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
	535042	A. BUILDING _____ B. WING _____	C 03/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY CARE CENTER	60 MAGNOLIA CASPER, WY 82604

(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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN: registered nurse LPN: licensed practical nurse CNA: certified nursing assistant DON: director of nursing MDS: Minimum Data Set CAA: Care Area Assessment MRSA: methicillin-resistanse Staphylococcus aureus, a MDRO MDRO: multidrug-resistant organism UTI: urinary tract infection Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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, resident and staff interview, and medical record review, the facility failed to ensure 6 of 21 sample residents (#69, #91, #105, #118, #145, #135) and 6 non-sample residents (#141, #26, #21, #9, #104, #71) were treated in a manner that maintained each resident's dignity. In addition, resident #105 experienced psychosocial harm based on the reasonable person concept in that s/he had become resigned to being incontinent of bowel and bladder due to lack of staff assistance and no	F 241		

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

CEO / Administrator 4-21-11

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.

RECEIVED
Wyoming Dept. of Health
APR 25 2011
Office of Healthcare Licensing and Surveys

Refer to Page 2.

4/3/12

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F 241	Continued From page 1 longer bothered to ring the call light for assistance after every instance of incontinence. Findings were: 1. Interview on 3/27/11 at 3 PM with resident #105, who was totally dependent on staff to provide incontinence care, revealed s/he does not call staff for assistance each time s/he is incontinent of urine or bowel. The resident stated staff take such a long time to answer his/her call light, s/he has become resigned to letting incontinence episodes build-up 2-3 times before calling for assistance. Refer to F309 regarding the lack of bowel incontinence care for this resident. 2 Observation of the noon meal on 3/27/11 revealed at 12:21 PM seven residents: #69, #91, #135, #21, #104, #9, #26 were all seated at the assisted dining table in the central dining room. Observation showed all seven residents required extensive or total assistance with their meals. Observation also showed one CNA #1 was assisting all seven residents with occasional help from CNA #2. Observation revealed CNA #1 stood and walked around the table feeding each resident one spoonful of food at a time. The CNA continued this process until the meal was over. Observation of the noon meal on 3/28/11 revealed six of the same residents (#69, #91, #135, #21, #104 and #9,) were seated at the assisted table and CNA #1 again stood and walked around and around the table feeding each resident one spoonful at a time until the meal was finished. Interview with the administrator on 3/29/11 at 12:15 PM revealed she thought there was enough staff to assist dependent residents with their meals, but that the problem was because there was no "horseshoe" table where	F 241	**F241. The facility will 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 will be accomplished by:** , #104 1. **Residents # 9, 21, 26, 69, 91 and 135 will be offered assistance at mealtime per change in policy.** 2. **Resident's # 7 and 141 will have clean shoes and resident # 7 felt hat will be cleaned as needed.** 3. **Resident # 118 behavioral issues affecting staff's ability to provide care have been addressed on her plan of care.** 4. **Resident #91 will be offered different food choices if refusing what has been offered or requested.** 5. **Resident # 105 was interviewed and an overview of her need for incontinence assistance was discussed. This resident will receive timely toileting assistance per change in Toileting Program Policy.** 6. **Resident # 145 will receive oxygen per MD orders.** 7. **The policy and procedures for offering food choices, feeding assistance, changing clothes and**	

This POC accepted on 5/3/11 with agreed to changes between J. Hvlt, Administrator and Tony Mallon

5/3/11

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F 241	Continued From page 2 the CNA could sit and go from one resident to the other without standing. 3. During an observation of the midday meal on 3/28/11 the cook provided a peanut butter and jelly (PBJ) sandwich for resident #91. When the cook told the resident what kind of sandwich s/he was being given, the resident yelled out "I don't want it. I don't want it; I'm sick of peanut butter and jelly sandwiches." The cook left the sandwich and walked away. Despite the resident's statements s/he did not receive any other food to replace the PBJ sandwich. 4. Interview with resident #145 on 3/28/11 at 12:45 PM revealed when staff changed his/her oxygen tanks out, they would take away the empty tank and then go obtain a full tank. Meanwhile the resident was left without any oxygen. The resident said s/he had told staff s/he needs the oxygen immediately, but staff would say, "Just go to your room." According to the 2/28/11 physician's orders, this resident required oxygen at all times. The resident stated s/he felt staff were not understanding of or considerate to his/her needs. 5. Random observations on 3/26, 3/27, and 3/28/11 revealed non-sample resident #71 wore black shoes and a black hat which were visibly soiled with spilled/splattered food debris. Interview with RN #1 unit on 3/28/11 at 1:48 PM revealed staff were to send soiled clothing to the laundry or clean the items. 6. Observation on 3/29/11 at 12:50 PM revealed resident #118 was wearing the same green shirt that s/he had worn on 3/27/11 and 3/28/11. Observation on 3/28/11 at 3 PM showed there	F 241	**cleaning clothing items, oxygen use and oximeter readings and toileting programs were reviewed and revised.** 8. **Nursing and dietary staff will be inserviced to deficiency and newly implemented policies and procedures.** 9. **Additional nursing staff have been assigned to monitor staff on each nursing unit providing immediate inservicing when deviation from policy is observed.** 10. **Results of the above audits will be presented at the monthly QA meeting x 90 days. After 90 days the QA team will direct the frequency of subsequent audits until such time that that ongoing compliance is achieved.**	05/08/11

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F 241	Continued From page 3 was a small food stain on the shirt near the third button. Observation on 3/29/11 at 12:50 PM showed the shirt was still stained in that spot. Interview with the resident at that time revealed s/he would never wear dirty clothes, s/he stated s/he kept his/her clothes clean. 7. Review of the medical record for resident #141 showed s/he required assistance with personal hygiene care due to cognitive impairment and physical limitations. Periodic observation from 3/26/11 to 3/29/11 revealed an area of dried feces on the resident's left shoe. The resident was observed wearing the soiled shoe during meal times and as s/he wheeled himself/herself throughout the unit. On 3/29/11 at 10:35 AM, CNA #10 stated she had not noticed the fecal stains on the resident's shoe until the surveyor called her attention to it. The CNA further stated the resident frequently resisted care provided by staff, and the best time to clean the resident's shoe would be at bedtime.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure 15 non-sample residents (#8, #22, #23, #25, #30, #36, #48, #73, #75, #94, #110, #111, #112,#136, #148) and 3 sample residents (#92, #121, #147)	F 248		

