) was asked to provide a policy for the use of hot packs. She left to check on the policy. When she returned, she stated that there was no policy, but that it was the same as the clinic's policy. She stated that she would get the clinic's policy and provide it to the surveyors. 2. Due to the medication error rate observed during the medication pass, the surveyor requested to see the medication administration policies/procedures. A general policy entitled "Administering Medications" printed from "Operational Policy and Procedure Manual 2001 MED-PASS, Inc. (Revised 2006)" was provided to the surveyor. The Policy Statement was "Medications will be administered in a timely manner and as prescribed by the resident's Attending Physician or the facility's Medical Director." 3. On 7/23/09, in an interview with the Director of Nursing (DON), she verified that the facility did not have specific medication administration policies, such as for nasogastric, inhalers, and injections. A. STANDARD OF PRACTICE: ADMINISTRATION OF MEDICATIONS: Standards for nursing practice for administration of medication provide, in pertinent part that: The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients. Medications must be accurately administered and	F 281		

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F 281	Continued From page 34 documented. Accurate administration includes, in the first instance, a physician order authorizing the administration of the medication; if an order is not clear, the nurse should communicate with the physician to seek clarification. Thereafter, accurate administration includes transcribing the drug order correctly, delivering the correct drug, to the correct resident, by the correct route, in the correct dose. Accurate documentation involves recording information on the drug administered, including the client's response to the medication. The physician may order a drug on a PRN basis (when a client requires it). The nurse uses objective assessments, subjective assessments, and discretion in determining the client's need. When medications are administered, the nurse documents the assessment made and the time of drug administration. The nurse should make frequent evaluation of the effectiveness of the drug and record findings in the appropriate place. See generally: Lippincott, Nursing Drug Guide, 1998 (Lippincott) and Perry & Potter, Clinical Nursing Skills & Techniques; 1998, (Perry & Potter). B. FOLLOWING PHYSICIAN ORDERS Fundamentals Of Nursing, Potter and Perry, 4 th Edition, 1997, Chapter 20, pg 341, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients."	F 281		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	Residents #4, #28 and #23. Bowel monitoring forms will have documentation daily by the nurses. The standing orders will be recorded on the medication administration records and	

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F 309	Continued From page 35 and plan of care. This Requirement is not met as evidenced by: Based on observation, record review, and family and staff interview, it was determined that the facility failed to provide care in a manner to ensure adequate pain relief, monitor and manage residents' bowel movements, and provide adequate and appropriate diabetic monitoring and treatment for residents who received insulin. This failure affected five of 12 sample residents' (#4, #9, #8, #11, and #1) and three supplemental resident's (#28, #35, and #23) ability to reach their highest practicable level of physical, mental, and/or psychosocial functioning. The findings included: BOWEL MANAGEMENT 1. Record review for resident #4 revealed that the resident was admitted 1/23/08 with diagnoses that included bipolar, manic depression, stroke, breast cancer, congestive heart failure, and pain. a. Review of the resident's 5/6/09 significant change Minimum Data Set (MDS) assessment evidenced that the resident was assessed to need extensive assistance with bed mobility, transfer, and eating and total assistance with toilet use and bathing. The resident was assessed to be occasionally incontinent of bowel and frequently incontinent of urine. b. On 7/23/09 at 11:25 AM, in an interview with nurse (A), she verified that the resident needed staff assistance with toileting. c. Review of the resident's physician orders	F 309	followed as written. The care plan will include and address risks for constipation related to pain and medications. Staff will encourage residents to drink fluids. Residents #9 and #35. Bowel monitoring forms will have daily documentation by the nurse. The standing orders will be recorded on the medication administration records and followed as written. Staff will courage resident to drink fluids. A new pain assessment will be completed and a new pain scale implemented for resident #4. The care plan will address pain management. A nursing assessment will be completed for resident #1. The physician orders will be followed for resident #4's diabetic management. Nurses will follow physician orders for diabetic monitoring for resident #11. Monthly physician orders will be reviewed by medical records and nursing staff for accuracy prior to implementation each month. Nurses will document accurately on the medication administration record.	

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F 309	Continued From page 36 related to pain management and BM management evidenced the following orders: Morphine Sulfate 0.25 mg (milligrams) every four hours Fentanyl 100 mcg (micrograms) every 72 hours (increased from 50 mcg to 75 mcg on 6/10/09 and from 75 mcg to 100 mcg on 6/25/09) Lortab 5/500 as needed Milk of Magnesia (MOM) 30 cc (cubic centimeters). The resident's physician had standing orders in place which were not all noted on the MAR. These standing orders were "Milk of Magnesia 30 ccs by mouth at bedtime as needed for bowel elimination. If no bowel movement after three days, (day) five Fleets enema per rectum." d. Review of the resident's 6/09 and 7/09 BM (bowel movement) monitoring forms revealed the following dates when no BM was recorded for the resident (dates - number of days without a BM, intervention): 6/4 - 6/14/09 - 10 days 6/15 - 6/21/09 - 6 days 6/23 - 6/28/09 - 5 days. 7/3 - 7/21/09 - 18 days. MOM was charted as given one time in June, 2009 (6/7) and none was noted for July, 2009. e. Review of the resident's care plan evidenced.	F 309	In-services will be conducted for nursing staff on accuracy of documentation pain management and monitoring and use of standing orders. The Director of Nursing and medical records will monitor medication administration records, bowel monitoring, care plans, standing orders and pain scales for all residents. Results of audits will be reported to CQI monthly to determine continued compliance. Completed by: 8/28/09	

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F 309	Continued From page 37 that although the resident was on narcotic pain medications, there was no bowel management plan in place. This increased the resident's potential for fecal impaction or obstruction. The facility was requested to provide any documentation related to monitoring/managing of the resident's bowel status. The surveyors were not provided with any additional information as of their exit. 2. Record review for resident #9 revealed that the resident was re-admitted to the facility on 5/9/09 after a hospitalization with diagnoses that included fractured hip and fecal impaction/mega colon. a. Review of the resident's 4/21/09 quarterly MDS assessment evidenced that the resident was assessed to require total assistance for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to be incontinent of bowel and bladder. b. On 7/23/09 at 11:25 AM, in an interview with nurse (A), she verified that the resident needed staff assistance with toileting. c. Review of the resident's care plan evidenced that a plan was developed on 5/9/09 for "History of obstipation R/T (related to) slow moving motility and mega colon". d. On 7/24/09 in the morning, in an interview, the DON indicated that the system of tracking had changed and that previously, the BMs were noted on the Medication/Treatment sheets. e. Review of the facility's BM tracking form evidenced that there was documentation from 5/8-	F 309		

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F 309	Continued From page 38 to 5/19 and 6/3 to current. However, there was no evidence found of the BM tracking for 4/09 and the beginning of 5/09 for this resident. f. Review of the resident's 4/09 and 5/09 (prior to hospitalization with fecal impaction) MARs revealed an order dated 2/5/04 for Dulcolax suppository as needed. None were charted for this resident. g. The resident's physician had standing orders in place which were not noted on the MAR. These standing orders were "Milk of Magnesia 30 ccs by mouth at bedtime as needed for bowel elimination. If no bowel movement after three days, (day) five Fleets enema per rectum." 3. Record review for resident #28 evidenced that the resident had diagnoses that included stroke, depression, and constipation. a. On 7/23/09 at 11:25 AM, in an interview with nurse (A), she verified that the resident needed staff assistance with toileting. b. Review of the resident's physician orders related to BM management evidenced the following orders: Miralax 17 gm (grams) daily Colace 100 mg twice a day Dulcolax suppository PR (per rectum) daily as needed (prn) Milk of Magnesia (MOM) 30 cc (cubic centimeters) as needed. c. Review of the resident's 5/09 and 6/09 BM	F 309		

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F 309	Continued From page 39 (bowel movement) monitoring forms revealed the following dates when no BM was recorded for the resident (dates - number of days without a BM, intervention): 5/10 - 5/14/09 - 4 days 6/3 - 6/11/09 - 8 days 6/14 - 6/19/09 - 5 days. The prn Dulcolax suppository and MOM were not charted as given in May, 2009 or in June, 2009. d. Review of the resident's care plan evidenced that although the resident had a diagnosis of constipation, there was no bowel management plan in place. 4. Record review for resident #35 evidenced that the resident had diagnoses that included stroke, diabetes, aphasia, and congestive heart failure. a. On 7/23/09 at 11:25 AM, in an interview with nurse (A), she verified that the resident needed staff assistance with toileting. b. Review of the resident's physician orders related to BM management evidenced the following orders: Benefiber one teaspoon twice a day (started 5/23/09 and discontinued 7/22/09) Miralax 17 grams daily (started 7/21/09) Milk of Magnesia (MOM) 15 or 30 cc (cubic centimeters) every evening (noted as started 6/12 and 6/10/09, respectively)	F 309		

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F 309	Continued From page 40 Milk of Magnesia (MOM) 15 cc (cubic centimeters) every three days as needed. The resident's physician had standing orders in place which were not noted on the MAR. These standing orders were "Milk of Magnesia 30 ccs by mouth at bedtime as needed for bowel elimination. If no bowel movement after three days, (day) five Fleets enema per rectum." c. Review of the resident's 5/09, 6/09, and 7/09 BM (bowel movement) monitoring forms revealed the following dates when no BM was recorded for the resident (dates - number of days without a BM, intervention): 5/18 - 5/22/09 - 4 days 5/23 - 5/29/09 -6 days 5/30 - 6/4/09 - 5 days 6/5 - 6/9/09 - 4 days 6/17 - 6/22/09 - 5 days 7/2 - 7/17/09 - 15 days. The prn Dulcolax suppository and MOM were not charted as given in May, 2009 or in June, 2009. d. Review of the resident's care plan included a problem of constipation (dated 6/1/2009). 5. Record review for resident #23 evidenced that the resident had diagnoses that included Parkinsons syndrome, depressive disorder, stroke, and constipation. a. On 7/23/09 at 11:25, in an interview with nurse	F 309		

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F 309	Continued From page 41 (A), she verified that the resident needed staff assistance with toileting. b. Review of the resident's physician orders related to BM management evidenced the following orders: Miralax 17 grams daily c. The resident's physician had standing orders in place which were not noted on the MAR. These standing orders were "Milk of Magnesia 30 ccs by mouth at bedtime as needed for bowel elimination. If no bowel movement after three days, (day) five Fleets enema per rectum." d. Review of the resident's 5/09, 6/09, and 7/09 BM (bowel movement) monitoring forms revealed the following dates when no BM was recorded for the resident (dates - number of days without a BM, intervention): 5/8 - 5/12/09 - 4 days 5/22 - 5/26/09 -4 days 6/14 - 6/19/09 - 5 days 6/20 - 6/24/09 - 4 days 6/26 - 7/2/09 - 6 days 7/9 - 7/13/09 - 4 days 7/17 - 7/22/09 (none recorded) - 5 days. The prn Dulcolax suppository and MOM were not charted as given in May, 2009 or in June, 2009. e. Review of the resident's care plan revealed no	F 309		

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F 309	Continued From page 42	F 309		

problem of constipation.

Reference for BOWEL MANAGEMENT

1. The Merck Manual of Geriatrics, Chapter 110 "Constipation, Diarrhea, and Fecal Incontinence," some medications, low dietary fiber, inadequate hydration, and reduced caloric intake are common causes of constipation. Functional impairment from immobility, muscular weakness, some neuromuscular disorders, altered mental status or depression may also contribute to constipation. Dietary approaches begin with adequate hydration, a cornerstone to treating constipation.

2. A presentation, entitled Management of Diarrhea and Constipation (2005), given by David R.P. Guay, Pharm.D., F.C.P, F.C.C.P, F.A.S.C.P listed "Complications of Constipation in the Elderly." This list included fecal impaction and sigmoid volvulus.

3. 'Medical Update November, 2001 [Update 01-11], Office of the Ombudsman for Mental Health & Mental Retardation, Minnesota, Bowel Obstruction Alert indicated the following:

"Factors that may contribute to constipation:
Dietary factors - low residue (low fiber) diet, not drinking enough liquids
Inactivity and immobility....
Environmental factors...
Structural abnormalities...
Smooth muscle or connective tissue disorders...
Depression
Neurological disorders...
Metabolic/endocrine disorders...

Medications "This list is intended to give common

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F 309	Continued From page 43 examples and cannot include all current or future medications that can cause constipation. Opioid analgesics... Nonsteroidal antiinflammatory drugs... Antacids... Anticholinergic drugs... Antidepressants - particularly lithium and tricyclics (like Elavil, Anafranil, desipramine, Pamelor, Tofranil/Imipramine) Antipsychotics... Antihypertensives... Inderal... Antiarrhythmics... Diuretics... Anticonvulsants... Dilantin... Antihistamines - Benadryl Anti-ulcer medications... Antilipidemics... Monitoring bowel function: It is important for every facility and home health care program to have an established procedure for monitoring bowel function and responding to changes. Clients should be asked on a daily basis whether they have had a bowel movement. The information needs to be documented in order to learn what the individual's normal routine is and to monitor for the development of problems." PAIN MANAGEMENT 1. Record review for resident #4 revealed that the resident was admitted 1/23/08 with diagnoses that included bipolar, manic depression, stroke, breast cancer, congestive heart failure, and pain.	F 309		

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F 309	Continued From page 44 a. Review of the resident's 5/6/09 significant change and 4/1/09 quarterly Minimum Data Set (MDS) assessments evidenced that the resident was assessed to be able to make self understood and to understand others. b. Review of the resident's 6/09 MAR revealed that the resident's received nine doses of Lortab as documented on the Medication Administration Comments form. There were no notations that indicated the pain scale was utilized for assessing the pain level of the resident's pain before or after the administration of the medication and no results were documented for seven of the nine doses. 2. Resident #8's medical record review revealed the resident was admitted to the facility on 3/29/09 with diagnoses which included: Alzheimer's disease, hypertension, senile dementia, osteoporosis, arthritis, and anxiety. a. On 7/20/09 at 3:10 PM on initial tour of the facility with Nurse (F) resident #8 was identified as being on Hospice Care, having leg contractures and skin breakdown behind the right knee. The area was described as being a recurrent pressure wound, Stage IV to the popliteal area. b. Review of a FAX to the physician dated 6/22/09 identified the resident having pain with wound care. The sheet noted, "Could we get a order for a pain med. Tylenol dose not working, especially with wound care. Hospice nurse suggested something stronger then Tylenol if just for pre-wound care." The response was, Lortab 5/500 is ordered PRN (as needed). If it is not please order this every 4 hours PRN". Lortab was given 6/24/09, 6/29/09 and 6/30/09.	F 309		

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F 309	Continued From page 45 Cross refer to F314 c. Review of the plan of care did not address pain management for this resident on Hospice with a Stage IV wound. Professional Standards of Practice: PAIN MANAGEMENT Fundamentals of Nursing, The Art & Science of Nursing Care, Fourth Edition, Taylor, Lillis, LeMone, Lippincott, 2001, Chapter 40: Comfort, page 1047-1055 indicates that a comprehensive pain assessment would identify the causes of pain, how intensely the pain was experienced, when the resident experienced the pain, which pain medication was most effective in relieving the pain, and how the pain affected other needs such as agitation and adequate sleep. Factors to assess would include 1) The characteristics of the pain (location, duration, quantity, quality, chronology, aggravating factors, and alleviating factors), 2) The resident's physiologic response to the pain (vital signs, skin color, perspiration, pupil size, nausea, muscle tension and anxiety), 3) The resident's behavior responses (posture, gross motor activities, facial features and verbal expressions), and 4) Affective responses of the resident such as anxiety or depression. Additionally the pain assessment should include how the pain experience affects the resident's interactions with others, how it interferes with activities of daily living, meaning of pain to the resident and the resident's expectations for pain relief. A system for comprehensive pain assessments should also include a means for	F 309		

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assessment of pain in residents who are cognitively impaired and guides to validate pain cues and recognize pain when the resident is unable to verbalize pain.

PRN MEDICATION ORDERS

Fundamentals of Nursing, Potter and Perry: "PRN ORDERS: The physician may order a drug on a PRN basis (when a client requires it). The nurse uses objective assessments, subjective assessments, and discretion in determining the client's need. When medications are administered, the nurse documents the assessment made and the time of drug administration. The nurse should make frequent evaluation of the effectiveness of the drug and record findings in the appropriate place."

According to World Health Organization the use of pain medication should be guided by principle to "start low, go slow", which means start with a low dose and titrate carefully especially in frail, older individuals.

According to the U.S. Department of Health and Human Services Clinical Practice Guidelines "Management of Cancer Pain: Adults" (94-0593), "titration" means a medication is to be increased or decreased by one-quarter to one-half of the previous dose.

DIABETIC MONITORING

1. On 7/22/09 at 3:00 PM a record review for resident #1 revealed diagnoses that included Diabetes Mellitus.

a. A review of Physician Order Report dated

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F 309	Continued From page 47 May 2009 and June 2009, revealed the following order: "FSBS AC & HS sliding Scale Humulog (sic) < 101 - no insulin 101-120 = 2 units, 121-150 = 4 units, 151-200=6 units, 201-250=8 Insulin; 251 to 350 = 10 units; 351 to 450 = 12 units; <70 or > 450 Call MD. Notes: Before administering insulin please make sure Pt is prendial (sic) and is about to eat. Otherwise cut insulin dose to ½." b. A review of Licensed Nurses Notes dated 4/1/09 1 AM for resident #1 revealed the following "Called into room, resident thrashing uncontrollably unresponsive to verbal stimuli, activity lasted approx 4 min follow by stillness (nurse's symbol for "with") snoring, respirations, (symbol zero) responsive & (symbol zero) responding to deep pain stimuli, O2 sat 93 o n 5L per NC BS 100, was 309 earlier & given 14 U of Humalog per MD orders, (Physician name) notified & received ordered to send to ER per emergent ambulance. Wife (name) notified of cond. & transfer to hospital." c. A review of the Admission Summary Sheet for Memorial Hospital of Converse County reveals resident #1 was admitted to the hospital 4/2/09 at 4:30 AM. d. A review of Licensed Nurses Notes dated 4/4/09 10:30 AM revealed the following: "resident FS @ 0700 116. Sliding Scale given of insulin. Appetite fair. Ambulate to meals (symbol for with) walker SBA. Neb Tx as ordered No adverse reaction to antibiotic therapy. Sat @ 91%. He is alert/oriented - B/P 102/56 - 97.5- 87-22." e. A review of Medication Administration Record for April 2009 reveals that medications were administered on 4/3/09 1700 (5:00 PM)	F 309		

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F 309	Continued From page 48 f. The Treatments record showed that a daily weight was competed and initiated for 4/3/09 at 08:00 (8:00 AM). g. The Licensed Nurses Notes did not show that a Nursing Assessment was completed upon return from the hospital on 4/3/09 at 2:00 PM. h. On 7/23/09 at 2:00 PM, an interview with Staff (F) and Staff (H) confirmed there was no Nursing Assessment completed upon readmission to the facility. I. On 7/21/09 at 9:30 AM, an interview with a family member revealed concerns that Blood Sugar monitoring was not being done as ordered by the physician. 2. On 7/22/09 at 9:00 AM, a review of medical records for resident #11 revealed diagnoses that included Diabetes Mellitus. a. A review of the Medication Administration Record (MAR) for June 2009 revealed the following order: "4/8/09 (Admission Date) for Accuchecks BID (Every week on Tuesday twice each day) Accuchecks BID weekly and PRN; with sliding scale insulin: Humalog; > 500=15 units;401 to 500 =10 units; 301 to 400 = 8 units; 251 to 300 = 6 units; 201 to 250 = 4 units; 151 to 200 = 3 units; 121 to 150 = 2 units; < 120 = 0 units." b. A review of the Medication Administration Record for June 2009 revealed staff initials after the 0700 time on June 2, 9, 16 and 30. There were no initials for 0700 on 6/23/09. There were no staff initials for the HS check during the month of June 09.	F 309		

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F 309	Continued From page 49	F 309		

c. A review of the Douglas Care Center Diabetic Monitoring Sheet for July 09 revealed blood sugar checks completed
7/7 at 0500 with results of 103,
7/14 at 0500 with results of 120,
7/18 at 0500 with results of 107,
7/21 at 0500 with results of 93 and at 1100 Lantus Insulin 10 was administered.

d. The Accuchecks order indicates BID weekly on Tuesday. There was no documentation that Accuchecks were completed on 7/7/09 PM, 7/14/09 PM, 7/21/09 PM, 7/28/09 PM.

e. A review of the Physician Order Report effective 7/1/2009 revealed no order for Accuchecks or sliding scale insulin administration.

f. A review for Physician's Orders did not reveal an order changing or discontinuing the order for Accuchecks and sliding scale insulin administration established 4/8/09.

g. On 7/23/09 at 2:15 PM an interview with Staff (F) verified that the Physician's Orders and MAR for July 2009 did not show the order.

h. A review of Diabetic Monitoring records for resident #11 revealed incomplete documentation for the months of 3/9 (March 2009), April/2009, 5/9 (May 2009). The chart shows the dates listed horizontally and the time of day, results, units and initials listed vertically.

1) March 2009:

a) 0630 (6:30 AM) Accuchecks for March 9, 13 and 27 do not indicate the number of units

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F 309	Continued From page 50 according to the sliding scale. b) 1100 (11:00 AM) Accuchecks for March 14 and 20 do not indicate the number of units according to the sliding scale and are not initialed. c) 1600 (5:00 PM) Accuchecks for March 11 and 20 do not indicate the number of units according to the sliding scale. The March 20 date is not initialed. d) 2000 (8:00 PM) Accuchecks for March 10, 11, 15 and 21 do not indicate the number of units according to the sliding scale and are not initialed. March 31 dose not indicate the Accucheck results, number of units according to the sliding scale and is not initialed. 2) April 2009: a) 0630(6:30 AM) Accuchecks for April 17 and 27 do not indicate the number of units according to the sliding scale. b) 1100 (11:00 AM) Accuchecks for April 10 and 21 do not indicate the results, number of units according to the sliding scale and are not initialed. April 27 dose not indicate the number of units according to the sliding scale. c) 1600 (5:00 PM) Accuchecks for April 9 dose not indicate the number of units according to the sliding scale. The March 20 date is not initialed. April 16 is not initialed. 3) May 2009 a) 0630 (6:30 AM) Accuchecks for May 13, 18 and 28 do not indicate the number of units according to the sliding scale.	F 309		

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F 309	Continued From page 51 b) 1100 (11:00 AM) Accuchecks for May 8 and 9 do not indicate the results, the number of units according to the sliding scale and are not initialed. May 30 is not initialed. c) 1600 (5:00 PM) Accuchecks for May 8 do not indicate the results, the number of units according to the sliding scale and is not initialed. May 18 dose not indicate the units according to the sliding scale and is not initialed. May 25 and 26 do not indicate the number of units according to the sliding scale. d) 2000 (8:00 PM) Accuchecks for May 61 dose not indicate the number of units according to the sliding scale and is not initialed. March 25 dose not indicate the number of units according to the sliding scale. Reference for Professional Standards of Practice for hyperglycemia and hypoglycemia: According to the American Diabetes Association, for residents diagnosed with diabetes mellitus, blood glucose levels should be maintained between 70 milligrams per deciliter (mg/dL), and 110 mg/dL. Normally, blood glucose levels stay within narrow limits throughout the day, 70 to 150 mg/dl. Levels rise after meals and are usually lowest in the morning, before the first meal of the day. If levels remain too high, appetite may be suppressed. Long-term hyperglycemia causes many of the long-term health problems associated with diabetes, including eye, kidney, and nerve damage. Glucose levels vary before and after meals, and at various times of day; and what is "normal" varies among medical professionals, and can vary between patients. Symptoms that can indicate that blood sugar	F 309		

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F 309	Continued From page 52 levels are too high include polyphagia (frequent hunger, especially pronounced hunger), polydipsia (frequent thirst, especially excessive thirst) and polyuria (frequent urination, especially excessive urination). Sustained higher levels of blood sugar cause damage to the blood vessels and to the organs they supply, leading to the complications of diabetes. According to the Lippincott Manual of Nursing Practice (eighth edition), wide fluctuations in blood glucose control increases the risk of greater cell damage and may result in peripheral neuropathy, stroke, cardiac arrhythmias, dehydration, retinopathy, and renal damage.	F 309		
F 311 SS=E	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This Requirement is not met as evidenced by: Based on observation and resident and staff interview, it was determined that the facility failed to provide adequate meal assistance to one of 12 sample residents (#11) and seven supplemental residents (#20, #23, #28, #29, #18, #39, and #36). These residents were facility assessed and/or observed to be able to feed themselves all or part of his/her meals, but required supervision, cueing, and/or physical assistance to eat. The findings included: 1. On 7/21/09 from 5:00 PM to 6:15 PM, the following observations were made in the dining room: a. The first meal was served to a resident at 5:08 PM.	F 311	Residents #11, 18, 20, 23, 28, 36 and 39 will receive assistance and cueing at meal times. All residents assessed and care planned to need assistance/cueing at meal times will receive those services. Nursing and CNA staff will be in serviced on dining room competencies for assistance and cueing. Administrator will audit each of the three daily meals at least weekly to determine compliance. Audits will be reported to CQI monthly for 90 days and quarter thereafter to determine continued compliance. Completion date: 8/28/09	

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F 311	Continued From page 53 b. The fish sandwiches were each made with a thick piece of fish, placed in the center of two slices of bread. The bread was observed to break apart when the residents tried to pick the sandwich up. c. At 5:20 PM, when resident #20 was served his/her meal, a staff member provided set-up assistance. The resident was observed to eat very slowly and to consume approximately 15 % of his/her food. No assistance or cueing was offered to this resident. d. At 5:26 PM, when resident #23 was served his/her meal, a staff member provided set-up assistance. The resident picked up the slice of tomato with his/her fingers, taking five minutes for the resident to consume it. The resident was observed to eat very slowly and to consume approximately 25 % of his/her food. No assistance or cueing was offered to this resident. e. At 5:12 PM, when resident #28 was served his/her meal, a staff member provided set-up assistance. The resident picked up the slice of tomato with his/her fingers so that he/she could eat it. The resident was observed to eat slowly and to consume approximately 15 % of his/her food and a small amount of fluids. No assistance or cueing was offered to this resident until 6:02 PM (50 minutes after being served his/her meal). f. At 5:20 PM, when resident #29 was served his/her meal, a staff member provided set-up assistance. The resident picked up the slice of tomato with his/her fingers so that he/she could eat it. The resident was observed to eat approximately 15 % of his/her food and a small amount of fluids. No assistance or cueing was	F 311		

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F 311	Continued From page 54 offered to this resident. g. At 5:15 PM resident #18 was served a pureed meal. The resident began to feed him/herself. The resident was noted to have deformities of both hands but was able to eat. The resident spilled food down his/her chin and clothing protector. Staff did not cue or assist the resident until 5:38 PM (23 minutes after the resident was served food) when the nurse consultant offered assistance. h. At 5:45 PM in an interview, staff, who wished not to be identified, voiced concern with staffing. Staff reported, "We are short of help in the dining room. There are three CNAs on and the fourth one who is here until 8:00 PM. Residents don't get the assistance they need because staff can't be in two different places." 2. On 7/22/09 from 11:58 AM to 1:05 PM, the following observations were made in the dining room: a At 11:58 AM, the dietary staff announced in an overhead page that the noon meal was ready to be served. b. At 12:05 PM, an overhead call was heard for "all Department Heads to assist in the dining room". c. At 12:07 PM, the staff began to serve the food to the residents. d. At 12:19 PM, when resident #23 was served his/her meal, a staff member provided set-up assistance. The resident was observed to eat very slowly and to consume approximately 10 % of his/her food and a small amount of fluid. No	F 311		

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F 311	Continued From page 55 assistance or cueing was offered to this resident until 1:02 PM (43 minutes before assistance was offered to the resident), at which time the resident refused to eat more. e. At 12:13 PM, when resident #20 was served his/her meal, a staff member provided set-up assistance. The resident was observed to eat very slowly, to hold the inside top of the glass while trying to drink out of it, and to consume approximately 10 % of his/her food. No assistance or cueing was offered to this resident until 12:54 PM (31 minutes after being served his/her food) when the resident was leaving the dining room, he/she was asked if he/she wanted anything else to eat. The resident refused. f. At 12:15 PM resident #36 was served his/her meal. The resident was seated in a wheelchair away from the table. The resident was noted to be reaching to the table to eat the fruit cup that had been served. The resident was noted to spill food on his/her lap and the floor. The resident was not offered assistance until 12:40 PM (25 minutes later) from the nurse consultant. g. At 12:40 PM, resident #17 called out that one of the residents (resident #11) at his/her table had not received food. Although both other residents seated at the same table with resident #11 had almost finished eating, resident #11 was not served his/her food for approximately ten more minutes. h. On 7/22/09, during the noon meal service resident #39 was observed trying to pour coffee from a thermos. The thermos was large, heavy and awkward for the resident to handle. The resident gave up for awhile and trying again a few moments later. Another resident sitting next to	F 311		

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F 311	Continued From page 56 resident # 39 struggled to assist. The lid to the thermos was unscrewed and a very small amount of coffee (one swallow) was poured into a cup. The resident continued trying to pour more coffee, eventually removing the lid entirely, exposing the hot coffee. This surveyor requested immediate assistance from staff. 3. On 7/23/09 at 6:30 AM dietary staff announced overhead that the food was ready to be served. At this time, there were 17 residents seated in the dining room and two nurses who were passing medications in the dining room. There were no CNAs present. Resident #18 was repeatedly saying "come on, come on". This resident was the only resident to have some food in front of him/her. At 6:39 AM, the Minimum Data Set (MDS) Coordinator began serving trays while the Certified Nurse Aides (CNAs) continued to bring residents into the dining room. 4. On 7/21/09 at 3:50 PM during group interivew residents agreed that they "do not get offered more food as staff is over helping those residents that need assistance."	F 311		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed	F 312	All residents of the facility, including residents #5, #8 and #18 will receive proper and complete peri care. CNAs will use proper infection control techniques while providing peri care to residents.	