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F 248	Continued From page 4 who resided in the secure unit received an ongoing program of activities during all days of survey. In addition, 9 of 21 sample residents (#7, #66, #69, #72, #92, #100, #121, #142, #147) lacked an individualized activity assessment. The findings were: Observation in the secure unit showed there were 3 sample residents (#147, #92, #121) and 15 non-sample residents (#8, #22, #23, #25, #30, #36, #48, #73, #75, #94, #110, #111, #112,#136, #148) who resided there during the survey. Periodic observations on 3/26/11, 3/27/11, and 3/28/11 showed no group or individual activities ever took place in the secure unit for any residents. With the exception of 2 residents who left the unit to attend church services on 3/27/11 at 9:30 AM, the residents remained on the unit without any activities provided. Review of the medical records related to activities for the 3 sample residents on the secured unit showed the following: 1. Review of the 12/4/10 annual MDS assessment for resident #92 showed s/he triggered for a problem in activities. Review of this MDS assessment showed the following activities were very important for the resident: to have books, newspapers, and magazines to read, to listen to music, and to participate in religious activities. Also, the following activities were somewhat important for the resident: to be around animals such as pets, to keep up with the news, to do things with groups of people, and to go outside to get fresh air when the weather is good. Review of the 12/2/10 CAA for activities showed the resident was interviewed and current activity pursuits were self-directed or done with others and/or planned by others. The assessment	F 248	**F 248** **The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. This will be accomplished by:** **1) Residents # 7, 66, 69,72, 92, 100, 121, 142,and 147 will have an individualized activity program based on respective activity assessment.** **2) All residents, including # 8,22, 23, 25, 30, 36, 48, 73, 75, 92, 110, 111, 112, 121 136, 147, 148 residing in the secure unit will be provided ongoing daily activities per a revised activity schedule and calendar.** -494 **3) Activity personnel will be inserviced to the above infractions, to a revised Policy and Procedure, and to a revised activity scheduled and calendar.** **4) The Activity Director received inservice and instruction from a Licensed Recreational Therapist regarding activity schedules, activity calendars that best accommodates individualized meaningful activities for residents.** **5) Additional personnel were added to Activity department.**	

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F 248	Continued From page 5 further showed the resident had dementia and anger episodes which resulted in reduced activity participation at times. The following concerns were identified: a. The last activity assessment for this resident was dated 6/20/10. It had not been updated to address the CAA identified issues of dementia and anger. b. Review of the activity care plan revealed it did not include a specific, individualized plan for activities for this resident. c. Review of the resident's March 2011 activity log showed the resident had a documented activity during only four days, three of which were chaplain visits. All other days when activities might have occurred were left blank. 2. Review of the 11/12/10 admission MDS assessment for resident #121 showed s/he triggered for a problem with activities. Review of the MDS assessment showed the following activities were very important for the resident: listening to music, and keeping up with the news. The following activities were somewhat important to the resident: having books, newspapers, and magazines to read, doing the resident's favorite activities, and to go outside to get fresh air when the weather is good. The following concerns were identified: a. The 3/21/11 activity assessment stated the resident slept most of the time and refused activities. The assessment documented a goal of one-to-one activity with staff, with no frequency documented. Review of the activity care plan for this resident showed the plan did not reflect the goal of one-to-one activities with staff. b. Review of the March 2011 activity log showed the resident did not participate in activities for that month. A note on the back of the	F 248	**6) As each resident assessment period is realized, all residents will have a comprehensive assessment and individualized care plan crafted.** **7) Activities provided will be audited regularly for 90 days and the results shared at the monthly QA meeting. Subsequent monitoring will be conducted as directed by the QA committee until achieving compliance.** **8) Corrective action will be monitored by the Activity Personnel, Corporate Consultant and Administrator.**	05/08/11

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F 248	Continued From page 6 log dated 3/20/11 stated "follows his own schedule-does make [his/her] way to meals." 3. Review of the 1/3/11 annual MDS assessment for resident #147 showed the following activities were very important for the resident: to have books, newspapers, and magazines to read, to listen to music, to be around animals such as pets, to keep up with the news, to do things with groups of people, to go outside to get fresh air when the weather is good, and to participate in religious activities. The following concerns were identified: a. There was no activity assessment for this resident. b. Review of the resident's March 2011 activity log showed the resident did not participate in activities for thirteen days. The log documented that a friend visited on several of those days, but no specific activity was documented. During an interview on 3/26/11 at 5:15 PM, the resident's friend said s/he stopped by each day to see how the resident was doing. 4. Interview with the activities director on 3/28/11 at 2:50 PM revealed she was aware that some individual activity assessments were lacking. She stated that, since the last survey they were working to get caught up, and the needed activity assessments were only being done when the annual MDS assessments as they came due. She then revealed that recently she was made aware that the CAAs for activities were not being completed correctly. The director stated two of the three members of the activity staff were newly hired, and they were working to get things re-organized. She revealed the plan for the secure unit was to have an activity staff member provide group activities for a block of time each	F 248		

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F 248	Continued From page 7 day. However, she verified this was not consistently happening, and there was a lack of activities for the residents on this unit. She also verified there was a lack of items available in the unit for residents to self initiate any activities. Finally, the activity director verified that, after having reviewed the medical records, the following additional sample residents lacked comprehensive activity assessments: #66, #142, #72, #69, #100, #7.	F 248		
F 272 SS=E	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; 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	F 272	**F 272. The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. This will be accomplished by:** 1. **Care Area Assessments were written in accordance with CMS guidelines for residents # 5, 64, 66, 69, 135, 138 and 147.** 2. **Inservicing will conducted for the MDS team.** 3. **All Comprehensive MDS's will have CAA's according to CMS guidelines.** 4. **The DON and MDS Nurses will audit CAA's routinely making immediate correction when warranted.** 5. **The results of the audits will be reported at QA meeting for a minimum of 90 days. The QA team will then determine frequency of audits until compliance is achieved.**	5/8/11

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F 272	Continued From page 8 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 medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed for 6 of 21 sample residents (#64, #66, #69, #135, #138, #147) and 1 non-sample resident (#5) in variety of areas. The findings were: 1. Review of the 10/20/10 annual MDS assessment for resident #135 showed s/he required comprehensive assessment in the following areas: pain, vision, ADLs (activities of daily living), and psychotropic medication. Review of the CAAs showed no evidence the data collected in these areas was analyzed and synthesized to provide rationale for care planning. 2. Review of the 10/5/11 comprehensive MDS assessment for resident #69 showed the following areas were triggered for further assessment: falls, ADLs, communication and dental. Review of the CAAs showed no evidence the data collected described the problem or was analyzed to assist in determining the need to proceed to care planning. 3. Review of the 1/24/11 admission MDS assessment for resident #64 showed the following areas were triggered, requiring further assessment: urinary incontinence, activities, pain, pressure ulcers, psychotropic drug use, and communication. Review of the CAAs showed that data was collected; however, the data was not	F 272		