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F 312	Continued From page 57 to assist two of 12 sample residents (#5 and #8) and one supplemental resident (#16) with appropriate and adequate peri-care. These residents were facility assessed and/or were observed to be unable to perform this Activities of Daily Living (ADL), requiring extensive/total assistance. The findings included: 1. Resident #5's medical record review revealed the resident was admitted to the facility on 10/29/99 with diagnoses which included: CHF (congestive heart failure), heart disease, hypertension, dementia, osteoarthrosis, RA (rheumatoid arthritis), anxiety, and fractured femur. a. Review of the significant change MDS (Minimum Data Set) assessment dated 6/3/09 identified the resident as being total care and as having skin ulcers. The assessment included: Total dependence (full staff performance) with two staff persons physical assistance for bed mobility, transfers, and toilet use, Total dependence with one staff person physical assistance for dressing, eating, and personal hygiene. It also addressed bowel and bladder incontinence as four (inadequate control with multiple episodes, all or almost all the time). b. Observations and staff interviews for resident #5 included: 1) 7/20/09 at 3:10 PM on the initial tour of the facility with Nurse (F), resident #5 was identified as having skin breakdown and recent treatment for a UTI (urinary tract infection). 2) 7/21/09 at 8:55 AM three CNAs (Y, O, and Q) were observed transferring resident #5 into bed with a mechanical lift. The resident was	F 312	All CNAs will be in serviced on proper and complete peri care. In servicing will also include infection control techniques including proper use of gloves during peri care. Weekly audits of CNA competencies for peri care and glove use will be completed to determine compliance. Weekly audits will be reported to CQI monthly for 90 days and quarterly thereafter to determine continued compliance. Completion date: 8/28/09	

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F 312	Continued From page 58 positioned on her back in bed. Staff (O and Y) donned gloves to do perineal care. The resident was noted to have a large yellow liquid stool when the brief was pulled back. Staff (O) used multiple wipes down each side of the resident's groin and pushed the wipes down between the resident's closed legs in an attempt to remove stool. Then without removing the dirty gloves, the resident was turned on to her left side. Staff was observed to touch the soaker pad, sheets, and disposable wipes container with soiled gloves. Staff (Y) then removed the wipes which had been pushed down between the resident's legs. Staff (O) continued to wipe the resident's buttocks. Staff (O) confirmed and the resident was observed to have a small open area on the right gluteus next to the gluteal fold. Staff (O) applied barrier cream before placement of a brief. Staff did not open the resident's legs to ensure the urethra and labia area were properly cleaned after the resident had the liquid stool. The staff failed to provide adequate perineal care for this resident who was high risk for skin breakdown and who had recurrent E.coli (Escherichia coli) resistant UTIs (urinary tract infections). [Escherichia coli (abbreviated as E. coli) are a large and diverse group of bacteria. Although most strains of E. coli are harmless, others can make you sick. Some kinds of E. coli can cause diarrhea, while others cause urinary tract infections, respiratory illness and pneumonia, and other illnesses.] 3) 7/22/09 at 9:30 AM CNA (P and Y) were observed providing care for resident #5. The Nurse Consultant was also in the room to observe care. The resident had a liquid stool and staff was noted to touch multiple items including	F 312		

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F 312	Continued From page 59 the soaker pad and sheets, with soiled gloves. The Nurse Consultant cued staff on the proper perineal care, glove use, handwashing, and removing multiple layers from under the resident and pressure reducing surface. c. Review of "Licensed Nurses Notes" included documentation of Resident #5's UTIs (urinary tract infections) which were identified as Resistant E.coli (Escherichia coli). The resident had a UA (urinalysis) done 5/21/09 which confirmed E.coli. The "Monthly Summary" sheet dated 6/6/09 identified the resident was started on IV (intravenous) antibiotics for the UTI. d. Review of the care plan dated 6/10/09 revealed it was not updated to address the resident's infection or history of Resistant E.coli to ensure interventions were addressed. 2. Resident #8's medical record review revealed the resident was admitted to the facility on 3/29/09 with diagnoses which included: Alzheimer's disease, hypertension, senile dementia, osteoporosis, arthritis, and anxiety. a. On 7/20/09 at 3:10 PM on the initial tour of the facility with Nurse (F), resident #8 was identified as being on Hospice Care, having leg contractures, skin breakdown behind the right knee, and dependent on staff for all cares. b. Review of the significant change MDS (Minimum Data Set) assessment dated 6/3/09 identified the resident as being totally dependent for care and on Hospice. c. Resident #8 was identified with ongoing UTIs (urinary tract infections) which were determined to be Resistant E.coli (Escherichia coli) infections.	F 312		

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F 312	Continued From page 60 d. Observations and interviews for resident #8 included: 7/23/09 at 4:55 AM, CNA (U) went into resident #8's room. The CNA woke the resident up and reported she was going to get the resident dressed. The covers were then pulled back and the resident was observed laying on her left hip. The CNA donned gloves, pulled back the brief and wiped the resident buttocks and rectal area. A small amount of feces was noted on the wipes. The brief was pulled off without turning the resident. Then with the soiled gloves, the CNA placed a new brief under the resident, applied barrier cream. The resident was turned to fasten the brief and turned back on left side without changing gloves. Staff did not wipe the resident's groin creases or urethra when the resident was on her back. The CNA confirmed that the resident's brief was wet. The CNA also failed to ensure the left hip was properly cleansed. Review of the care plan dated 4/29/09 revealed it did not address the resident's history with Resistant E.coli infections. 3. Resident #18 was observed during care on 7/23/09 at 5:35 AM. Staff (T) entered the resident's room. The resident who was asleep was awakened by the CNA. The CNA told the resident it was time to get up for breakfast. The resident's reply was "No." The CNA put on gloves and continued with cares. The covers were pulled back and brief pulled down. The CNA wiped down each side of the groin but made no attempt to separate the resident's legs to wipe down the center over the labia and the urethra. The resident was noted to have edema of the legs, ankles and feet and a deformity of right foot	F 312		

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F 312	Continued From page 61 making one person doing care difficult. The CNA then turned the resident to her right side and finished wiping the resident's buttock while attempting to keep the resident turned on her right side. The wet brief was pulled out, new brief was positioned under the right hip, the resident was turned to his/her back, and the brief was pulled up. The CNA failed to ensure the resident's right hip was properly cleansed. REFERENCE According to The Merck Manual, Second Edition, Escherichia coli (E. coli) is the most common cause of urinary tract infections (UTIs) in adults. These bacteria are normally present in the colon and may enter the urethral opening from the skin around the anus and genitals. Poor perineal care can contribute to UTIs. According to University of Iowa's Health Center, Department of Obstetrics and Gynecology information sheet entitled "Urinary Tract Infections (Bladder Infections); Ways to Prevent a Urinary Tract Infection", good personal hygiene is important. Proper personal hygiene includes blotting or wiping gently from front to back after urinating or having a bowel movement. This will reduce or prevent the spreading bacteria from the rectum to urethra.	F 312		
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	Resident #5 has an accurate MDS, appropriate peri care, a new wheel and appropriate relief device in bed and chair. A new dietary assessment has been completed. The care plan has been updated to address nutritional and skin issues.	

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F 314	Continued From page 62 This Requirement is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to implement appropriate, timely interventions to prevent the development of pressure ulcers and/or to treat the ulcers once they developed for two of 12 sample residents (#5 and #8). These residents were facility assessed to be at risk for the development of pressure ulcers. The findings included: 1. Resident #5 medical record review revealed the resident was admitted to the facility on 10/29/99 with diagnoses which included: CHF (congestive heart failure), heart disease, hypertension, dementia, osteoarthrosis, RA (rheumatoid arthritis), anxiety and fractured femur. a. Review of the annual MDS (minimum data set) assessment dated 3/28/09 had no ulcers or skin issues identified for resident #5. b. Review of the significant change MDS assessment dated 6/3/09 identified the resident as being total care and skin ulcers. The assessment included: -Ulcers (number of ulcers at each stage) a) Stage 1 -persistent areas of redness as 5 identified as pressure ulcers. The area under skin treatment listed pressure device for chair, bed, turning / repositioning program, nutrition or hydration intervention to mange skin problems, ulcer care, application of ointments/medications and other preventative or protective skin care. -Total dependence (full staff performance)	F 314	Resident #8 is healed. Resident #8's bed is set at 5 and appropriate pressure relief is in place. Hospice will provide pressure relief device to chair. The lift sling will not left under resident #8. Proper position for right leg contracture is in place. Care plan has been updated for skin at risk issues. Amedysis hospice and their medical director has been notified of this deficiency and the need for their prompt participation in seeing that their residents receive the appropriate pressure relieving devices. Skin rounds are completed weekly for open wounds and residents at high risk for skin breakdown. The facility policy addresses Stage IV and unstageable wounds. Family and physician are notified when wounds are identified. Nursing staff will be in serviced on proper pressure relieving devices and use of lift slings.	

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F 314	Continued From page 63 with two staff persons physical assistance for bed mobility, transfers, and toilet use, -Total dependence with one staff person physical assistance for dressing, eating and personal hygiene. -Bowel and bladder incontinence of four (inadequate control with multiple episodes, all or almost all the time). c. Review of the "Braden Scale" for predicting pressure sore risk dated 4/4/09 identified the resident as a score of 10 (HIGH RISK). A total score of 12 or less represents HIGH RISK. d. Observations and staff interviews for resident #5 included: 1) 7/20/09 at 3:10 PM on initial tour of the facility with Nurse (F) resident #5 was identified as having skin breakdown. Nurse (F) reported that the resident had a black area on the left heel. The area was described as being facility acquired and starting as a fluid filled blister. The resident was resting on a made bed with a positioning device under legs keeping pressure off her heels. The mattress was identified as a specialty mattress. The resident also had dressings on the upper arms which staff reported were due to skin tears from repositioning while in the wheelchair. 2) 7/21/09 at 7:40 AM resident #5 was noted to be sitting in the dining room in a wheelchair with a mechanical lift sling under the resident. The resident's feet were elevated on a pillow and had multiple abrasions and scabs noted to left foot. At 8:05 AM the resident was taken back to her	F 314	Skin committee meets weekly to implement skin interventions, monitor healing process and program compliance. Results of the skin committee is reported monthly to CQI for 1 year to determine continued compliance. Completed by 8/28/09	

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F 314	Continued From page 64 room. Staff (Y) reported she needed help to lay the resident down and she would come back after all the residents were out of the dining room. At 8:55 AM three CNAs (Y, O and Q) came to transfer resident #5 into bed. A mechanical lift was used for the transfer. The resident had been sitting on a bed pillow, covered by a soaker pad and lift sling, in the wheelchair. The resident was positioned on her back in bed. Staff (O and Y) donned gloves to do perineal care. The resident was noted to have a large yellow liquid stool when the brief was pulled back. Staff (O) used multiple wipes down each side of the resident's groin and pushed the wipes down between the resident's closed legs in an attempt to remove stool. Then without removing the dirty gloves, the resident was turned on to her left side. Staff was observed to touch the soaker pad, sheets, and disposable wipes container with soiled gloves. Staff (Y) then removed the wipes which had been pushed down between the resident's legs. Staff (O) continued to wipe the resident's buttocks. Staff (O) confirmed and the resident was observed to have a small open area on the right gluteus next to the gluteal fold. Staff (O) applied barrier cream before placement of a brief. Additionally, the resident was noted to have indentation on her buttocks and back from the sling straps and layers in the wheelchair. The resident had foam sleeves on both arms which staff reported was being used due the resident's recent skin tears. The resident also had multiple scabs and abrasions on her toes and an area approximately a 3 cm black area on the left heel. Staff did not open the resident legs to ensure the urethra and labia area were properly cleaned after the resident had the liquid stool. The staff	F 314		

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F 314	Continued From page 65 failed to provide adequate perineal care for this resident who was high risk for skin breakdown and who had recurrent E. coli resistant UTIs (urinary tract infections). 3) 7/22/09 at 9:30 AM CNA (P and Y) were observed providing care for resident #5. The Nurse Consultant was also in the room to observe care. The resident had a liquid stool and staff was noted to touch multiple items including the soaker pad and sheets, with soiled gloves. The Nurse Consultant cued staff on the proper glove use, handwashing and removing multiple layers from under the resident and pressure reducing surface. e. Review of "Licensed Nurses Notes" included: 1) "5/31/09 (_Resident name) has redden area to lower buttock, Left and right heel. She is potential for breakdown will monitor and pass on to evening nurse." 2) "6/1/09 12:45 PM Resident dozing in W/C (wheelchair) in room ... Noted +3 pitting edema bilateral lower legs, L worse than R. Noted toes 1-5 on R foot scabbed, reddened around scabs, slightly warm to touch. Noted Blister on R (right) heel fluid filled open to air approx. quarter to 50 cent piece sized. Noted Coban on R wrist CDI (clean,dry,intact) hand slightly edematous. Res. left for apt. at hospital for IV abx (intravenous antibiotics)." There was no documentation the physician and the family was notified of the resident's blister or left foot trauma. (Cross refer to F157) 3) "6/19/09 Resident in bed R buttock examined, noted small pinch like blister on R	F 314		

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F 314	Continued From page 66 buttock, (sign for no) fluid noted in blister, no open areas noted. Baza applied. Noted scabs on L toes falling off, Cap (capillary) refill brisk. Noted on L heel dried into yellowish scab with small reddened area in center blanches slightly." 4) "6/25/09 ... PT (physical therapy) here to evaluate L heel wound, see yellow wound eval document per PT continue "Heels Off" (keeping pressure off of heels at all times..." 5) "6/25/09 Heels (__Sign for up) off mattress and off foot rest when in wheelchair. Blister type area L heel resolving." f. Review of the "Wound/Skin Evaluation and Documentation" sheet dated 6/25/09, the area on the heel was identified was unstaged and described as "yellowish scab like surface, length 4.8 cm, and width 2.9 cm". The area on the diagram was marked on the left heel. The treatment identified, "Treatment is keep all pressure off of heels at all times et have it open to air. Check minimum daily." There was no evidence that a wound sheet was started when the blister to the heel was identified or of treatment or interventions to address the resident's heels on 6/1/09. g. Review of resident #5's "Comprehensive Plan of Care" identified a problem of "Abrasion to top of toes left foot and blister to left heel". The date for this care problem looked to be 6/16/09 and was written over to be 6/10/09 which included, "Heels off bed and chair". However there was no evidence the plan of care was updated on 6/1/09 when the blister to the heel was identified.	F 314		

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F 314	Continued From page 67 The care plan did not identify the open area on the buttocks, skin tears to both upper arms, use of foam arm protectors, use of pressure reducing surfaces for bed and chair, or turning and repositioning for this dependent resident. Additionally there was no evidence that this resident who was assessed as being a high skin risk and at risk for pressure ulcers had a care plan to address preventative measures and services for skin care prior to the blister to the heel. The annual MDS assessment dated 3/26/09 and RAP dated 4/4/09 triggered pressure ulcers and proceed to care plan. There was no evidence provided to show pressure ulcers were addressed in the resident's plan of care 4/4/09. h. Review of the resident "Nutritional Assessment" dated 6/5/09 identified a weight loss of 6% in six months. It listed Med Pass TID as supplement foods. The physician order showed that Med Pass 30 cc TID was ordered 6/26/06. The RD's (Registered Dietitian) note identified the resident with chronic UTI, low albumin and extra protein supplement to help meet estimate needs. The diet listed was "pureed fortify diet". There was no indication that any changes/alternate interventions were made or addressed with the resident increased needs and skin breakdown. The resident was on MED Pass TID since 6/26/06. h. Review of the facility's policy and procedure for wound care revealed it did not address Stage IV (four) ulcers, blisters and unstageable wounds. It also was not followed as evidenced by not notifying the physician when wounds were identified for treatment orders.	F 314		

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F 314	Continued From page 68 Facility's policy and procedures included: WOUND CARE PROTOCOL, DOUGLAS CARE CENTER JAN 2008 1. Abrasion Cleanse with Wound Cleanser, leave open to air check Q shift. 2. Skin Tear: Cleanse area with Wound Cleanser, approximate edges, apply sterstrips as indicated, apply thin layer Vasoline cover with non stick Telfa & secure in place with hyper fix or stockinette. Check for s/s infection Q shift, change dressing Q day until area is resolved. 3. Stage I: Monitor daily, reposition off affected side @ least Q 2 hours. 4. Stage II: Cleanse with Wound Cleanser, apply Vasoline apply non stick telfa & secure in place with hyperfix or stockinette. Check for s/s infection Q shift, change dressing Q day PRN. Notify Dr. 5. Stage III: Wound Care Team to assess for appropriate treatment. Notify the Dr. Wound Care Team will assess each wound upon initial identification and weekly unless otherwise indicated. Physician will be notified of wound care to be used on each individual resident. If indicated treatment is unsuccessful, Wound Care Team will discuss alternative and notify physician. Changes in wound treatment must be preceded by physician order. Nurses' notes should reflect wound changes and success/failure of treatment. Treatment sheet will reflect changes as they occur with appropriate dates.	F 314		

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F 314	Continued From page 69 Charge Nurse will report any observations/concerns to team. Any changes in wound care will be made by Wound Care Team Only. 2. . Resident #8's medical record review revealed the resident was admitted to the facility on 3/29/09 with diagnoses which included: Alzheimer's disease, hypertension, senile dementia, osteoporosis, arthritis, and anxiety. a. On 7/20/09 at 3:10 PM on initial tour of the facility with Nurse (F) resident #8 was identified as being on Hospice Care, having leg contractures and skin breakdown behind the right knee. The area was described as being a recurrent pressure wound, Stage IV to the popliteal area. The resident was observed to be laying on a made bed which did have an air mattress set on 2 . [The mattress was later identified as supposed to be set at 5 by the Hospice nurse.] b. Review of the medical record revealed the resident was put on Hospice Care 1/30/09 with discharge 3/20/09 and readmitted to Hospice Care 5/27/09 for wound care. c. Review of "Doctor's Progress Notes" included: 1/23/09 "...continues to lose weight and has flexion contractures of both knees. She has an avoidable ulcer in the right popliteal space with exposed tendons, PT and OT has been working with the care team to try to improve this. Oral intake is very minimal. ... Short of feeding tubes etc. improving situation is next to impossible." [Note: During the survey the "Doctor's Progress Notes" were reviewed with the staff who contacted the physician and reported "avoidable" should have been "Unavoidable".]	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	07/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS CARE CENTER, WY 82633

(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 314	Continued From page 70 3/09/09 "...The ulcer in her popliteal space is virtually completely healed with Optifoam and this is a beautiful improvement. ... The wound in her right popliteal space is almost completely healed. ..Hospice service has been very helpful in caring for this severe wound." d. Review of the quarterly MDS assessment dated 4/20/09 had no ulcers or skin issues identified. e. Review of the significant change MDS (minimum data set) assessment dated 6/3/09 identified the resident as being totally dependent for care, having a Stage IV pressure sore and weight of 80 pounds. The assessment included: -Ulcers (number of ulcers at each stage) Stage 4. A full thickness of skin and subcutaneous tissue is lost exposing muscle or bone. marked as one. -Total dependence (full staff performance) with two staff persons physical assistance for bed mobility, and transfers. f. Review of "Licensed Nurses Notes" included: 5/24/09 "Noted to have blood on leg dsg. Area now open, will refer to wound care." 5/24/09 "NOC. Resident in shower. Skin assess (assessment) performed p wards (afterwards). Res. has some old areas that are healing. She has a Stage IV wound behind her R knee. Day nurse referred to wound care. Vaseline and Telfa with stockinette applied." [Note the facility protocol did not address Stage IV wounds.]	F 314		

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F 314	Continued From page 71 5/27/09 returned to Hospice Services. g. Observations and interviews for resident #8 included: 7/21/09 at 9:30 AM CNA (O) and (Y) transferred the resident with the mechanical lift from the Geri chair to the bed. The bed was made with two sheets, bed spread and soaker pad between the resident and the air mattress. The air mattress was set on "2". The resident had a guaze dressing behind the right knee held in place with a stockinette. The resident had flexion contractures of both legs. Staff (O) place sheepskin between the resident's knees. There was no splint or device used to open the right leg to reduce pressure to the popliteal area and the wound. 7/21/09 at 10:00 AM interview with CNA (Y) reported that resident #8 was one of the residents that the night shift gets up about 5:30 AM. The night shift is supposed to get up six to eight residents who are two person transfers and assist and do a couple baths before they leave at 6:30 AM. Based on the meal service and staff availability the length of time the resident was up in the Geri chair was a minimum of over three hours. 7/22/09 at 8:25 AM Hospice Nurse and CNA entered the resident's room to provide care. The nurse checked and reported that the air mattress should be set at "5". The air mattress was then turned up from 2 to 5. The resident was transferred by two person lift into bed and bed bath was given. After the bed bath, wound care to the pressure area behind the right knee was provided. The nurse reported the wound was improving. The nurse reported that the rolled	F 314		

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F 314	Continued From page 72 sheepskin was to be positioned between the right leg contracture (behind the knee) to reduce the pressure to the popliteal wound and a pillow was be used between the knees. The Nurse was asked about the inflatable cushion in the Geri chair. She reported she would follow up as she was unsure of the pressure rating for that device and if it was effective for meeting this resident's needs. The Nurse stated, "We have told them not to leave the transfer sling under her because it has left creases and mesh marks on her skin." 7/23/09 at 4:55 AM, CNA (U) went into resident #8's room. The CNA woke the resident up and reported she was going to get the resident dressed. The covers were then pulled back the resident was laying on her left hip. The resident did not have support or a positioning device to the right leg contracture or pillows to keep her knees from rubbing together. The air mattress was turned on 3. The CNA donned gloves, pulled back brief and wiped the resident's buttocks and rectal area. A small amount of feces was noted on wipes. The brief was pulled out without turning the resident. Then with the soiled gloves, the CNA placed a new brief under the resident, applied barrier cream and turned the resident to fasten the brief and turned the resident back on her left side without changing gloves. The CNA confirmed that the resident's brief was wet. The CNA failed to ensure the left hip was properly cleansed. The sheepskin was placed between the resident knees but no support or positioning device was used to support the right leg contracture. Staff then left the room and returned at 5:40 AM to get the resident into the Geri chair, using the mechanical lift. One staff was observed to turn this resident even though she was assessed as needing a two person assist with bed mobility; this increased the resident's risk for	F 314		

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F 314	Continued From page 73 skin tears, shearing, and pain. 7/23/09 at 11:45 AM, resident #8 was observed to be laying on top of the made bed with the air mattress set at 3. Nurse (F) was asked to come to the resident's room to verify the setting of the mattress and follow up with the resident's positioning. Nurse (F) placed the sheepskin between the right leg contracture and reported she would follow up with staff. h. Review of resident #8's "Comprehensive Plan of Care" identified a problem dated 5/27/09 as: "Impaired skin integrity Stage IV right popliteal area". The goal stated, "will be healed next 90 days". The approaches addressed monitoring of the wound, dressing changes, and Med pass 60 cc three times a day. The plan of care did not address the use of an air mattress and the appropriate setting to meet the resident's needs, pressure relieving device for the Geri chair, turning and repositioning, and the sheepskin use to splint the flexion contracture of the right leg. i. Review of the "Hospice Visit Note and Care Plan" sheets from 6/29/09 to 7/22/09 did not address the use of an air mattress and the appropriate setting to meet the resident's need, pressure relieving device for the Geri chair, turning and repositioning, and the sheepskin use to splint the flexion contracture of the right leg. A note on 7/20/09 stated, "HHA (Home health aide) 3 x (times) week facility staff for majority of care." j. Review of a FAX to the physician dated 6/22/09 identified the resident as having pain with wound care. The sheet noted, "Could we get a order for a pain med. Tylenol does not work, especially with wound care. Hospice nurse suggested something stronger then Tylenol if just for	F 314		

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F 314	Continued From page 74 pre-wound care." The response was, Lortab 5/500 is ordered PRN (as needed). If it is not please order this every 4 hours PRN". Lortab was given 6/24/09, 6/29/09 and 6/30/09. The facility failed to ensure there was an integrated plan of care to met this resident's skin care needs. The facility failed to ensure this resident who had pressure sores received necessary treatment and services to promote healing and pain management. Reference: Professional Standards of Practice: According to the CMS (Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 2.0 Manual, revised last in June, 2005, Chapter 3, page 3-160: "If necrotic eschar is present, prohibiting accurate staging, code the skin ulcer as Stage '4' until the eschar has been debrided (surgically or mechanically) to allow staging." According to the "Clinical Practice Guidelines, Pressure Ulcer Treatment" (pages 12-13) used by the facility as a treatment reference, a stage I pressure area is an area of erythema of "intact" skin. AA Stage II is a partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial & presents clinically as an abrasion, blister, or shallow crater. Inconsistent or inaccurate staging of ulcers has the potential for implementation of inappropriate or inadequate treatment. A stage III pressure ulcer is a full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. When	F 314		

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F 314	Continued From page 75 eschar is present, a pressure ulcer cannot be accurately staged until the eschar is removed. Eschar is described as thick, leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue that has lost its usual physical properties & biological activity. Eschar may be loose or firmly adhered to the wound. According to "Pressure Ulcers in Adults: Prediction and Prevention", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 3, "Any person at risk for developing a pressure ulcer should avoid uninterrupted sitting in any chair or wheelchair. The individual should be repositioned, shifting the points under pressure at least every hour or be put back to bed if consistent with overall patient management goals." According to "Pressure Ulcer Treatment", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 15, the resident should have an individually prescribed seat cushion which will relieve or reduce pressure on bony prominences. Support surface and positioning needs should be assessed and reviewed regularly and determined by results of skin inspection, patient comfort, ability, and general state. Covering these support services with bed linens, towels or incontinent pads decreases their effectiveness for pressure relief.	F 314		
F 323 SS=K	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	The facility will 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.	

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F 323	Continued From page 76	F 323		

This Requirement is not met as evidenced by:
I. Based on observation, record review and staff interview, it was determined that the facility failed to maintain safe water temperatures in the facility. This failure resulted in a potential for residents, staff, and visitors to be scalded or burned, constituting an immediate jeopardy situation. The findings included:

1. On 7/20/09 at 5:00 PM a concern with water temperature was identified in the public restroom. A check of the water temperatures found the temperature to be 123.3 F (degrees Farenheit). A further check of water temperatures included:
Nurse's station hand sink 122.0 F,
Shower east hall 113.5,
Tub room hand sink 120.0 F and tub 106.0 F,
Shower west hall 106.0 F.

2. Observations and interviews on 7/21/09 included:

a. At 7:45 AM a random check of water temperatures was done to follow-up on the previous days concern with hot water temperatures. The findings included:
Public restroom hand sink 116.2 F,
Sink at the nurses station 118.0 F,
Sink in the east tub room 113.8.

b. In an interview after checking the water temperatures, staff (I) reported the maintenance person was on medical leave and a Maintenance Consultant was coming from another facility to do the environmental tour and follow-up with the concerns of water temperatures.

3. On 7/21/09 at 11:40 AM, the public restroom

Maintenance staff or his designee will check water temperatures twice daily & as needed; and keep a log.

All staff has been in-serviced on reporting unsafe temperatures & checking water temperatures prior to each bath or shower.

Resident #12 is discharged.

Resident #3 will be transferred using gait belt.

Resident #26 was not admitted on 6/11/09. He was admitted on 6/19/09.

Residents #20 & #27 will have falls evaluated & appropriate interventions implemented.

Resident #17 has new arms for his wheelchair ordered.

All storage cabinets in the shower rooms are locked.

Supplies will not be left unattended.

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F 323	Continued From page 77 water temperature was very hot to touch. Starting at 11:45 AM, using the surveyors' digital thermometers, the following water temperatures (stated in degrees Farenheit) were obtained: a. Public restroom in front lobby: 139.6 Room 1: 139.3; This temperature was the same in a recheck in the presence of the Director of Nursing (DON), who was also present for the temperature checks in rooms 15, 5, and 12. (Note: The residents who resided in room 1 were able to access and use the water in their room.) Room 15: 130.8 Room 5: 127.8 Room 12: 126. b. On 7/21/09 at 11:50 AM, the hot water temperature in resident room #21 was 137.4 degrees Fahrenheit. In room #23 at 11:52 AM the hot water temperature was 137.5 degrees Fahrenheit. c. At 11:45 AM another surveyor asked for assistance to check water temperatures due hot water identified in the public restroom. Staff (Y) accompanied the surveyor to check water temperatures on the east hall which revealed: Resident room 24 water temperatures in the resident's hand sink was 138.0 F. Resident #19 was in room 24 and was identified by staff as ambulatory and able to use the bathroom independently. Sink in the east tub room 140.0 F.	F 323	In-service to all staff on keeping our environment as free from accident hazards as possible & to provide adequate supervision & assistance to prevent accidents. This will be audited weekly by DON or designee & reported monthly to CQI.	8/28/09

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F 323	Continued From page 78 The water temperature from the fill hose for the tub was 135.5 F. The hose was identified by staff (Y) as being used to fill the tub for the hot water due to the tub dial /control not working properly. The water temperature from the fill hose was 135.5 F. d. After identifying 140.0 F hazardous water temperatures in hand sinks, showers, and the tub the surveyors then went to the basement to check the boiler room. Upon entering the boiler room the surveyors were met by a staff member who identified himself as the Corporate Maintenance Consultant. He reported, "I'm having trouble with the mixing valve. I'm trying to get the water adjusted." There were three tanks identified as the hot water tanks with the temperature gauge noted at 146.0 F. The Corporate Maintenance Consultant confirmed that the three hot water tanks were on the water line supply going to the resident rooms. The mixing value was supposed to add cold water to the line to decrease the hot water temperature before going to resident rooms. He reported that he was told there had been a problem with the mixing value and the facilities maintenance man had ordered a new mixing value. The Corporate Nurse Consultant came into the boiler room and instructed the CMC to turn off the hot water. e. At 12:10 PM the Corporate Nurse Consultant reported that the hot water was shut off and the CMC was working on cooling down the water in the hot water tanks. f. In an interview with Staff (F) at 12:12 PM, the staff member stated, "I was not aware of a water problem until yesterday when you were checking water temperatures. We had not been told about a mixing valve problem. Staff (I) told me	F 323		

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F 323	Continued From page 79 yesterday a mixing valve was ordered. We called __(name facility's maintenance man) yesterday and found out it was a problem." 4. At 12:04 PM, the acting Administrator (AA) was notified that a serious situation, which needed immediate attention, had been identified. The immediate jeopardy problem related to very hot water in resident rooms. The AA reported that the problem was a mixing valve and the Maintenance Manager (MM) had ordered the mixing valve on 7/8/09. The AA revealed that she had not been informed of this problem until Thursday (July 16 th). In an interview with the AA, DON, and nurse (F), they verified that they were not made aware of the hot water issues. 5. At 12:30 PM, in an interview with the AA, DON, nurse (F), and the corporate nurse (H), they were requested to provide a copy of the invoice for the mixing valve, water log, and incident reports. 6. The CMC had turned off the hot water supply in the entire facility. At 12:45 PM, the surveyors verified that the hot water was shut off. 7. At 2:10 PM, the AA reported that there were no incident reports related to residents being burned by hot water. 8. The CMC stated that he had the water set at 104 degrees F. He confirmed that staff would have thermometers to monitor the water temperatures. 9. Review of the faxed letter from the plumbing supply company evidenced "A new mixing valve was ordered on July 8, 2009 from the factory,	F 323		

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F323	Continued From page 80 shipped on July 14, 2009, due to arrive on Thursday July 23, 2009." 10. Review of the facility's water logs evidenced that there were no documented temperature spikes or problems which would require the ordering of a mixing valve. 11. At 2:52 PM, in an interview with the AA, she stated that she had contacted the facility's MM who was at the time not available to work. She reported that the MM had come into the facility on 7/7/09 at 1:00 AM because a squirrel had chewed some of the wiring. At this time there was not enough hot water, so he increased the water temperature in the boiler. He ordered the part on 7/8/09. The facility gave the survey team a plan of correction describing their efforts to abate the immediate Jeopardy situation and to prevent its re-occurrence. The immediate jeopardy situation was abated on 7/21/09 at 3:35 PM. Prior to the surveyor team exiting the facility, the AA provided evidence that all nurses on duty had been inserviced and the trainer was in the building preparing to inservice the oncoming night shift. Following the abatement, the deficient practice would be at a pattern with a potential for more than minimal harm. "Plan of Correction 7/ 21/09": "Maintenance personnel turned off the hot water immediately at 12:15 PM. The water at the nurses station was tested to ensure the hot water was completely off. It was also tested in the bathroom downstairs and resident room #28. No hot water is accessible to any resident, staff or visitors.	F 323		

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Staff that were serving in the dining room were inserviced at 12:20 PM to not use any hot water that it is critically hot and not safe to use until further notice. Inservice was conducted with all staff at 1:10 PM regarding safe water temperatures. See attached inservice sheet.

It was announced overhead, "Attention all staff do not use the hot water until further notice." Signs were posted at 12:20 PM at the front door, in the bathrooms and at the nurses station, in the kitchen, in laundry and at all exits that stated, "Do not use the hot water until further notice."

Maintenance staff began draining the hot water at 12:30 PM. The hot water system feeds to the kitchen, bathing areas and throughout the building. Emptying the tank eliminates the risk for burns.

Dietary department will use paper service until water temperatures are at a safe range. The laundry service will be done outside the facility if necessary or chemically sanitized when water temperature are at a safe range to sanitize the laundry.

The water temperature is set less than 110 degrees F. and will remain at that temperature until the mixing valve arrives and repair is completed. Mixing valve will arrive by 7/23/09. The water temperature will be checked before each bath or shower is given.

Maintenance staff or designated staff will check water temperatures until a safe range is maintained for at least 4 hours and will be checked every 8 hours for 3 days and daily thereafter. A log will be kept of all temperatures taken.