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F 272	Continued From page 9 fully analyzed to determine the needs of the resident for appropriate care planing. 4. Review of the 11/19/10 admission MDS assessment for resident #66 showed the following areas were triggered, requiring further assessment: activities of daily living, falls and psychotropic drugs. Review of the CAAs showed that data was collected; however, the data was not fully analyzed to determine the needs of the resident for appropriate care planing 5. Review of the 1/3/11 annual MDS assessment for resident #147 showed s/he required comprehensive assessment in the following areas: visual function, communication, urinary incontinence and indwelling catheter, and falls. Review of the related CAAs showed no evidence the data collected in those areas was analyzed to provide rationale for care planning. 6. Review of the admission MDS dated 12/18/10 for resident #138 showed the resident triggered for the use of psychotropic drugs. Review of the CAA for psychotropic medication dated 12/22/10 showed it was not comprehensive. Although the assessment showed the resident was on Ativan due to a diagnosis of anxiety and COPD, it failed to address potential alternatives to the use of drugs to treat these diagnoses. 7. Review of the 11/24/10 annual MDS assessment and CAAs for non-sample resident #5 showed each identified triggered area did not have a corresponding CAA. During interview on 3/29/11 at 9:40 AM, the MDS Coordinator stated she was unable to find the CAAs that had been developed by the nursing staff.	F 272		

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F 272	Continued From page 10 Interview with the two MDS coordinators, and the corporate nurse on 3/29/11 at 11:20 AM verified they were aware that an analysis of findings for each CAA needed to be done in order for the CAA to be considered a comprehensive assessment. Further discussion revealed the areas that were most problematic were those related to the nursing areas. The corporate nurse stated they were aware of the need for additional training in this area.	F 272		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to ensure professional standards of quality were met in regard to following physician orders as written for 2 sample residents (#105, #145). In addition, two of four nursing units (east and west) failed to follow acceptable practices related to medication administration. The findings were: 1. Following physician orders: a. Review of the March 2011 recapitulation of physician orders for resident #145 showed s/he was admitted with diagnoses including end stage chronic obstructive pulmonary disease, congestive heart failure, asthma, and obstructive sleep apnea. Review of the 2/28/11 physician's orders showed the resident required the use of oxygen at all times and that oxygen saturations	F 281		

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F 281	Continued From page 11 for this resident were to be performed daily. Review of the March 2011 vital sign flow sheet, MAR, and treatment records showed the resident did not have his/her oxygen saturation rate assessed on 18 out of 27 days. Interview with LPN #1 on 3/29/11 at 9:30 AM confirmed the physician's orders were not followed in regard to monitoring oxygen saturation rates. b. Review of the physician's orders for sample resident #105 showed s/he was to have Nystop powder applied topically to the groin twice daily. Review of the treatment record revealed s/he was scheduled to have the powder applied in the morning and at "supper." The treatment record for March showed the powder was not applied in the morning and only 13 of 24 days at "supper." Interview on 3/28/11 at 1:30 PM with RN #3 revealed the treatment book was the only place for documenting resident treatments. Further, when the treatment was done, the nursing staff was expected to document in the treatment book. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," 7th Edition, 2008: "Skills and functions that professional nurses perform in daily practice include: ...Administer treatments per physician's order." 2. Medication administration: a. During an observation in the west secure unit on 3/27/11 at 5:40 PM, multiple medications were set-up ahead of administration time. Interview with RN #2 at that time revealed that it was her routine to set-up medications for all residents in the secure unit ahead of time. During an observation in the secure unit on 3/28/11 at 8:15 AM, LPN #2 was beside the medication cart,	F 281	**F 281. The services provided or arranged by the facility must meet professional standards of quality. This will be accomplished by:** **1. The treatment for oximeter readings for resident #145 and Nystatin powder for resident #105 will be completed and documented per MD order.** **2. Nursing staff was inserviced on pre-pouring medications and educated on the proper unit dose process, in addition to completing and documenting treatments.** **3. Staff Development Nurse and Nurse Managers will audit the efficacy of inservicing, provide immediate corrective counseling if an infraction is noted.** 4. **The audits will be reviewed during QA meetings for a minimum of 90 days. The frequency of audits will then be determined by the QA team until ongoing compliance is achieved.**	5/8/11

5/3/11 M

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F 281	Continued From page 12 and six cups of medication were noted to be set-up ahead of administration time. The medications had been removed from their individual packages/wrappers and placed into medication cups labeled with each resident's name. Interview with LPN #2 on 3/28/11 at 11 revealed that all of the secure unit noon medications had already been set-up, and it was routine in the secure unit to set medications up ahead of schedule. b. Observation of the medication pass on 3/26/11 at 5:30 PM revealed medication had been removed from the packages and placed loosely in labeled medication cups in the drawers of the medication carts. Observation revealed RN #3 administered the medications to the residents on the east unit. The RN stated that she had prepoured the five and six o'clock medications between one and two o'clock that afternoon. Interview with RN #3 and RN #5 on 3/26/11 at 5:40 PM revealed the nurses routinely pre-poured medications because it saved time. According to Elkin, Perry and Potter in "Nursing Interventions and Clinical Skills," 4th edition, 2007, page 375: "...8. Keep tablets and capsules in their wrappers and open them at the resident's bedside."	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 and plan of care.	F 309		

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F 309	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to provide appropriate incontinence care for 1 of 16 sample residents (#105) with bowel incontinence. This resident experienced psychosocial harm based on the reasonable person concept because the resident had become resigned to his/her incontinence due to a lack of care. In addition, the facility failed to ensure effective wound treatment was provided for 1 of 1 sample residents (#4) who were identified to have non-pressure wounds. The findings were: 1. Observation during incontinence care for resident #105 on 3/27/11 at 5:35 PM revealed the resident was lying on linens and pads saturated with both urine and loose stool. Stool was found on the anterior perineum and was also dried on the resident's skin. Interview with CNAs #3 and #4 revealed they were uncertain when the resident was last checked for incontinence. Interview with the resident earlier that day at 3 PM revealed she was last checked and changed at 11 AM (six hours and 35 minutes prior). Review of the MDS assessment dated 1/23/11 revealed the resident was totally dependent on staff for incontinence care. Refer to F241 related to details regarding how the resident felt about being incontinent and why. 2. Review of the 1/15/11 quarterly MDS assessment for resident #4 showed the resident was totally dependent on staff for all activities of daily living. Review of the 1/25/11 nursing assessment and 1/26/11 physician's orders showed staff found a 2 x 3 inch bruise on the resident's inner thigh that was believed to have	F 309	**F 309. Each resident will receive and the facility will 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 and plan of care. This will be accomplished by:** **1. Resident # 105 will be provided timely incontinent care.** **2. Resident # 4 skin alteration will continue the healing process.** **3. The policy and procedures for wound care, communication, documentation and toileting program was reviewed and revised.** **4. Nursing staff was inserviced to the above deficiencies and policy revisions.** **5. Weekly skin rounds will be be initiated with the Staff Development Nurse, Nurse Managers, and Specialized Therapy to visually review each wound for process in healing.** **6. New Toileting Records were implemented as a tool for the Nursing Assistants to enhance communication and compliance with resident toileting.**	