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F 323	Continued From page 82 All staff will be educated on reporting unsafe temperatures and checking water temperatures prior to each bath or shower." II. Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure that the environment was as free of accident hazards as possible and that safe transfer techniques were utilized. The failure to safely transfer residents affected two of 12 sample residents (#12 and #3) and four supplemental residents (#20, #26, #17, and #27). The findings included: 1. On 7/21/09 at 3:00 PM, a review of the facility's incident reports evidenced that the facility's safety committee met on 7/21/09 and reviewed the incident reports for residents who experienced falls. A sample of these reviewed forms revealed that resident #20 fell on 6/8/09, resident #26 fell on 6/11/09, resident #12 fell three times on 6/13/09, and resident #27 fell on 6/14/09. 2. On 7/21/09 at 3:25 PM, in an interview with nurse (F), she confirmed that the safety committee met "today". She was not sure when the last meeting of the committee occurred. The facility failed to review and develop or change care plan interventions in a timely manner. 3. On 7/23/09 at 5:25 AM, two CNAs (Q and R) were observed transferring resident #3 to the wheelchair and then to the toilet. The staff lifted the resident under his/her arms during both	F 323		

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	535040	A. BUILDING _____ B. WING _____	07/24/2009

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F 323	Continued From page 63 transfers. When the resident was transferred off the toilet, a gait belt was used. The facility's Gait Belt Policy Statement stated "Gait belts will be used by employees to transfer and ambulate residents unless contraindicated on the resident's care plan." 4. On 7/23/09 at 1:05 PM, the arm rests on resident #17's wheelchair were cracked. There was clear tape on the arm rests but this tape had peeled, leaving cracked plastic. This cracked arm rest created a potential for the resident to get skin tears. 5. On 7/20/09 at approximately 3:00 PM, during the initial tour of the facility observations were made of an unlocked shower room which contained an unlocked storage cabinet. A key was inserted in the lock which was observed to lock and unlock the cabinet. Inside the cabinet the following items were found: a. Ecolab Antibacterial - All Purpose Cleaner the label revealed a warning of Keep out of the reach of children, Hazardous to humans and domestic animals. b. Apricot Shampoo & Body Wash - External use only. Avoid contact with eyes. c. Lobana body lotion - External use only d. One pair of nail clippers 6. On 7/20/09 at approximately 3:00 PM, during the initial tour of the facility observations of the unattended Nurses Station found an open cardboard box containing the following:	F 323		

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F 323	Continued From page 84 a. 1 bottle 1000 count Acetaminophen 500mg. b. 2 packaged bottles of 100 count Tylenol 325mg. c. 4 packages Muncinex d.1 box Lancet Safety Pressure Activated.	F 323		
F 325 SS=E	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident 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. This Requirement is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to ensure that four of 12 sample residents (#4, #7, #5, and #9) maintained acceptable nutritional parameters. The facility failed to assess the residents' nutritional status and implement nutritional interventions in a timely manner when the residents experienced significant weight loss and/or skin breakdown and failed to document residents' supplement intakes in order to evaluate the effectiveness of planned nutritional interventions. The findings included: 1. On 7/22/09 at 4:00 PM, in an interview with the interim Dietary Manager (DM), she indicated that a resident would receive a "fortified" diet when ordered by the physician usually based on a recommendation by the Registered Dietitian (RD). The DM explained that the fortified diet was fortified milk (one gallon milk plus four cups of non-fat dry milk powder) and was also used in	F 325	Resident #7 has expired. Resident #4's supplement list indicated full assistance. The Med-Pass increased to 90 cc TID. Resident #9 will have weekly weights documented on vital record. Care plan updated to weekly weights. Dietary assessment was completed to include weight loss and nutritional risks. Resident #5's dietary assessment includes low albumin, extra protein needs and skin integrity. In service to all staff on acceptable parameters of nutritional status. Weight committee to meet each Friday to implement interventions and monitor weight issues. Results of the weight committee will be submitted to CQI monthly for 1 year to determine continued compliance.	Completed by 8/28/09

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F 325	Continued From page 85 place of Boost. The DM confirmed that the residents' fluid intake which was charted on the Meal Intake sheets included the total amount of supplement/fortified milk and that snack intake was not charted. Further, the DM verified that the RD currently was doing the nutritional assessments, including the Minimum Data Set (MDS) assessments, for the residents 2. On 7/24/09 at 7:50 AM, in an interview with the RD, he revealed the residents were weighed on Wednesday or Saturday by any Certified Nurse Aide (CNA) and that if there was a variance in the resident's weight, a re-weight would be done. He verified that the supplements/fortified milk and snacks were not charted separately. During this interview, the RD was questioned about his plan for nutritional interventions for resident #7. This plan included 90 cc (cubic centimeters) of Med Pass (supplement) three times a day, a fortified diet, and milk (Boost). 3. Record review for resident #7 revealed that the resident had diagnoses that included aphasia, congestive heart failure, heart attack, osteoporosis, urinary tract infections, depression, and stroke. a. Review of the resident's 4/28/09 significant change MDS assessment evidenced that the resident was independent with all activities of daily living (ADLs) except bathing, for which the resident required extensive assistance. b Review of the resident's Physician Order Report (effective 7/1/09) revealed that the resident was to receive a fortified regular diet with a consistency (texture) as tolerated (origin date 7/1/06) and Med Pass 30 cc three times a day	F 325		

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F 325	Continued From page 86 (2/19/08). On 12/19/08 there was telephone order for the resident to receive a fortified diet and Med Pass or similar 90 ml (milliliters) three times a day for weight loss. Review of the resident's Physician Order Report (effective date 7/1/2009) listed the regular diet, fortified food (with an order date of 12/19/08) and Med Pass 30 cc three times a day with meals (with an order date of 1/27/09). There was no telephone order dated 1/27/09. Review of these orders revealed that there were discrepancies in the orders with no evidence of the actual orders being given by the physician. The RD's plan was not implemented. c. Review of the resident's meal (tray) card noted that the resident was to receive a fortified regular diet of a regular texture. The resident was listed to receive 6 ounces of fortified milk at each meal. d. Review of the facility's weight tracking form evidenced the following weights (in pounds) for this resident: 7/08 - 153 8/08 - 155 9/08 - 154 10/08 - 152 11/08 - 154 12/08 - 146 1/09 - 148 2/09 - 152 3/09 - 151 4/09 - 152 5/09 - 145 6/09 - 144 7/09 - 142.5. e. Review of the facility's vital signs record evidenced the following weights (in pounds) for	F 325		

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F 325	Continued From page 87 this resident: 8/25/08 - 153.2 9/6/08 - 153.6 9/13/08 - 155.3 10/4/08 - 152.1 10/25/08 - 121.4 3/1/09 - 150.5 4/1/09 - 152.3 5/2/09 - 148 6/1/09 - 141.9. There were discrepancies in the weights as documented on the weight record and the vital sign forms. f. Review of the resident's 5/09 and 6/09 Medication Administration Records (MARs) and 7/09 Physician Order Flow Sheet (used as a MAR) revealed that the resident was receiving 30 cc of Med Pass three times a day with order dates of 12/19/08, 12/19/08, and 2/19/08, respectively. g. Review of the resident's care plan evidenced that the 5/21/09 problem of "potential for further weight loss R/T (related to) decline in condition" included approaches of fortified food program, Med pass 30 cc three times a day, and monitor and record weight every month. h. Review of the resident's dietary progress notes written by the RD (except for the 6/2/09 note which was documented by the DM) evidenced the following: 12/19/08 - "Res seen secondary wt (weight) loss of 5.4 % in 1 mo, 5.2 % 3 mo, 5.5 % in 6 mo. ... At this point we could look at diet fortified yet due to acute medical events with wt loss I feel we will	F 325		

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F 325	Continued From page 88 start weekly wts...if wt loss not improving then start supplement." 12/19/08 - "Wt team met - Fortify diet, Add Med Pass." 1/22/09 - "Wt @ 147.7 #, increase about 2 # ...P (plan) F/U prn (as needed) after Feb wt." 2/13/09 - "... P: Cont interventions..." 4/10/09 - "Wt @ 152.3 # Stable ... P: No change, follow.." 5/1/09 - "Wt 151 #..." 5/15/09 - "Wt down to 143 #. ... Accepts Med Pass, but we will also try Boost TID (three times a day) with a 3 day trial. Res won't accept any feeding assistance. .." 5/22/09 - "... MD (doctor) faxed on continued wt loss and poss (possible)...if med change may help with intake & wt goal. Res accepting supplements and sweets better than meals yet intake overall is poor (<25 %) Wt @ 138.4 #...P: await possible med change from MD." 6/2/09 - "Resident not eating ..." i. Review of the resident's Diet Order & Communication" form dated 12/19/08 noted that the resident was to receive a regular, fortified diet with Med Pass 90 ml TID. j. Review of the Fax form dated 5/22/09 from the RD to the resident's physician regarding Wt loss evidenced the following: "Res with significant weight loss over time. 152 #	F 325		

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F 325	Continued From page 89 (4/09), 144 (5/09), 138 # (this week). Diet is Regular, Fortified, Boost TID, Med Pass TID. Overall intake is poor (<25 %). Accepts supplements and desserts a little better. Res not leaving ___(his/her) room for meals very often. Refuses some meals. Staff, RN, reports some depressive symptoms yet not fully known if symptoms have increased during this Paxil taper/wean (MD note 5/6/09). As documentation of Depressive Symptom - stable. There has been an increase in lethargic documentation Symptoms. Please advise if medication change, Appetite stimulate, would help with intake/wt loss, or continue to monitor after recent change." ____(name) RD." There was no evidence to show that the physician responded to the request for an appetite stimulant. However, there was a 5/22/09 telephone order to "Restart Paxil 20 mg PO. (orally) qd (daily)." There were no more RD/DM notes after 6/2/09. k. Review of the physician's progress notes evidenced that the physician visited the resident on 12/17/08 and 5/6/09. On 7/24/09 at the exit conference the Director of Nursing verified that the physician had not made any other visits to the resident and the resident had not been hospitalized. This resident who was assessed as nutritionally at risk had experienced weight loss in the recent past. There was no evidence to show that the facility had implemented the RD's recommendations and/or physician orders for	F 325		

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F 325	Continued From page 90 nutritional interventions related to the resident's weight loss. Based on interview, the facility was providing fortified milk as the fortified diet and also as Boost. So for this resident, he/she was getting fortified milk with his/her meals, but no additional Boost or fortified food. The nursing staff were giving the resident's 30 cc of Med Pass three times a day, instead of the ordered 90 cc of Med Pass three times a day. 4. Record review for resident #4 revealed that the resident was admitted 1/23/08 with diagnoses that included bipolar, manic depression, stroke, breast cancer, congestive heart failure, and pain. a. Review of the resident's 5/6/09 significant change Minimum Data Set (MDS) assessment evidenced that the resident was assessed to need extensive assistance with bed mobility, transfer, and eating and total assistance with toilet use and bathing. b. Review of the facility's weight tracking form evidenced the following weights (in pounds) for this resident: 7/08 - 146 8/08 - 147 9/08 - 146 10/08 - 142 11/08 - 141 12/08 - 133 1/09 - 132 2/09 - 130 3/09 - 129 4/09 - 127 5/09 - 125 6/09 - 125.1 7/09 - 121.4.	F 325		

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F 325	Continued From page 91 c. Review of the resident's Nutritional Assessment dated 7/10/09 revealed that the resident was on an "as tolerated fortified diet with puree and thickened liquids", had lost 7 % in 6 months, was consuming < (less than) 10 %, and required increased assistance and cueing. This assessment indicated that the resident was being followed by the IDT. d. Review of the 10:00 AM, 2:00 PM, and HS (bedtime) supplement lists evidenced that this resident was to receive a 2:00 PM supplement of ice cream and was to feed self. No 10:00 AM or HS supplements were listed for the resident. e. Review of the resident's physician orders revealed that the resident was to receive 60 cc Med Pass three times a day. f. Observation during the evening meal on 7/21/09 and the noon meal on 7/22/09 revealed that the resident consumed only a bite or two of food. He/she did drink the fortified milk and hot chocolate with extensive assistance. During the RD interview on 7/24/09 at 7:50 AM, resident #4's meal consumption of only milk and hot chocolate was discussed. There was no evidence that the facility attempted to increase the resident's intake by providing more high calorie, high protein liquids or supplements. The RD's recommended plan was not implemented. 5. Record review for resident #9 revealed that the resident was re-admitted to the facility on 5/9/09 after a hospitalization with diagnoses that included fractured hip and fecal impaction/mega colon. a. Review of the resident's 4/21/09 quarterly MDS	F 325		

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F 325	Continued From page 92 assessment evidenced that the resident was assessed to require total assistance for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing and extensive assistance with eating. b. Review of the facility's weight tracking form evidenced the following weights (in pounds) for this resident: 7/08 - 120 8/08 - 123 9/08 - 126 10/08 - 122 11/08 - 122 12/08 - 116 1/09 - 119 2/09 - 114 3/09 - 116 4/09 - 125 5/09 - 121 6/09 - 125.7 7/09 - 127.5. c. Review of the facility's vital signs record evidenced the following weights (in pounds) for this resident: 8/2/08 - 123.1 9/6/08 - 125.5 10/4/08 - 122 10/25/08 - 121.4 1/3/09 - 118.8 2/5/09 - 114.2 3/1/09 - 116.1 3/15/09 - 124 4/1/09 - 124.8 4/11/09 - 129 5/1/09 - 127.9 weight was crossed off and 119.8 written in	F 325		

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F 325	Continued From page 93 6/1/09 - 127.9. There were discrepancies in the weights as documented on the weight record and the vital sign forms. d. Review of the resident's physician orders revealed an order dated 6/12/06 for a weekly weight. e. Review of the resident's care plan revealed a problem for wt loss/dehydration with an approach of weigh monthly and record. f. Review of the resident's 4/09, 5/09, 6/09, and 7/09 Treatment sheets revealed a section for the weekly weights to be done on Saturday. No weights were recorded in this section for the four months reviewed. On 6/6/09 a staff initial was written in the space. g. Review of the resident's dietary progress notes were as follows: 2/13/09 "Res (resident) followed by IDT (interdisciplinary team) secondary wt (weight) loss and behavior with diet ... P (plan): follow (?) IDT, sweetened foods and monitor for improved intake & wt maintenance." 2/20/09 "... accepting sweetened food....changes." 2/25/09 "Resident is down in weight, ----- (he/she) is fortified and on med pass, resident still is not eating or drinking a lot....I have recommended to nursing to put resident's on Boost. .." 2/27/09 - "Agree with above, we also ordered Megace to try and help with some wt gain..."	F 325		

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F 325	Continued From page 94 3/13/09 "Diet change to puree meat, mech (mechanical) soft with thin liquid. Seems to be tolerated at this point...Res has been loving the supplements ....wt at 116 # (pounds), increase about 2 # from last month...P: positive change of recent, follow by IDT, continue to F/U (follow up) with wts & observation." 4/3/09 "Wt on (3/28) - 124.8 # - Intervention working - follow" 5/1/09 "IDT met, yesterday wt was 119.8 #. ..Re-wt requested as it was felt ___(he/she) had not declined 6 # from 4/25 (approx 5 days). ... P: R/O (rule out) acute illness, Cont (continue) with interventions & re-wt after very good Brk (breakfast) intake this AM (morning)." No other dietary progress notes were found for this resident. There was no evidence that the RD or DM had continued to assess this resident who had a history of weight loss, whose weight appeared to be fluctuating, and who had been hospitalized for a fractured hip and fecal impaction/mega colon. This resident was high risk nutritionally. 6. Resident #5 medical record review revealed the resident was admitted to the facility on 10/29/99 with diagnoses which included: CHF (congestive heart failure), heart disease, hypertension, dementia, osteoarthrosis, RA (rheumatoid arthritis), anxiety and fractured femur. a. Review of the significant change MDS (minimum data set) assessment dated 6/3/09 identified the resident as being total care and as having skin ulcers.	F 325		

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F 325	Continued From page 95 b. Review of the resident's "Nutritional Assessment" dated 6/5/09 identified a weight loss of 6% in six months. It listed Med Pass TID as supplement foods. The physician order showed that Med Pass 30cc tid was ordered 6/26/06. The RD's note identified the resident with chronic UTI, low albumin and extra protein supplement to help meet estimate needs. The diet listed was pureed fortify diet. There was no indication that any changes/alternate interventions were made or addressed with the resident's increased needs and skin breakdown 6/5/09. The resident had been on MED Pass TID since 6/26/06 (three years). (Cross refer to F314) Reference: 2005 American Dietetic Association, Scope of Dietetics Practice Framework, Standards of Practice in Nutrition Care for the Registered Dietitian (RD) " STANDARD 2: NUTRITION DIAGNOSIS The registered dietitian identifies and describes an actual occurrence, risk of, or potential for developing a nutrition problem that the registered dietitian is responsible for treating independently. Rationale: At the end of the assessment step, data are clustered, analyzed and synthesized. This will reveal a nutrition diagnostic category from which to formulate a specific nutrition diagnostic statement. A nutrition diagnosis changes as the client response changes, whereas a medical diagnosis does not change as long as the disease or condition exists. There is a firm distinction between a nutrition diagnosis and a medical diagnosis. The main difference	F 325		

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F 325	Continued From page 96 between the two types of diagnoses is that the nutrition diagnosis does not make a final conclusion about the identity and cause of the underlying disease. A client may have the medical diagnosis of "Type 2 diabetes mellitus"; however, after performing a nutrition assessment, the RD may determine a nutrition diagnosis(es) with nutrition diagnostic labels for example, "excessive energy intake" or "excessive carbohydrate intake". In the community or public health setting the nutrition diagnosis may relate to a population based condition (food safety and access) rather than a medical diagnosis. Examples of nutrition diagnostic labels may then be "intake of unsafe food" or "limited access to food". The nutrition diagnosis(es) demonstrates a link to setting realistic and measurable expected outcomes, selecting appropriate interventions and tracking progress in attaining those expected outcomes." " STANDARD 3: NUTRITION INTERVENTION The registered dietitian identifies and implements appropriate, purposefully planned actions designed with the intent of changing a nutrition-related behavior, risk factor, environmental condition, or aspect of health status for an individual, target group, or the community at large. Rationale: Nutrition intervention involves a) selecting, b) planning and c) implementing appropriate actions to meet clients' nutritional needs. The selection of nutrition interventions is driven by the nutrition diagnosis and provides the basis upon which outcomes are measured and evaluated. An intervention is a specific set of activities and associated materials used to address the problem. The registered dietitian may actually perform the interventions, or may delegate or coordinate the nutrition care that	F 325		

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F 325	Continued From page 97 others provide. All interventions must be based on scientific principles and rationale and when available grounded in a high level of quality research (evidence-based interventions). The registered dietitian works collaboratively with the client, family, caregiver or community to create a realistic plan that has a good probability of positively influencing the nutrition diagnosis/problem. This client driven process is a key element in the success of this step, distinguishing it from previous steps that may or may not have involved the client to this degree of participation." According to the CD-HCF (Consultant Dietitians in Health Care Facilities) Pocket Resource for Nutrition Assessment 2001 Revision, page 2, a "Nutrition assessment is a comprehensive approach completed by the dietetic professional to define nutrition status which employs medical history, nutrition intake, nutrition history, medication, physical examination, anthropometric measurements and laboratory data. Nutrition assessment includes interpretation of data from the screening process. The assessment process includes a review of other disciplines' data that may affect the assessment process such a physical therapy, occupational therapy, speech therapy, etc. It includes the organization and evaluation of information to declare a professional judgment. Nutrition assessment precedes a care plan, intervention and evaluation."	F 325		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This Requirement is not met as evidenced by:	F 332	Resident #1 has been discharged Residents #33 and #34 receive medication on time Resident #7 has expired.	

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F 332	Continued From page 98 Based on observation, record review, and staff interview, it was determined that the facility failed to ensure that three of 12 sample residents (#1, #7, and #11) and three supplemental residents (#33, #34, and #25) received their medications free of medication errors. A total of 41 medications were observed to be given by a total of two nurses. Fifteen medication errors were made, resulting in a 36.5 % medication error rate. The findings included: 1. On 7/21/09 at 7:50 AM, during a medication pass observation with nurse (B), she administered resident #1's medications, including one Mucinex 600 mg (milligrams) tablet. The nurse indicated that the resident was also to receive Zyrtec but that she wasn't sure if the medication by the generic name was the correct medication. She said that she would call the doctor and check. Later in the day, she reported that she had called and that it was the correct medication. When asked if she gave the medication, she hesitated and then said "yes". Review of the resident's physician orders evidenced that the resident was to receive Mucinex 600 mg two tablets. Review of the resident's 7/09 Medication Administration Record (MAR) revealed that the resident was to receive Mucinex 600 mg two tablets and that the Zyrtec was not charted as given. This counted as two medication errors (wrong dosage and omission). 2. On 7/21/09 at 9:00 AM, during a medication pass observation of nurse (D) with nurse (C) assisting, nurse (D) prepared and administered	F 332	Resident #11 has received the correct amount of insulin as ordered. Resident #25 received medication on and receives calcium carbonate 600/200 as ordered. All nursing staff have been in serviced on providing medications to residents as ordered by the physician. Medication pass audits will be completed weekly to determine compliance. Audits will be reported to CQI monthly for 1 year to determine continued compliance. Completed by 8/28/09	

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F 332	Continued From page 99 medications to resident #33. These medications included Accupril 40 mg and Metoprolol 50 mg which are antihypertensive medications. According to the resident's 7/09 MAR, the medications were to be given at 7:00 AM. These medications were given two hours after the scheduled time. This counted as two medication errors. 3. On 7/21/09 at 9:06 AM, during a medication pass observation of nurse (D) with nurse (C) assisting, nurse (D) prepared and administered medications to resident #34. These medications included iron. According to the resident's 7/09 MAR, the medication was to be given at 7:00 AM. This medication was given two hours after the scheduled time. This counted as one medication error. 4. On 7/21/09 at 9:22 AM, during a medication pass observation of nurse (D) with nurse (C) assisting, nurse (D) prepared and administered medications to resident #7. These medications included Potassium Chloride ER, Plendil ER, Inderal LA, and Prinivil. Nurse (D) was observed to open the Inderal LA capsule and combined it with the crushed ER medications. These medications were mixed in applesauce and given to the resident. The resident was not given any water after he/she took the medications. The resident's blood pressure and pulse were not checked by the nurse prior to the administration of the Inderal LA. Review of the resident's 7/09 MAR evidenced that the Prinivil was to be given at 7:00 AM. This medication was given two hours and twenty minutes after the scheduled time.	F 332		

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F 332	Continued From page 100 According to the Nursing 2010 Drug Handbook, Lippincott, 30 th Anniversary Edition: Inderal LA is to be given consistently with meals and a blood pressure and apical pulse are to be checked before the medication is given. Plendil ER is to be given whole and not crushed. Potassium ER is not to be crushed. This counted as four medication errors. 5. On 7/21/09 at 9:38 AM, during a medication pass observation of nurse (D) with nurse (C) assisting, nurse (D) prepared and administered a medication to resident #11. The medication was a Fentanyl patch. When nurse (D) applied the patch, the resident stated that he/she had not received his/her morning insulin. The nurses (C and D) explained that the resident's Lantus insulin, which was scheduled to be given before breakfast, was held because his/her blood sugar was below 100 (was 93). The resident told the nurses that 93 was not low for him/her and that the insulin had not been held before. The nurses insisted on the resident having another finger stick blood sugar done before he/she could receive the insulin injection. The resident's blood sugar was 136. Nurse (D) prepared the insulin, but there was a large air bubble in the syringe and the amount was not quite 10 units. The nurse (D) asked the surveyor if it was correct. The surveyor indicated that nurse (C) should check the insulin. Nurse (C) instructed nurse (D) to start over due to the air and the amount of insulin in the syringe. After the medication was prepared again, nurse (D) administered the insulin.	F 332		

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F 332	Continued From page 101 Review of the resident's physician orders failed to show an order to hold the resident's insulin for a blood sugar less than 100. According to the Nursing 2010 Drug Handbook, Lippincott, 30 th Anniversary Edition: Lantus insulin has an onset of one hour, does not peak, and lasts for 24 hours. This counted as one medication error. 6. On 7/21/09 at 10:24 AM, during a medication pass observation with nurse (B), she administered resident #25 6 medications, including Calcium Carbonate, Diovan, Presevation, Prilosec, and Synthroid. The resident was out of the building for a doctor appointment (8:15 AM). The Diovan, presevation, Prilosec, and Synthroid were all scheduled to be given at 7:00 AM (prior to the resident leaving for the appointment). The nurse administered Calcium Carbonate 600/400 (600 mg calcium and 400 iu of Vitamin D). Review of the resident's physician orders revealed that Calcium Carbonate dose was 600/200. This counted as five medication errors.	F 332		
F 353 SS=F	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	F 353	The facility will provide adequate staffing to provide care and services in accordance with resident assessment and care plans.	

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F 353	Continued From page 102 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This Requirement is not met as evidenced by: Based on the observations, record review, and resident, family, and staff interviews, it was determined that the facility failed to provide sufficient, qualified nursing staff to meet the needs of the residents. The facility had a census of 48 residents. The direct resident care was provided by certified nurse aides (CNAs) with the nurses passing medications and doing treatments. The failures were evidenced by the deficient practices cited in this survey report and residents, family, and staff who complained about the shortage of staff to assist the residents with their activities of daily living (ADLs). The nurses failed to follow current professional standards and the facility's policies for diabetic management, for pain management, for bowel monitoring and management, when administering medications and narcotics, and when assessing residents. The findings included: 1. On 7/21/09 at 5:20 PM, in a family interview, the family member indicated that his/her family member (resident) was not always kept clean or	F 353	Administrator will review daily staffing posted to determine adequate numbers of staff for each shift. The Director of Nursing services will report to Administrator if there are problems with the staffing schedule that could impact care and services. Daily rounds completed by Administrator will determine compliance with staffing numbers and provision of care and services. Results of audit will be reported to CQI monthly for 90 days to determine continued compliance. Completed by 8/28/09	

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F 353	Continued From page 103 cleaned up timely after being incontinent. 2. On 7/23/09 at 5:00 AM, during the observation of morning cares, one resident, who was awakened to get up, was asked if he/she likes getting up early. The resident commented that he/she doesn't know whether or not he/she likes getting up early, but just does it. 3. On 7/23/09 at 4:45 PM, in a family interview, the family member reported that there was not always enough staff to meet the residents' needs. The family member indicated that his/her family member (resident) was not always cleaned up in a timely manner after the resident experienced diarrhea. The family member rated the facility as "only fair" and commented that staff are observed just sitting at the nurses' station chatting when residents needed assistance. 4. 7/21/09 at 10:00 AM interview with CNA (Y) reported that resident #8 was one of the residents that the night shift gets up about 5:30 AM. The night shift is supposed to get up six to eight residents who are two person transfers and assist and do a couple baths before they leave at 6:30 AM. 5. 7/23/09 from outside the facility at 4:45 AM staff were observed assisting resident #16 with cares and using a mechanical lift. Upon entering the facility CNA (T) was observed pushing resident #16 down the hall in a shower chair and into the shower room. 6. 7/23/09 at 4:55 AM CNA (U) went into resident #8's room. Resident #8 was identified as being on Hospice. The CNA woke the resident up, reported she was going to get the resident dressed and	F 353		

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F 353	Continued From page 104 proceeded with care. The CNA was observed turning and moving the resident in bed by herself. The resident had been assessed as being a two person assist with bed mobility and high risk for skin tears. The resident was noted to have leg contractures which increased the difficulty of one person providing care and increased the resident's risk for skin tears and shearing. Interview with the CNA confirmed that the two CNAs on night shift had a "get up list". They were to get the residents dressed and into their chairs. The residents on the list were total care and two person assist with transfers. However the CNA reported that each CNA does cares on their own and then assist each other with transfers. CNA (U) reported that if two person cares were done they would not get done by 6:30 AM. The CNA also confirmed that residents were awakened for cares and night staff had two or three showers to do before leaving at 6:30 AM. 7. Observations of the medication pass identified late medication administration. Refer to F281 and F332 for details. 8. On 7/21/09 at 3:50 PM, during the Resident Group interview it was revealed that the response to call lights can take a "pretty long time", "Sometimes an hour." 5 of 6 residents attending the interview agreed that response to call lights is slow. 9. On 7/21/09 at 9:30 AM, an interview with a family member for a resident revealed that the family frequently visits with the resident and that on several occasions they have observed that call lights are not answered in a timely basis. The interview further revealed that on one occasion the call light was observed by another family	F 353		

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F 353	Continued From page 105 member to have gone unanswered for more than one hour. 10. On 7/21/09 and 7/22/09, during meal observations, residents who were able to feed themselves but needed assistance and/or cueing were not provided these services by the facility staff. The staff were observed to be busy assisting residents who required extensive to total assistance with eating. Additionally, when the dietary staff indicated that the food was ready to be served, staff were not present to begin serving the meals. a. On 7/21/09 during the evening meal service resident #37 was observed seated in dining room. The resident waited and watched the meal service. At 5:30 PM the first tray was served to the more independent residents. The resident observed his/her entire table served. As the next tray was served to the next table the resident waved at staff asking about his/her tray. The resident was clearly distraught. The resident was told it would be along shortly. The next table was served completely and room trays deliveries were started. At 5:45 PM, the resident again ask the same staff member about his/her food. The same staff acted surprised and returned with a tray. b. On 7/22/09, during the noon meal service resident #39 was observed trying to poor coffee from a thermos. The thermos was large, heavy and awkward for the resident to handle. The resident gave up for awhile and trying again a few moments later. Another resident sitting next to resident #39 struggled to assist. The lid to the thermos was unscrewed and a very small amount of coffee (one swallow) was poured into a cup. The resident continued trying to pour more	F 353		

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F 353	Continued From page 106 coffee, eventually removing the thermos lid entirely, exposing the hot coffee. This surveyor requested immediate assistance from staff. Several residents at other tables were observed to have similar issues. c. On 7/22/09 during the noon meal observations (12:00 PM - 1:10 PM) revealed that the tray service was slow. Initially there were multiple staff assisting with the delivery of trays to residents. As the higher level of care, residents were served the staff providing feeding assistance would stop serving and begin individual assistance. The more independent residents were served last. Resident #15 was seated in the dining room at his/her usual place. At 12:59 PM resident #15 had not received his/her tray. All residents in the dining room had been served. The delivery of room trays began. The resident wheeled to the kitchen service area, spoke with kitchen staff, and then left the dining room. At 1:15 PM an interview with resident #15 revealed, "This is the third time that this has happened." Refer to F311 for additional details. d. On 7/21/09 at 5:45 PM in an interview, staff, who wished not to be identified, voiced concern with staffing. Staff reported, "We are short of help in the dining room. There are three CNAs on and the fourth one who is here until 8:00 PM. Residents don't get the assistance they need because staff can't be in two different places "	F 353		
F 354 SS=F	483.30(b) NURSING SERVICES - REGISTERED NURSE Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 354	There will be an RN on duty for 8 consecutive hours, 7 days a week. RN coverage will be posted on the licensed staff schedule.	