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F 309	Continued From page 14 been caused by the straps on the mechanical lift. Review of the care plan showed approaches that addressed the resident's skin integrity and included the following: apply protective skin barrier ointment, turn and reposition every two hours, lay down between meals and observe and report signs of skin breakdown. Observation on 3/27/11 at 2 PM revealed nurse aide (NA) #1 and CNA #11 provided urinary incontinence care for the resident. At that time bloody drainage from the previously healed bruised area on the resident's right inner thigh was observed. During the observation, the NA and CNA both stated the open area had not been present prior to this day. They completed the incontinence care and applied the protective skin barrier ointment. Interview on 3/28/11 at 8:30 AM with RN #5, who was responsible for the resident's care that day, revealed she had not received any reports and had no knowledge of this resident's previously healed area on the thigh reopening. At 1:15 PM, on 3/28/11 when CNAs #10 and #12 provided incontinence care for the resident, it was noted that the area on the resident's right thigh was open and moist. There was no evidence of any care or treatment of this open area. Interview with the wound care nurse on 3/28/11 at 1:15 PM and 3:15 PM revealed the area on the resident's right thigh that was initially identified on 1/25/11 had healed and no longer required monitoring or weekly assessments. The nurse stated the area was just scar tissue. She further stated that she had not received any reports from staff that the area had re-opened. On 3/29/11 at 10:10 AM, CNAs #13 and #11 were	F 309	7. **The DON, Nurse Managers, Staff Development Nurse will monitor compliance with above policy, providing immediate correction for non-compliance.** 8. **The audit results will be provided at the QA meeting for review x 90 days. After that time, the audits will be conducted as directed by QA until it is determined the facility has achieved ongoing/compliance.**	5/8/11

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F 309	Continued From page 15 observed providing urinary incontinence care for the resident. The bloody drainage from the resident's right thigh wound was noted. After the observation, a review of the March 2011 treatment record, care plan, and medication administration records showed no evidence that nursing staff had assessed, monitored or implemented treatment for the thigh wound identified on 3/27/11.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 and staff interview, the facility failed to ensure staff provided the assistance for 3 of 6 sample residents (#69, #91, #135) and for 4 non-sample residents (#21, #104, #9, #26) who required extensive or total assistance with maintenance of nutrition. The findings were: Observation of the noon meal on 3/27/11 revealed at 12:21 PM seven residents, #69, #91, #135, and non-sample residents #21, #104, #9, and #26 were all seated at the assisted dining table in the central dining room. Observation showed all seven residents required extensive or total assistance with their meal. Further observation showed one CNA #1 was assisting all seven residents with occasional help by CNA #2. Observation showed CNA #1 stood and walked	F 312	**F 312** **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 will be accomplished by:** 1. **Residents # 9, 21, 26, ~~89,~~ 91 104 and 105 will receive assistance with eating.** 2. **Central station dining room arrangement was altered to better provide necessary assistance.** 3. **Break times for nursing staff were reviewed and revised to allow adequate staffing during the resident meal periods.** 4. **A Diningroom "host" program will be instituted whereby Management staff will be assigned dining room "host" and monitoring responsibilities. Activity and Restorative staff were also assigned to assist with resident meal service.**	

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F 312	Continued From page 16 around the table feeding each resident one spoonful of food at a time and continued this process until the meal was over. Observation of the noon meal on 3/28/11 revealed six of the same residents, (#69, #91, #135, #21, #104 and #9) were seated at the assisted table and CNA #1 again stood and walked around the table feeding each resident one spoonful at a time. Interview on 3/29/11 at 12:06 PM with CNA #2, who used the same process when she was assisting those residents revealed she felt there were not enough staff to help all the residents that needed total assistance with their meals. Interview with LPN #1 on 3/29/11 at 11:58 AM revealed she believed more staff was needed to assist the residents with their meals. She stated a CNA should have no more than three residents to feed at one time. Interview with the administrator on 3/29/11 at 12:11 PM revealed she thought there were enough staff to assist dependent residents with their meals, but that the problem was the lack of a horseshoe shaped table.	F 312	**5. Nursing staff were inserviced to the deficient practice and to the plan of correction.** **6. The Nurse Managers and Management staff will monitor the dining rooms for compliance making immediate correction when warranted.** **7. The audit results will be presented at the QA meeting for minimum of 90 days with ongoing monitoring as needed to realize compliance.**	5/8/11
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL 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. This REQUIREMENT is not met as evidenced	F 314		

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F 314	Continued From page 17 by: Based on observation, medical record review, staff interview and review of wound treatment information, the facility failed to appropriately identify, treat, and monitor a pressure ulcer for 1 of 5 sample residents (#100) who were identified as being at risk for developing pressure ulcers. The findings were: Review of the quarterly MDS assessment dated 2/10/11 for resident #100 showed the resident was totally dependent on staff for bed mobility, toileting, and hygiene. Further, it showed the resident was always incontinent of urine and was at risk for the development of pressure ulcers. Review of the 2/2/11 skin/pressure ulcer risk assessment also showed the resident was at high risk for the development of pressure ulcers, and there were multiple interventions in place. These interventions included a pressure relief mattress, a turning schedule clock and wheelchair seat cushion. The assessment also showed as of 2/11/11 the resident had no skin breakdown. The following concerns were identified: a. Observation during incontinence care on 3/27/11 at 4:30 PM revealed the resident had an open wound on his/her coccyx that was irregular in shape with a white, macerated (softening) wound edge, approximately 1 inch long x 0.5 inches wide. At that time, CNA #4 stated the area of the wound looked worse. She continued cleaning the resident's perineum then applied Calazime (barrier cream) to the buttocks, including the open wound. b. Review of a list showing residents who were receiving wound treatments, provided by the wound care nurse on 3/28/11 at 9:15 AM showed, resident #100 was not currently being treated for	F 314	**F 314** **The facility will ensure that a resident who enters the facility without a 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. This will be accomplished by:** **1. Residents # 100 will continue to receive appropriate care for a pressure ulcer.** **2. Nursing staff were inserviced to the deficient practice and to the plan of correction.** 3. **The Nurse Managers will monitor resident skin conditions on their respective units with immediate implementation of appropriate assessment, documentation and intervention delivered.** 4. **The audit results will be presented at the QA meeting for minimum of 90 days with ongoing monitoring as needed to realize compliance.** 5/8/11	

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F 314	Continued From page 18 wounds. c. Review of the March 2011 treatment records for this resident showed there were no treatments for pressure ulcers being provided. d. Interview on 3/28/11 at 4:00 PM with the wound care nurse revealed she was not aware of the open wound and asked where it was located. She stated nursing staff were expected to report any open wounds to her and that she had not received any written or oral communication concerning this resident. The wound care nurse further stated she didn't understand how this could happen and would assess the wound that evening. Interview with the wound care nurse on 3/29/11 at 8:46 AM revealed she assessed the wound and determined it was a Stage II pressure ulcer and applied Allevyn (a wound dressing) to be changed three times a week. She stated there would be an in-service for nursing staff on documentation and treatment of pressure ulcers. She also stated she requested a consult for occupational therapy and dietary to see the resident and attempted to contact the family. e. Review of additional documentation dated 4/7/11 from the administrator showed CNA #16 who worked with resident #100 remembered noticing the resident had a pressure ulcer "about two weeks ago." The documentation showed the CNA reported she was "certain" she reported to one of the two nurses on duty on 3/15/11 or 3/16/11. Additional review of the documentation showed when these two nurses were interviewed they could not recall specifics. Interview with the administrator related to the documentation provided on 4/7/11 at 11:35 AM revealed there was no medical record information found to	F 314		