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	535040	A. BUILDING _____ B. WING _____	07/24/2009

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F 354	Continued From page 107 Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to provide eight consecutive hours of Registered Nurse (RN) coverage seven days a week. The facility did not have Nursing Waiver in effect. The findings included: 1. Review of nursing schedules and Timecard Reports from 5/09 through 7/09 showed there was not a Registered Nurse (RN) available for at least eight hours a day, seven days a week on the following days: 5/3/09 - Licensed Practical Nurses (LPNs) were present in the facility with 2.5 hours of RN coverage for the 24 hours. 5/11/09 - Licensed Practical Nurses (LPNs) were present in the facility with 5.5 hours of RN coverage for the 24 hours. 5/24/09 - Licensed Practical Nurses (LPNs) were present in the facility with 4.5 hours of RN coverage for the 24 hours. 5/25/09 - Licensed Practical Nurses (LPNs) were present in the facility with 5 hours of RN coverage for the 24 hours.	F 354	RN schedule of coverage will be audited by Director of Nursing Services or Administrator weekly for upcoming week's coverage and make adjustments as necessary to ensure 8 hours of RN coverage each day. Compliance with this regulation will be reported monthly to CQI for 1 year to determine continued compliance. Completed by 8/28/09	

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F 354	Continued From page 108 6/26/09 - Licensed Practical Nurses (LPNs) were present in the facility with 2.75 hours of RN coverage for the 24 hours. 2. Review of the Timecard Reports revealed that on 6/4, 6/7, 6/11, 6/22, 6/30, and 7/1 the RNs worked 14 hours, 14.5 hours, 14.25 hours, 16.25 hours, 20.75 hours, and 14 hours respectively. Working this length of time greatly increases the potential for medication/treatment errors and adverse resident outcomes. 3. On 7/24/09 at the exit conference, the Director of Nursing (DON) inquired about the RN coverage requirement. She asked if the RN could be working the night shift or if RNs could split shifts in order to have 8 hours of RN coverage.	F 354		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to store, prepare, and distribute food in a manner that minimized the potential for the spread of food-borne illness. The findings included: 1. On 7/20/09 at 4:00 PM, in an initial tour of the dietary department in the presence of the Interim Dietary Manager (DM), the following observations were made:	F 371	**The facility will store, prepare and distribute food under sanitary conditions.** **A fly strip has been placed outside the back door** **Doors and cupboards have been cleaned and be cleaned weekly** **A drip pan has been put under coffee maker.** **Stove has been cleaned and will be cleaned quarterly.** **Chemicals have been moved to a locked closet.**	

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F 371	Continued From page 109 a. There were several flies in the kitchen area on the food preparation areas. . b. The cupboard doors and drawers were tacky to touch. c. There were brown stains and coffee grounds on the floor in front of the coffee maker. d. The stove hood was greasy to touch e. There were chemicals stored in the kitchen area on a cart at the end of the three compartment sink. f. The wooden shelves inside the spice cupboard were rough, making them uncleanable. g. The floor tile had cracks in it. h. Open drink containers were observed on the shelf above the three compartment sink. The DM verified that the drinks belonged to staff. i. In the walk-in refrigerator, there was a gallon of milk which had been opened but was not dated. The DM indicated that the gallon of milk was used daily. However, she verified that the milk should have been dated when it was opened. j. In the dry storage area, there was a crack in the wall which extended down the wall and across part of the wall behind the shelving. Five boxes with six Jello sugar free individual serving cups were stored on the shelves. (Note: The manufacturer's directions indicated that this product was to be refrigerated.) The temperature in the dry storage room was 83.5 degrees Fahrenheit (F). There were several boxes of food items, including chicken and brown gravy mixes	F 371	Contact paper will be put on shelves for a cleanable surface. Tiles have been replaced. Staff will not have open container drinks in the kitchen All products will be dated when opened The crack in the dry storage area has been fixed. Foods are stored according manufacturer's instructions. The janitor's closet has been cleaned and added to the cleaning schedule. Cleaning of the ice machine will be documented The gap under the kitchen door has been fixed and drawers will remain closed. Opened dry goods are stored in covered plastic containers Dishes will be washed properly if utilizing 3 compartment sink.	

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F 371	Continued From page 110 and mayonnaise, which indicated that they were to be stored in a cool, dry place. k. The dietary department's janitor closet was located behind the door which led into the dining room. The door was not locked at the time of the observation. The floor, the walls, and the equipment were dirty. No chemicals were stored in this closet. The DM indicated that the chemicals were all stored in the kitchen (next to the three compartment sink). l. The DM confirmed that the ice machine, located in the dining room, was cleaned by dietary. She commented that the staff cleaned the inside of the bin and wiped off the outside. The DM verified that maintenance staff only repaired the ice machine when it was broken and did no cleaning of the machine. 2. On 7/22/09 starting at 8:26 AM, the following observations were made in the kitchen: a. The silverware drawer was standing partially open. There were flies on the counter top by the silverware, as well as throughout the kitchen. The door to the outside was noted to be loose fitting with a gap under the door. b. In the dry storage area, a bag of brown gravy mix and a box of bran cereal were open. 3. On 7/22/09 at 8:45 AM, an observation of the dietary staff (W and X) washing dishes in the three compartment sink was made. Due to the hot water being turned off, all dishes, water and coffee containers, utensils, and pots and pans were to be washed in the three compartment sink.	F 371	Refrigerator at nursing station has been defrosted and will be maintained at 41 degrees. Grease compartment was emptied and cleaned. The compartment will be cleaned on a quarterly basis. A contracted company steam cleaned the hood system. Cleaning will be done on a quarterly basis. Garbage disposal guard is in place. All dietary staff will be in serviced on each of the items listed in the POC. Administrator will conduct daily rounds of the kitchen for 90 days to determine compliance and weekly thereafter. Audits will be reported to CQI monthly for 1 year to determine continued compliance.	8/28/09

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F 371	Continued From page 111 At the beginning of the observation, two sections of the sink contained dirty cooking items. Dietary staff (W) moved the dirty items from the first section to the third section. Staff member (W) filled the first section of the sink with water which was heated to 120 degrees Farenheit (F) and soap (Dawn dishwashing soap). Water and coffee carafes were washed and placed in the second section of the sink while dirty dishes were moved around and emptied into the third section (dirty next to clean). Staff member (W) emptied the coffee pitchers into the third section of the sink and then requested staff member (X) to move the dirty dishes, pans, and utensils out of that section of the sink. Staff member (X) placed the soiled items on the adjacent food preparation table/counter. Once the items were out of the third section of the sink, staff (W) attempted to get the small amount of liquids to drain out of it, stating that the sink drains really slowly. After approximately three minutes, the sink was drained. The third section was cleaned. Then the already washed water and coffee carafes were set on top of the dirty dishes in the first sink while the hot water was poured into the second section of the sink. The sanitizer was added to the water in the second sink. The first test strip measured 10 ppm (parts per million). The second test strip was done to verify that an adequate amount of bleach had been added to the water; the results were 50 ppm. Staff member (W) commented that the test strip should be 50 to 100 ppm (to sanitize). The third section of the sink was filled with hot water. The washed water and coffee carafes were returned to the second section of the sink and were briefly dipped in the sanitizer and then rinsed in the third section of the sink and placed in the drying rack.	F 371		

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F 371	Continued From page 112 While more water was heating for the dishwashing process, staff member (W) used cloths from the green bucket (identified by the staff member to be soapy water) and from the red bucket (identified to be sanitizer) to wipe the counter tops. The staff member put the trash lid on the trash barrel and continued to sanitize the counters without wash his/her hands. When the staff tested the sink water sanitizer, the surveyor requested that the sanitizer in the red bucket of water be tested. The test strip was very light in color (10 ppm or less). Staff added more bleach until the level reached 50 ppm. Staff did not wipe the counter surfaces off again after the sanitizer was at the appropriate level to sanitize. The staff members confirmed that normally all dishes were washed in the dishwashing machine. On 7/22/09 at 9:40 AM, the observation of the dishwashing with staff utilizing an improper sequence (wash, sanitize, and rinse, instead of wash, rinse, and sanitize) was discussed with the AA. She indicated that she would talk to the dietary staff about the correct method of using the three compartment sink. (Note: A 3-step process is used to manually wash, rinse, and sanitize dishware correctly. The first step is thorough washing using hot water and detergent after food particles have been scraped. The second is rinsing with hot water to remove all soap residues. The third step is sanitizing with either hot water or a chemical solution maintained at the correct concentration, based on periodic testing, and for the effective contact time according to manufacturer's guidelines. After washing and rinsing, dishes and utensils are sanitized by immersion. When using a chlorine sanitizer, adequate ppm is 50 - 100 with a	F 371		

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F 371	Continued From page 113 minimum ten second contact time.) 4. On 7/22/09 from 11:58 AM to 1:05 PM, during an observation of the noon meal service in the dining room, there were flies present at the tables. The residents were observed to shoo the flies away from themselves and other residents. 5. On 7/23/09 at 3:55 PM, the snack refrigerator located at the nurses' station was observed. The thermometer inside of the refrigerator showed a temperature of 52 degrees F. There was an ice build-up of 1 1/2 to 2 inches inside the freezer section of the refrigerator. Review of the temperature log for this refrigerator revealed temperatures from 41 to 47. The directions on the form stated "Check every shift, defrost as needed, maintain temp between 36 and 46 degrees". (Note: Cold food items are to be stored at 41 degrees F or less.) 6. During the environmental tour on 7/22/09 from 2:50 PM to 4:00 PM, the CMC (Corporate Maintenance Consultant) was asked to follow up on concerns identified in the kitchen. A tour of the kitchen was done and the following issues were reviewed which included: a. The facility had a three compartment sink which was being used. Staff had also voiced concern with it being slow to drain. When checking the sink the CMC identified a metal compartment under the sink as being a grease trap. The grease trap was setting on the floor, approximately 16 inches in length, 8 inches in width, and 12 inches in height. The lid was removed from the grease trap, which was found to have debris approximately 2 inches from the top of the container. The plastic pipes draining into the grease trap from the sink and out to the	F 371		

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F 371	Continued From page 114 sewer were limited due to the debris in the grease trap. The CMC confirmed that the trap was in need of cleaning. In an interview with Dietary staff, they reported that they were not aware of when or if the grease trap had ever been cleaned. The facility failed to ensure the grease trap was properly cleaned. Additionally, at issue was a concern with a direct connection between the sewage system and a drain originating from three compartment sink where equipment and utensils were washed, rinsed and sanitized. The CMC reported that there would be follow up with a Plumber to ensure plumbing codes were being followed. [A direct connection was observed between the sewer at the three compartment sink located in the kitchen. The USPHS Food Code (United States Public Health Services) indicates at section 5-402.12, "a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment or utensils are placed."] b. A check of the stove's hood system found the filters in the hood had a build up of dust, debris, and greasy residue. The dietary staff reported to the Maintenance Consultant that they were not sure when the filters had been cleaned last. On the last day of the survey, the CMC reported that the company that had deep cleaned the stove's hood and exhaust system was no longer in business. He indicated that a new company was coming out to ensure the exhaust hood system was properly cleaned and the cleaning of the filters had been put on the cleaning schedule. c. The kitchen had a garbage disposal in the dish room. The disposal was missing pieces of the	F 371		

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F 371	Continued From page 115 rubber gasket at the opening of the disposal which left the inside blades of the disposal visible. There was not a cover to place over the garbage disposal when being used to prevent back splash of garbage and debris and for staff safety. Reference: Food Code 2005 U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service Food and Drug Administration 5-402.10 Establishment Drainage System. FOOD ESTABLISHMENT drainage systems, including grease traps, that convey SEWAGE shall be designed and installed as specified under ¶ 5-202.11(A). 5-402.11 Backflow Prevention.* (A) Except as specified in ¶¶ (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. (B) Paragraph (A) of this section does not apply to floor drains that originate in refrigerated spaces that are constructed as an integral part of the building. (C) If allowed by LAW, a WAREWASHING machine may have a direct connection between its waste outlet and a floor drain when the machine is located within 1.5 m (5 feet) of a trapped floor drain and the machine outlet is connected to the inlet side of a properly vented floor drain trap.	F 371		

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F 371	Continued From page 116 (D) If allowed by LAW, a WAREWASHING or culinary sink may have a direct connection. 5-402.12 Grease Trap. If used, a grease trap shall be located to be easily accessible for cleaning.	F 371		
F 428 SS=E	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, it was determined that the facility failed to ensure that the consulting Pharmacist's recommendations/identified irregularities were acted on for two of 12 sample residents (#7 and #6). The findings included: 1. On 7/22/09 at 4:25 PM, in an interview with the consulting Pharmacist, the facility's follow-up to her monthly drug regimen review recommendations was discussed. She confirmed that sometimes the follow-up takes some time, depending on the physician involved. 2. Review of the Pharmacist's Monthly Drug Regimen Review forms for 2008 and 2009 for resident #7 evidenced that in 8/08 the Pharmacist	F 428	The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist and drug irregularities will be reported to the attending physician for each resident. The pharmacist will use the most current federal guidelines. The pharmacist will report irregularities directly to the physician and the Director of Nursing. The Director of Nursing will follow up for completion with the physician and keep documentation of the results. The pharmacist will audit monthly for follow up, adverse reactions, appropriate diagnoses, gradual dose reduction and potential poly pharmacy. Residents #6 and #7 have expired. Results of the monthly pharmacy review will be reported to CQI monthly for 1 year to determine compliance. Completed by 8/28/09	

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F 428	Continued From page 117 noted "No TSH (Thyroid Stimulating Hormone) in chart" She asked again in 3/09 as no level had been done, noting "No response from before - no TSH in chart". The action taken column was blank for 8/08 and 3/09. There was no evidence to show that the facility had addressed the 8/08 TSH level recommendation until the TSH level was obtained in 4/09. 3. During the 7/22/09 interview with the Pharmacist, she revealed that she did not have the most recent guidelines for the drug regimen review (12/18/06 State Operations Manual). The following topics were discussed with her: unnecessary drugs, pain assessment, sleep assessment, Fentanyl policy, missing Morphine Sulfate (MS), and crushing of extended release medications. 4. During the interview with the consulting Pharmacist on 7/22/09 at 4:25 PM, she reported she completes the monthly pharmacy review on individual resident and gives the findings to the Director of Nursing (DON). The DON then would determine what issues needed to be taken to the physician for follow up. Review of the "Pharmacy Chart Review" sheets for April, May, and June, 2009 showed the pharmacist was doing the medication regimen reviews. However, follow up with the physicians for all the irregularities identified was not evident. The current system for medication review did not ensure the pharmacist reported drug irregularities to the attending physician and the DON, and these reports were being acted upon. 5. Review of resident #6's medical record revealed the resident was admitted to the facility	F 428		

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F 428	Continued From page 118 on 6/2/08. a) Review of the monthly drug regimen review sheets by the Pharmacist revealed reviews were being documented monthly as "no concerns". However, there was no evidence that the potential for "Adverse Consequences" was identified and reported with this resident's drug regimen. b) The resident's MAR (Medication Administration Review) for June 2009 included: Sinemet 25/250 1 PO TID (three times per day) started 7/10/08, Celebrex 200 mg 1 PO QD (everyday) started 7/10/08, (nonsteroidal anti-inflammatory) Amitriptyline (Elavil)10 mg 1 PO (orally) TID (three times per day) started 7/10/08, (tricyclic antidepressant) The Nursing 2010 Drug Handbook identifies potential drug to drug interaction with Fluoxetine which the resident was also on. It also identified the medication with a BLACK BOX WARNING. Tramadol (Ultram) 50 mg 1 PO QID (four times per day) OK up to 100 mg PO Q 4 Hours, [The MAR did not indicate which dose was administered.] For elderly patients over 75 years old, total dose should not exceed 300 mg/day. (The Nursing 2010 Drug Handbook identifies potential drug to drug interaction with SSRI (selective serotonin reuptake inhibitor) which the resident was also on.] Fluoxetine (Prozac) capsules 20 mg once daily started 7/10/08,	F 428		

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F 428	Continued From page 119 [Fluoxetine is a SSRI used to treat depression, anxiety disorders (panic attacks), obsessive-compulsive disorder (OCD), a certain eating disorder (bulimia), and a severe form of premenstrual syndrome (premenstrual dysphoric disorder). Interactions noted: drug to drug interaction with tricyclic antidepressant. May increase risk of serotonin syndrome, monitor closely if used together, and may increase CNS (central nervous system) effects.] Alprazolam (Xanax) 0.25 mg 1 PO PRN as (needed) BID started 7/10/08, [Xanax is a short-acting drug of the class used to treat moderate to severe anxiety disorders, panic attacks, and as an adjunctive treatment for anxiety associated with moderate depression. anxiety disorders, panic attacks.] Sotalol 40 mg 1 PO BID (twice a day) started 7/10/08, (beta-blocker) There was no evidence that the potential for "Adverse Consequences" was identified and reported with this resident's drug regimen for: -Use of a medication with potential for drug to drug interactions, an example was Fluoxetine and Tramadol and Fluoxetine and Amitriptyline . When those medications are used, the explanation as to why or how the benefit of a medication(s) outweighs the risk needs to be documented in the resident's record. -Medications with same use and having anticholinergic side effects. -Medications having a BLACK BOX WARNING.	F 428		