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F 314	Continued From page 19 support this information.	F 314		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide appropriate care to promote dryness for 3 of 17 sample residents (#4, #69, #105) and 1 non-sample resident (#5) who had urinary incontinence. The findings were: 1. Review of the current care plan for resident #69 showed s/he was incontinent of urine all of the time. Further review revealed the resident was to be checked and changed every two to three hours. Observation on 3/28/11 at 10 AM revealed the resident's incontinence brief was saturated with urine. Observation of the incontinence brief that was soiled had a date of 3/28/11 at 5 AM marked on it. Interview with CNA #6 at that time confirmed 5 AM was the last time the resident was checked and changed, five hours earlier. 2. Observation on 3/27/11 at 5:35 PM showed	F 315	**F 315** **The facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the residents clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This will be accomplished by:** 1. **Residents # 4, 5, 69, and 105 will be provided timely toileting upon their assessed needs** 2. **The policy and procedure for toileting needs was reviewed and revised.** 3. **Each resident's toileting assistance will be reviewed to assure their plan is appropriate.** 4. **Nursing Assistants will be provided a toileting tool to better track the toileting times of their assigned residents.** 5. **Nursing staff were inserviced to the deficient practice and to the plan of correction.** 6. **The DON and Nurse Managers will monitor resident toileting**	

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F 315	Continued From page 20 resident #105 had been incontinent of urine and was being provided incontinence care. During the incontinence care, the resident was noted to be lying on saturated pads and linens. Interview at that time with CNAs #3 and #4 revealed they were uncertain when the resident was last checked for incontinence. The CNAs stated there was a flow sheet for incontinence care in the resident's bathroom. Review of the flow sheet showed the resident was last changed at 4 AM that morning. However, interview with the resident earlier that day at 3 PM revealed s/he was last checked/changed at 11 AM, which was six hours and 35 minutes before the observation. Refer to F241 regarding this resident's statement of being resigned to being incontinent due to staff being unable to respond to his/her call light. 3. Refer to F309 for information regarding the failure to provide incontinent care for resident #4 in a timely manner. 4. Review of the 2/14/11 quarterly MDS for resident #5 showed the resident required staff assistance with personal hygiene and toileting. Review of the resident's care plan showed staff were to check and change the resident every two to three hours. Observation on 3/27/11 at from 10:30 AM until 2:20 PM revealed the resident sat in his/her wheelchair without being checked or changed during that time. At 2:20 PM when nurse aide (NA) #1 transferred the resident to bed, she removed the resident's urine-soaked disposable brief. At that time the NA stated the resident's brief had not been checked by staff since 8:45 AM that morning. The NA further stated staff were unable to check the resident earlier due to other tasks.	F 315	**with immediate re-education of identified deficits.** 7. **The audit results will be presented at the QA meeting for minimum of 90 days with ongoing monitoring as needed to realize compliance.**	5/8/11
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		

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F 318 SS=D	Continued From page 21 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 1 of 3 sample residents (#4) with contractures received care in accordance with professional recommendations. The findings were: Review of an occupational therapy rehab communication to staff, dated 3/3/11, showed directions for staff to place a wash cloth roll in resident #4's left hand "24/7." Review of the current care plan showed the resident was to wear the hand roll at all times. Periodic observations of the resident on 3/26/11, 3/27/11, and 3/28/11 showed the resident did not have the wash cloth roll in his/her left contracted hand. Interview with nurse aide (NA) #1 on 3/27/11 at 2:20 PM revealed she "forgot" to place the wash cloth roll in the resident's hand. Interview with CNAs #10 and #12 on 3/28/11 at 1:15 PM revealed they were aware of the need to apply the wash cloth roll but they had not had an opportunity to do it. Interview with the occupational therapist on 3/29/11 at 8:45 AM revealed she was concerned because staff were unable to consistently apply the washcloth as the resident needed. The occupational therapist	F 318	**F 318** **The facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motions. This will be accomplished by:** **1. Residents # 4, will benefit from a hand roll applied in accordance with plan of care.** **2. All residents receiving restorative nursing will be reviewed to assure their programs are current and reflective of their individualized needs.** **3. Nursing staff, Restorative Staff and Director of Specialized Therapy were inserviced to the deficient practice and to the plan of correction.** **4. The Nurse Managers, ADON, Restorative Nursing Assistants and Therapy Director will monitor residents range of motion programs with immediate re-education of identified deficits.** **5. The audit results will be presented at the QA meeting for minimum of 90 days with ongoing monitoring as needed to realize compliance.**	5/8/11

5/13/11

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
	535042	A. BUILDING _____ B. WING _____	C 03/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY CARE CENTER	60 MAGNOLIA CASPER, WY 82604

(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 318	Continued From page 22 stated she had placed pictures with instructions above the resident's bed but staff still were unable to provide the hand roll therapy everyday. She further stated that she noticed in the past two months a correlation between that lack of staff and the failure to consistently apply the resident's wash cloth roll.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment for residents and staff in two (secured and Krampert units) of four resident areas. The findings were: 1. Intermittent observations on 3/26/11 at 4 PM through 3/29/11 at 10:48 AM revealed the following environmental hazard concerns: a. Broken end caps were observed on the hand rails and wall bumper guards near resident rooms #215, #218, outside the conference room and in the hallway between the Krampert station and the West station. b. The door to the soiled utility room, across the hall from the Krampert nurse's station, was unable to shut completely. The soiled utility room	F 323	**F 323** **The facility will ensure that a resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by:** **1. The identified chemicals and treatment carts were locked.** **2. The fan in the west unit was removed.** **3. The soiled utility room door across from the Central/Krampert nurses station is repaired.** **4. Any chemicals in tub rooms will locked when staff is not present.** **5. The wall heater by room 108 is repaired.** **6. The splash guard, baseboard and wall heater in the SCU are repaired.** Handrail wire guard	

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F 323	Continued From page 23 was a hazardous area with a self closure device attached to the door. In the room on the counter next to the sink was a partially full 96 fluid ounce container of bleach. In addition, the bathing room of the Krampert station when not in use was unlocked. Inside the room was an unlocked cabinet containing a one gallon container of "Classic Whirlpool Disinfectant Cleaner." The active ingredient of the cleaner was ammonium chloride. According to the Columbia Encyclopedia 6th edition, 2006, ammonium chloride is harmful if swallowed and causes skin and eye irritation. c. A 2 x 5 inch sharp metal strip was hanging off a wall heater opposite resident room #108 (next to the cross corridor doors). The metal strip was protruding into the hallway at ankle level. d. Concerns in the secure unit during these observations were as follows: (i) The splash guard mounted on the wall behind the handrail near the private nurse's bathroom had pulled away from the wall, exposing a sharp edge. (ii) The temperature control knob on the baseboard heater was missing a plastic control knob cover, exposing a sharp metal stud. The heater was at the end of the hall near the exit leading into the south unit. (iii) The plastic baseboard on the west and south walls in the dining room and in the restroom next to the secured dining room had separated from the wall creating a sharp-edged safety hazard. (iv) The baseboard heater in the secure unit tub room was separated from the wall, exposing its sharp metal edges. (v) The metal joint cover on the baseboard heater in the secure unit television	F 323	**7. The nursing staff and Director of Maintence was inserviced to the above deficiencies. Corrective action detailing work order systems, storing and locking chemicals was included.** **8. Safety Committee walk-throughs will begin on a monthly basis to identify accident/hazard areas needing to be addressed.** **9. Results of the safety committee walk thoughs will be presented at the QA committee for a period of 90 days or until the Team is satisfied achievement of ongoing compliance.** 5/8/11	

5/5/11 M

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F 323	Continued From page 24 room was separated from the heater and protruding into the room, creating a sharp edge at ankle level. e. Observation of a treatment cart on the Krampert unit on 3/28/11 at 12:30 PM showed the bottom drawer was halfway open and contained the following hazardous liquids: one eight ounce bottle of iodine, one eight ounce bottle of Hibiclens, one sixteen ounce bottle of Dakins solution, one sixteen ounce bottle of skin cleanser, a ten ounce bottle of astringent and a sixteen ounce bottle of Triviline prep solution. In addition, the second and third drawers of the unlocked cart had 65 resident labeled ointments and creams accessible to residents milling about in the hallway after lunch.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure staff adequately monitored 1 of 9 sample residents (#145) who were dependent	F 328		

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F 328	Continued From page 25 upon oxygen. The findings were: Review of the March 2011 physician orders recapitulation for resident #145 showed s/he was admitted with diagnoses including end stage chronic obstructive pulmonary disease, congestive heart failure, asthma, and obstructive sleep apnea. Review of the 2/28/11 physician's orders showed the resident required the use of oxygen at all times and oxygen saturations were ordered daily. Observation on 3/27/11 at 1:30 PM and resident interview on 3/28/11 at 12:45 PM revealed the resident was attending a resident council meeting when his/her oxygen tanks became empty. A CNA replaced one of the oxygen tanks during that meeting. In the interview with the resident, s/he reported feeling dizzy, having some chest and shoulder pain and shortness of breath after the resident council meeting. Right after the meeting, the resident stated s/he asked LPN #2 to check the oxygen because it didn't seem to be working properly. The following concerns were identified: a. Interview with LPN #2 on 3/27/11 at 4:04 PM revealed the resident had asked him to check his/her oxygen after the resident council meeting on 3/27/11. The nurse stated that when he checked the liter flow it was set at three liters per minute and that was what was also written on the oxygen tubing. The LPN said the resident told him the liter flow should be six liters per minute, not three. The LPN further stated he checked the physician's orders and verified an order for six liters/minute of oxygen per nasal cannula. b. Review of the physicians orders for March 2011 showed no specific liter flow was established but that the liter flow should be set based on keeping the resident's oxygen saturation rate at 88 to 92%. In addition, the order	F 328	**F 328** **The facility will ensure that residents Receive proper treatment of respiratory care. This will be accomplished by:** **1. Resident #145 will receive oxygen flow based upon oximeter parameters per MD's order.** **2. The nursing staff was inserviced to the above deficiencies. Policy and procedure was addressed during this education.** **3. The DON and Nurse Managers will monitor all residents to assure that respiratory care is rendered in accordance with facility policy and procedure. Any failure to comply with policy will immediately be addressed with re-education.** **4. Results of the monitoring will be presented at the QA committee for a period of 90 days or until the Team is satisfied achievement of ongoing compliance.** 5/8/11	

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F 328	Continued From page 26 showed the resident's oxygen saturation rate needed to be checked every day. c. Review of the medical record showed staff had not checked the oxygen saturation rate on 3/27/11, the day the resident experienced dizziness, shortness of breath and chest and shoulder pain. d. Review of the medical record, interview with the resident on 3/28/11 at 12:45 PM, and interview with the LPN on 3/27/11 at 4:04 PM revealed the nurse did not assess the resident's oxygen level, vital signs, pain, or shortness of breath when the resident expressed his/her concern about the oxygen flow and subsequent discomfort.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimens were free of unnecessary drugs for 3 (#64, #66, #92) of 21 sample residents. The findings were: a. Review of the March 2011 medication administration record (MAR) for resident #66 showed Xanax 0.125 mg was ordered as a PRN (as needed) medication. The MAR showed the anti-anxiety medication was administered seven times from 3/1- 3/27/11. Review of the MAR notes showed, on 3/1/11 and 3/27/11, the medication was administered due to increased anxiety; however, there was no indication if the medication was effective. Review of the March 2011 anti-anxiety monitoring form showed it was blank. The form was designed to monitor behaviors warranting use of the medication as well as monitor the drugs side effects. Interview with the DON on 3/29/11 at 12:35 PM revealed the medications needed to be monitored for use and effectiveness. The expectation was to complete the behavior monitoring forms. b. Review of the March 2011 MAR for resident #64 showed s/he received routine Ativan, an anti-anxiety medication 0.5 mg twice daily, and also had orders to receive 0.5 mg as needed every 6 hours for anxiety and agitation. The MAR showed the PRN dose was administered 14 times from 3/1- 3/25/11. The nurses notes showed documentation 11 times for the use of the PRN	F 329	**F 329** **Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This will be accomplished by:** **1. Residents #64 and 66 will have effectiveness documented ~~when~~ upon receipt of a PRN medication. Resident # 92 behavior documentation tool was updated to include behaviors to be monitored.** **2. The nursing staff was inserviced to the above deficiencies.** **3. All residents receiving psychopharmacological medications will be reviewed to assure a tool to monitor effectiveness is in place.** **4. The MDS Nurses and Consulting Pharmacist will monitor effectiveness and**	

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F 329	Continued From page 28 dose, the reason was increased agitation or anxiety; however, there were only three times when the effectiveness of the medication was noted. Review of the March 2011 behavior monitoring form showed there were no behaviors identified to monitor, and the form was blank. Interview with the DON on 3/29/11 at 12:35 PM revealed the medications needed to be monitored for use and effectiveness. c. Review of the medical record showed resident #92 was admitted to the facility on 1/6/10 with diagnoses which included Alzheimer's dementia. Review of the physician's orders showed an order dated 6/13/10 for Zyprexa 2.5 milligrams by mouth at bedtime. Review of the March 2011 monthly anti-psychotic monitoring form for Zyprexa showed a category for behaviors to be monitored each shift. However, the form was left blank, no behaviors were identified. Review of the medical record failed to show what behaviors were being monitored or how effective the medication was to treat behaviors. During an interview with LPN #2 on 3/28/11 at 2:45 PM, he stated that behaviors for the resident and medication effectiveness related to behaviors should be documented in the nurses' notes. Review of the nurses notes showed incomplete information related to monitoring the Zyprexa.	F 329	**compliance of this policy with a quarterly review of residents taking such medications. The review will be based on MDS schedule cycle. The results of audit will be reported to the QA Team.** **5. Education /correction will be deployed for noted deficits.** **6. The QA committee will monitor results for a period of 90 days or until the Team is satisfied achievement of ongoing compliance is realized.**	5/8/11
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 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: Based on observation, medical record review,	F 332		