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F 428	Continued From page 120 The pharmacist failed to identify and report the absence of any explanation as to why or how the benefit of a medication(s) with potential for clinically significant adverse consequences outweighs the risk. BLACK BOX WARNING: A FDA ALERT [6/16/2008]: FDA is notifying healthcare professionals that both conventional and atypical antipsychotics are associated with an increased risk of mortality in elderly patients treated for dementia-related psychosis. Antipsychotics are not indicated for the treatment of dementia-related psychosis. Reference for Professional Standards of Practice in Drug Regimen Review: According to the American Society of Consultant Pharmacists, a Drug Regimen Review should encompass a range of activities designed to guarantee that residents receive the proper medications at the right time in the correct doses. This review begins by collecting information on the resident's medical history, diagnoses, treatments, physician orders, laboratory tests, medication history, diet and care plan. The drug review should sufficiently identify any drug-drug or diagnoses-drug combination which is potentially inappropriate for the elderly or creates a high risk for adverse drug reaction in the elderly. Other areas of consideration should include potential or actual drug-food interactions, the appropriateness of dosages and the intervals at which medications are to be taken. This drug review should insure that the resident's drug regimen is free of any drugs given in excessive dose, given in sub-therapeutic doses, duplicate therapies, excessive duration, without adequate indications for its use, without adequate monitoring or in the presence of potential dangerous adverse reactions.	F 428		

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F 431 F 431 SS=E	Continued From page 121 483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to limit access to the medication storage areas	F 431 F 431	The keys to the cupboards are kept on the nurses key ring which is kept on their person at all times throughout their shift. The key ring is passed to the successive nurse on the schedule. There is nothing stored under the sink. All narcotics are counted twice. There are no narcotics kept in the ER box. Ativan, which is kept in the locked refrigerator, is counted twice daily. Discontinued medications are kept in the med cart until sent to the pharmacy. Fentanyl patches and Morphine will be signed out upon removal from the narcotic storage. Compliance will be monitored by the Director of Nursing weekly and reported to CQI monthly for 90 days to determine continued compliance. Completed by 8/28/09	

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F 431	Continued From page 122 and ensure that all narcotics were accounted for. The findings included: 1. On 7/23/09 at 4:03 PM, nurse (A) opened the medication storage cupboards which were located behind the nurses' station. The nurse obtained the key to the cupboards from a hook which was located under the nurses' station counter. The placement of the key gave access to the medications to numerous persons. 2. During the observation of the medication storage area on 7/23/09, nurse (F) was present. The following observations were made: a. Under the sink in this area, there was a large box of spoons, two boxes of medication crushing plastic bag, and several chemical (at the back of the space). b. The Emergency Box was kept under the counter. The box was locked with a key lock type padlock. Nurse (F) revealed that the nurses kept the key to open the padlock. The surveyor requested to see inside of the box. Nurse (F) obtained the key from another nurse. The box held numerous medications, including Demerol, Morphine, Darvocet, and Vicodin. There were forms inside of the box which listed the medications that were kept in the box. The nurse (F) verified that these forms were to be used to sign the medications out. There was an inventory form with the numbers of medications which should be present. The nurse verified that these narcotics were not counted during the daily shift count. A count of the various narcotics revealed no discrepancies. The potential for drug diversion was present since the medications were not routinely counted and	F 431		

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F 431	Continued From page 123 the box could be opened and closed without evidence that it had been opened. The Ativan from the box was locked in the medication refrigerator and also was not routinely counted. 3. On 7/23/09 at 4:05 PM, nurse (A) opened the medication storage cupboards which were located behind the nurses' station. A cupboard above the sink had another locked box which was identified as discontinued medications to be sent back to the pharmacy. The facility failed to ensure only appropriately authorized staff may have access to the storage area. [Note: The facility is required to secure all medications in a locked storage area and to limit access to authorized personnel.] 4. During the observation of the medication passes, the nurses were not observed to sign out Fentanyl patches as they were removed from the narcotic storage or after applying these patches. Record review for residents #14, #9, and #4 evidenced that the Fentanyl patches and Morphine Sulfate were not always accounted for on the Medication Administration Record (MAR) and/or in the narcotic records. Refer to F281 for details.	F 431		
F 441 SS=F	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	F 441	The facility will 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	

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F 441	Continued From page 125 make you sick. Some kinds of E. coli can cause diarrhea, while others cause urinary tract infections, respiratory illness and pneumonia, and other illnesses. MRSA (Methicillin Resistant Staphylococcus aureus) are the most commonly encountered multidrug-resistant organisms in patients residing in non-hospital healthcare facilities. Non-hospital healthcare facilities can safely care for and manage these patients by following appropriate infection control practices. Clostridium difficile (C-diff) is a spore-forming, gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It is a common cause of antibiotic-associated diarrhea (AAD).] b. Medical record review for residents #5, #6 and #8 revealed they had problems with recurrent resistant E.coli UTIs (urinary tract infection). These problems were not addressed in their plans of care. (Cross refer to F280) c. Observation of perineal care for resident #5 and #8 identified that the residents were not being provided adequate incontinence care. NOTE: Pursuant to the National Kidney and Urologic Diseases Information Clearinghouse publication entitled "Urinary Tract Infection in Adults", normal urine is sterile. It contains fluids, salts, and waste products, but it is free of bacteria, viruses, and fungi. An infection occurs when microorganisms, usually bacteria from the digestive tract, cling to the opening of the urethra and begin to multiply. Most infections arise from one type of bacteria, Escherichia coli (E. coli), which normally live in the colon. If the infection is not treated promptly, bacteria may then go up the	F 441	Standing floor fans have been cleaned. The glucose monitor will be wiped down with anti-bacterial wipes before placing the monitor back on the tray. These will be audited weekly by DON or designee & reported quarterly to QA.	8/28/09

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F 441	Continued From page 124 resident; and maintains a record of incidents and corrective actions related to infections. This Requirement is not met as evidenced by: Based on record review, observation, and resident, family, and staff interview, it was determined that the facility failed to ensure that staff techniques during cares minimized the potential for cross contamination and the spread of infections. Additionally, the facility failed to maintain resident care equipment in a clean, sanitary manner. The findings included: INFECTION CONTROL PROGRAM: 1. The facility had an Infection Control Program through which residents with infections that were identified and tracked. However, preventative measures to prevent the potential spread of infections were not addressed. a. In an interview with the Director of Nursing (DON) on 7/23/09 at 2:50 PM, she confirmed the residents with problems of infections specifically those with MDRO (Multidrug-resistant organisms) such as E.coli (Escherichia coli), C Diff (Clostridium difficile) and MRSA (Methicillin Resistant Staphylococcus aureus) were not getting care planned. [Multidrug-resistant organisms (MDROs), have important infection control implications. MDROs are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. Escherichia coli (abbreviated as E. coli) are a large and diverse group of bacteria. Although most strains of E. coli are harmless, others can	F 441	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. Preventative measures to prevent the potential spread of infections will be addressed in the Infection Control Program. All residents with multi-drug resistant organisms will be care planned. All oxygen concentrators have had their filters changed. Centrad replaces filters weekly on Wednesdays. There will be a weekly audit done by DON or her designee & reported quarterly to QA. Resident #13's nebulizer has been rinsed & left to air dry. All residents with nebulizers will have them rinsed & left to air dry after each treatment.	

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F 441	Continued From page 126 ureters to infect the kidneys (pyelonephritis). According to The Merck Manual, Second Edition, Escherichia coli (E. coli) is the most common cause of urinary tract infections (UTIs) in adults. These bacteria are normally present in the colon and may enter the urethral opening from the skin around the anus and genitals. Poor perineal care can contribute to UTIs. According to University of Iowa's Health Center, Department of Obstetrics and Gynecology information sheet entitled "Urinary Tract Infections (Bladder Infections); Ways to Prevent a Urinary Tract Infection", good personal hygiene is important. Proper personal hygiene includes blotting or wiping gently from front to back after urinating or having a bowel movement. This will reduce or prevent the spreading bacteria from the rectum to urethra. The facility failed to ensure that the provision of incontinence care was done in a manner to prevent UTI (Cross Reference F312). Other Findings: 2. On 7/20/09 from 3:10 PM to 4:40 PM during tour of the facility with nurse (F), the following infection control issues were identified : a. The oxygen concentrators in resident rooms were noted to have dirty filters. The vents were checked behind the filters and found to have a build up of dust and debris and were in need of cleaning. Nurse (F) was not aware of when the concentrators had been cleaned last but confirmed they were in need of cleaning. The residents having dirty oxygen concentrators included: residents #2, #3, #4 and supplemental residents #19 (no filter and vent completely covered with dust), and #20.	F 441		

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F 441	Continued From page 127 The facility identified 28 of 48 resident with oxygen. The dirty oxygen concentrators had the potential for placing residents with compromised respiratory status at risk for URI (upper respiratory infections). b. On tour Resident #13 was noted to have a nebulizer laying across the bedside stand. Nurse (F) confirmed that the nebulizer had moisture and residue left in the medication cup on the nebulizer and proceeded to disconnect the med cup and rinsed the equipment. The nurse confirmed that the equipment was supposed to be rinsed and left to air dry after nebulizer treatments. On 7/21/09 at 9:45 AM the resident reported that she had a breathing treatment before breakfast. The nebulizer had not been cleaned and was laying across the bedside stand with moisture noted in the med cup on the nebulizer. [A nebulizer is a delivery system consists of a nebulizer (small plastic bowl with a screw-top lid) and a source for compressed air. The air flow to the nebulizer changes the medication solution to a mist. When inhaled correctly, the medication has a better chance to reach the small airways. This increases the medication's effectiveness. Instruction for use include washing and rinsing the medication cup and making sure the nebulizer is completely dry before storing.] The facility failed to ensure proper cleaning of equipment. 3. On 7/21/09 at 10:00 AM, a family member	F 441		

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F 441	Continued From page 128 demonstrated the unsanitary condition of a nebulizer. The nebulizer was observed to contain dried flaking mineral deposits. The family member commented that the nebulizer is often in this condition. 4. On 7/20/09 during initial tour functioning floor standing fans were observed circulating air in resident rooms. The fans had collected dust and dirt contaminate on the protective wire cage. 5. On 7/21/09 at 9:38 AM, during a medication pass observation of nurse (D) with nurse (C) assisting, both nurses insisted that resident #11 have another finger stick blood sugar done before the resident could receive his/her insulin injection. Nurse (D) placed the glucose monitoring tray on the resident's bedside stand. She then placed the glucose monitor on the resident's bedside table, performed the test, and then placed the glucose monitoring device back in the tray without cleaning it. The tray was taken back to the nurses' station without being cleaned.	F 441		
F 460 SS=D	483.70(d)(1)(iv)-(v) RESIDENT ROOMS Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide full visual privacy for the residents residing in semi-private rooms 1, 16, and 24. The findings	F 460	All residents will be afforded privacy of cares in their rooms. New tracks have been ordered for rooms of resident #1, 16 and 24 and will be installed upon arrival. Administrator will identify violations of privacy curtain on weekly rounds of the facility. Violations will be corrected. Results of weekly rounds will be reported CQI monthly for 90 days to determine continued compliance. Completed by: 8/28/09	

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(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 460	Continued From page 129 Included: 1. Observation was made of resident room 1 during a medication pass on 7/21/09 and during an environmental tour on 7/23/09. There was a privacy curtain between the two beds, but no curtain or curtain track was present at the foot of the beds. The two residents in this room were not provided curtains to ensure visual privacy. 2. During the environmental tour on 7/22/09 from 2:50 PM to 4:00 PM with the CMC (Corporate Maintenance Consultant), Housekeeping Supervisor, and Acting Administrator present, observations revealed issues with privacy curtains. Room one did not have privacy curtains at the foot end of the beds. The room had two residents #26 and #11. The resident by the door had the potential for visual exposure with opening the door to the room and no privacy curtain to pull. The CMC verified that the track for the curtain was also missing. 3. Observation on 7/23/09 from outside the facility at 4:45 AM staff were in room 24 assisting a resident. Upon entering the facility staff (T) was pushing resident #16 down the hall in a shower chair and into the shower room. At 5:05 AM staff T brought resident #16 back to his/her room. Staff (U) assisted staff (T) with transferring the resident back into bed. Staff (U) dried the resident's perineal area and applied a brief while the resident was in bed. During these cares the resident's window was uncovered and the resident was visible to the outside. There was a mini blind on half the window. Another mini blind was noted to be on the floor in the corner of the	F 460		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535040	A. BUILDING _____ B. WING _____	07/24/2009

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F 460	Continued From page 130 room. Staff (U) confirmed that the window was supposed to have two mini blinds. The privacy curtain was also pushed against the corner of the room partial hanging off the track which was not used. 4. Resident rooms 1A and 9A were each observed as not having a privacy curtain at the foot of the bed.	F 460		
F 465 SS=F	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 upon observation and staff interview, it was determined that the facility failed to provide safety equipment to prevent back siphonage of contaminated water into the potable water system of the building. The findings included: 1. During the environmental tour on 7/22/09 from 2:50 PM to 4:00 PM with the CMC (Corporate Maintenance Consultant), Housekeeping Supervisor, and Acting Administrator present, observations revealed issues with backflow devices. a. The equipment room on the west wing had a corner sink. The sink had a hose attached to the water faucet which did not have a backflow device. The housekeeping supervisor confirmed the hose was used to fill mop buckets. b. The sink in the laundry room had a hose attached. It also had a device used for eye washing. The CMC confirmed there was not a	F 465	The water to the sink was turned off and staff will be in serviced on the use of the sink. Back flow converter was installed as well as a thermometer to monitor temps will filling tub. Staff will be in serviced on tub filling procedure. Administrator will audit weekly to determine compliance. Audits will be submitted monthly to CQI for 90 days to determine continued compliance. Completed by 8/28/09	

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F 465	Continued From page 131 back flow device on the hose. c. The whirlpool tub on the east wing was noted to have a faucet on the outside of the tub. The faucet had a hose attached with a spray nozzle on the end. A prior interview during a check of water temperatures on 7/21/09 at 10:45 AM with staff (Y) confirmed the hose was used to get hot water into the tub as the dial /main control on the tub did not work. Interview with the CMC during the tour reported he was not aware of the hose being there and that there was no evidence of any type of backflow device on the faucet. The facility failed to ensure backflow devices were used for the prevention of siphonage of contaminated water into the potable water system.	F 465		
F 516 SS=D	483.75(l)(3), 483.20(f)(5) CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to safeguard	F 516	The facility will safeguard clinical record information against loss, destruction, or unauthorized use. All clinical records are locked & not accessible to unauthorized persons. Only authorized staff will have keep to clinical records. Audits will be done weekly by DON or her designee & reported to QA quarterly.	8/28/09

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F 516	Continued From page 132 medical records from unauthorized access, damage, and to protect the residents' privacy. The findings included: During the environmental tour on 7/22/09 from 2:50 PM to 4:00 PM with the CMC (Corporate Maintenance Consultant) and Acting Administrator present, observation of the basement revealed the facility did not safeguard resident clinical records. There were two rooms identified as having storage of residents' medical records which were accessible to unauthorized persons. a. The first room was identified as an equipment room which was locked. However, the key was hanging on a bulletin board next to the door. The Acting Administrator removed the key and opened the door. She reported that resident medical records were not kept in this room. Upon checking the two file cabinets in the room resident records and personnel records were found. A file pulled from the cabinet was checked and identified by the Acting Administrator as being a prior resident's and old medical record. The file was dated 2004 and had the resident's name, social security number and medical diagnoses. Additionally, the room was identified as having a recent water leak with water damage noted to the ceiling. The repair work in the room also increased unlimited access to the records. The key to the medical records hanging by the door left a potential for unlimited access to anyone going into the basement. b. The second room was identified as the medical	F 516		

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F 516	Continued From page 133 records room which was locked. The room was checked and found to have file cabinets and file boxes of resident medical records. The Acting Administrator reported the door was locked however the maintenance staff did have a key to access to the room.	F 516		
F 520 SS=F	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 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 observation, record review, and resident, family, and staff interview, it was determined that the facility failed to identify issues which were problems/concerns related to the quality of care and quality of life for the residents	F 520	The facility will maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. CQI committee will meet monthly to determine continued compliance with F Tags: F157, F225, F241, F246, F253, F272, F278, F280, F281, F309, F311, F312, F314, F323, F325, F332, F353, F354, F371, F428, F431, F441, F460, F465 and F516. Administrator will be responsible for compliance with this tag. Completed by 8/28/09	

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F 520	Continued From page 136 of the residents. F371: The facility failed to store, prepare, and distribute food in a manner which minimized the potential for food-borne illnesses. F441: The facility failed to maintain an infection control program in order to provide a safe, sanitary, and comfortable environment which minimized the potential for the spread of infection.	F 520		