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F 332	Continued From page 29 and staff interview, the facility failed to maintain a medication error rate under 5 percent (%). Out of 42 opportunities for errors, 4 errors were committed, resulting in an error rate of 9.5%. The residents affected by the errors were sample resident #149, and non-sample residents #17, #125, and #139. The findings were: 1. On 3/27/11 from 8:20 AM to 9:10 AM, RN #6 was observed to prepare and administer medications, including enteric coated aspirin for residents #139, #125 and #149. The observation also revealed the RN administered the enteric coated aspirin crushed and mixed with yogurt for residents #139 and #149. Reconciliation of the medications with the physician's order showed the physician ordered plain aspirin for the three residents instead of the enteric coated aspirin that was administered. Interview with the RN on 3/29/11 at 9:15 AM revealed she did not realize the order was not for enteric coated aspirin. 2. Observation on 3/27/11 during the mid-day medications pass for resident #17 showed nurse #12 administered Beano 1 tablet by mouth. The nurse stated a family member brought the medication in for the resident. Review of the physicians medication orders showed the order was written for Gas-X Extra Strength 125 mg by mouth three times daily with meals. Review of the March 2011 MAR showed "Beano" was written in parentheses below the original order for Gas-X. Interview with the DON on 3/29/11 at 8:30 AM revealed an order for the substitution of X-Gas for Beano was not obtained.	F 332	**F 332** **The facility must assure that it is free of medication error rates of five percent or greater. This will be accomplished by:** **1. Residents # 139, 125, and #149 will receive aspirin in accordance with physicians order.** **2. Enteric aspirin will not be crushed for residents #139 or #149.** **3. Resident # 17 will receive Beano in accordance with physicians order.** **4. The nursing staff was inserviced to the above deficiencies.** **5. Consultant Pharmacist, DON, and Nurse Managers will conduct audits of medication passes to assure compliance. Any noted deficits will be immediately addressed through education.** **6. Audit results will be reported to QA Team x 90 days. Subsequent audit requirements will be subject to the review of QA team until such time that the facility has achieved ongoing compliance.**	**5/8/11**
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or	F 353		

5/3/11

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F 353	Continued From page 30 maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 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 observation, medical record review, and resident, family and staff interviews, the facility failed to maintain sufficient members of nursing staff to answer call lights timely and to provide needed services for 6 sample residents (#4, #7 #69, #91, #105, #135) and 6 non-sample residents (#5, #9, #21, #26, #35, #104). The findings were: 1. Refer to F312 for details regarding lack of sufficient staff during meals to assist 3 of 21 sample residents (#69, #91, #135) and 4 non-sample residents (#9, #21, #26, #104) who required extensive or total assistance with dining. 2. Refer to F315 for details regarding the lack of	F 353	**F 353** **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. This will be accomplished by:** **1. Residents # 69, 91, 135, 9, 21, 26 and 104 will receive assistance during meals.** **2. Residents # 4, 69, 105, 5 will receive timely response to urinary incontinence care.** **3. Resident # 4 will receive range of motion.** **4. Resident # 105 will receive timely bowel incontinence care.** **5. Resident # ~~X~~ 35, 105, 7 will receive timely response to call lights** **6. The nursing staff was inserviced to the above deficiencies.** **7. An Additional 16 hours of professional licensed staff was added to the East station.** **8. An additional 4 hours of C.N.A. staffing was added to the East PM shift.**	

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F 353	Continued From page 31 staff to perform timely incontinence care and toileting for sample residents (#4, #69, #105) and 1 non-sample resident (#5) with urinary incontinence . 3. Refer to F281 for information regarding the pre-pouring of medications by nursing staff to enable them to administer medications in a timely manner. 4. Refer to F318 for information related to a lack of range of motion services provided to resident #4. 5. Refer to F309 related to the lack of timely bowel incontinence care for resdlent #105. 6. Delay in answering call lights: a. Observation on 3/27/11 showed resident #35 was in a wheelchair in his/her room with the call light on from 4:20 PM until 4:45 PM (25 minutes). At 4:45 PM, when the activity director responded to the resident's call light the resident requested medication for abdominal discomfort. b. Interview on 3/27/11 at 3 PM with sample resident #105 revealed s/he sometimes has to wait 1-2 hours for his/her call light to be answered. The resident stated the longest wait was during the morning hours. c. Interview on 3/28/11 at 8:05 AM with sample resident #7 revealed s/he has waited as long as 1-1.5 hours for the call light to be answered. The resident stated the longest wait was during the night and weekends. The resident further stated s/he has periodically received medications as late as 11:00 PM.	F 353	**9. Two full-time Registered Nurse Managers were added to the staffing matrix.** **10. Management, Activities and Restorative staff was dispatched to support the dining room meal services.** **11. Re-organization of the East station assignments and care model concept was introduced, inserviced and implemented with other stations to be on-line in next several months.** **12. The comprehensive management team will continue with daily staffing meetings to evaluate resident acuity, staff placement, sufficient staffing ratios, resident placement.** **13. All staff will be inserviced on the call light policy reminding all staff to respond to lights.** **14. Corporate Nursing consultants will review resident acuity and staffing patterns no less than quarterly to assure adequate resident/staffing ratios are maintained.** **15. Activity C.N.A. was added to the West SCU.** **16. Attendance policy has been reviewed with violations issued for excessive absence.**	

5/3/11

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F 353	Continued From page 32 d. Observation on 3/27/11 at 5:58 PM outside room 115 showed the staff took from 5:58 PM-6:20 PM (22 minutes) to answer the resident's call light. The resident was observed coming out into the hallway to get the attention of passing staff before the call light was answered. e. Observation on 3/26/11 at 5:20 PM outside room 105 showed the staff took from 5:10 PM-5:20 PM (10 minutes) to answer the resident's call light. The resident was heard calling out to passing staff prior to the light being answered. 6. Confidential interviews between 3/27/11 and 3/29/11 with two RNs and two CNAs revealed the facility did not consistently have sufficient staff on duty to meet the needs of the residents. The CNAs stated the lack of staff affected the residents because staff was unable to respond to the call lights, provide dining assistance and toileting in a timely manner. The RNs said they needed at least three nurses on duty on the east unit during the dayshift, but sometimes there were only two. During interview on 3/29/11 at 11:10 AM, the DON stated staffing and organization had been identified as two key areas of concern by the facility staff and they planned to address this in future weeks. 7. During an interview with the DON on 3/29/11 at 10 AM, she stated she was not involved in staffing the nursing units and did not know how staffing ratios were determined. She further stated the administrator was in charge of staffing ratios and it was done on a daily basis. Interview with the administrator on 3/29/11 at 12:15 PM revealed she attended morning meeting five days per week and knew the residents so well she	F 353	**17. Audit tools will be managed by the Nursing Administration team evaluating staffing patterns, work flow, assignments, resident acuity, resident placement. Results reported to the QA team for a period of 90 days. After 90 days, the QA team will determine audit frequency until such time that the facility has achieved ongoing compliance.**	**5/8/11**

5/3/11 M

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
	535042	A. BUILDING _____ B. WING _____	C 03/29/2011

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F 353	Continued From page 33 could determine the staffing requirements by listening to what was said in the morning stand-up meetings. She said she used no formal acuity system to determine staffing levels.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of maintenance records, the facility failed to ensure vents located in the kitchen, and 4 of 4 ice machines were adequately cleaned to prevent possible food contamination. In addition, the facility failed to ensure appropriate handwashing during food service. The findings were: 1. Random observation on 3/26, 3/27, and 3/28/11 showed 4 ice machines (located on the East, South, Krampert units, and in the kitchen) that were used to provide ice to residents. Upon closer inspection, each of these ice machines were noted to have a rusty brownish substance on the upper inside part of the hinged door. Review of the ice machine cleaning documentation showed the last time the maintenance staff cleaned the machines, was on 1/10/11. Interview with the maintenance director	F 371	**F 371** **The facility must store, prepare, distribute and serve food under sanitary conditions This will be accomplished by:** **1. Ice machines will be placed on a documented cleaning schedule on quarterly basis and prn.** **2. Vents in the food production areas of the kitchen will be placed on a documented quarterly and prn cleaning schedule.** **3. Nursing and Dietary Staff will be inserviced to the identified deficiency.** **4. Monitoring by the Director of Maintenance, Dietary Manager and Nursing Administration with immediate correction to identified deficits.** **5. Monitoring results will be reviewed by the QA team for a period of 90 days. After 90 days, the QA team will determine audit frequency until such time that the facility has achieved ongoing compliance.**	**5/8/11**

5/5/11
M

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F 371	Continued From page 34 on 3/29/11 at 8:55 AM revealed the ice machines were cleaned/sanitized quarterly. After observation of the rusty substance, the director verified more attention to the areas inside by the doors was needed. According to Food Code 2009, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch... (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 2. Observation on 3/26/11 at 2:20 PM revealed there were four vents in the food production areas of the kitchen. These vents were visibly soiled with an accumulation of dust and grease. Interview with the dietary manager on 3/28/11 at 12:40 PM revealed two of the vents were heaters, and the other two were for the air conditioner. The manager stated the maintenance department was responsible for the cleaning and she was unsure the last time the vents were cleaned. According to Food Code 2009, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch... (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 3. Observation of the mid-day meal service on 3/28/11 at 11:45 AM in the central unit dining room showed CNA #8 came into the dining room, and without washing her hands, began serving	F 371		

5/13/11
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F 371	Continued From page 35 residents food from the salad bar. Continued observation showed the CNA handled some of the glasses and small bowls by the rims. At 11:48 AM the CNA donned a pair of disposable gloves; however, she failed to wash her hands prior to this action. She continued to serve resident food, adjust clothing protectors, move wheelchairs, and provide bites of food to various residents with no hand hygiene or changing of gloves between these resident interactions. Interview with the dietary manager on 3/28/11 at 12:40 PM revealed the CNA was expected to follow appropriate hand hygiene techniques while serving the residents. According to Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES and...(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

5/3/11

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F 441	Continued From page 36 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control records, the facility failed to sustain an effective infection control program. The facility failed to complete an accurate and complete surveillance of resident infections and culture results. The facility also failed to enforce safeguards to prevent sick employees from having contact with residents and to maintain a sanitary setting for preparing and passing medications. In addition, the facility failed to require staff to comply with recognized guidelines	F 441	**F 441** **The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This will be accomplished by:** **1. Current Infection Control Policy and Procedure will be revised and implemented.** **2. Tracking and trending of infections will include Action Plans when a trend is identified by the QA Team.** **3. Infection control policy will articulate criteria and definitions of communicable disease.** **4. Nursing Staff was inserviced to the identified deficient practices including linen handling, employee illness, infection tracking and trending, appropriate eating areas, proper handwashing and gloving.** **5. One on one return demonstrations will be conducted for C.N.A.'s with immediate re-insevice for deficient practice.**	

For handwashing

5/3/11

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F 441	Continued From page 37 for hand hygiene, perineal care, use of personal protective equipment (PPE), and storage of regulated waste. The findings were: 1. Regarding surveillance activities: a. Surveillance records were reviewed on 3/28/11, data collection was discovered to be incomplete and inaccurate in the following ways: (i). 13 of 31 (42%) entries from January to date in March 2011 failed to include results of microbiology cultures when culture requests were marked "yes" and antimicrobial therapy had been initiated. (ii). 21 of 91 (22%) of resident infections failed to document whether the infection was clinically resolved or continued to be monitored. In addition, an entry for resident #145 on the January 2011 surveillance log contained no information other than the resident's name. (iii) An entry for resident #70 showed antibiotic therapy was discontinued because of antibiotic resistance, but failed to document whether another antibiotic was administered to treat a UTI and if the infection resolved. The log documented a request for culturing the resident's urine, but the outcome of the culture and resulting antibiotic sensitivities were not included on the surveillance log. (iv) Resident #7 was listed on the March 2011 surveillance log as having a soft tissue infection and receiving an antibiotic (Keflex). Review of the resident's medical record failed to show any evidence of a soft tissue infection or antibiotic administration in March 2011. (v) The facility kept a line listing of MDROs cultured from resident specimens, the last entry on the log was dated 9/27/10. Medical record review revealed resident #73 was culture	F 441	**6. Resident # 145, 7, 73, 70 surveillance records will be completed.** **7. Compliance with above infractions will be monitored by Nursing Administration, Corporate Nurse Consultant and Department Heads.** **8. Infection Control nurse will report compliance to the QA Team for a period of 90 days. After that time, the audits will be conducted as directed by QA until it is determined the facility has achieved compliance.** 5/8/11 8. Residents # 3, 145, 135, 104, 29 and 44 residents will receive benefit from services provided by staff who are adequate Nonnursing.	

5/3/11
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F 441	Continued From page 38 positive for MRSA (a MDRO as defined by the Centers for Disease Control & Prevention) on 3/8/11; however, this resident was not listed on the facility MDRO log. b. Surveillance logs and resident #7's medical record were reviewed with the infection control nurse (ICN) on 2/28/11 at 2:35 PM. The ICN determined the surveillance entry for resident #7 was an error perpetuated from incorrect entries in the resident's medical record. The ICN acknowledged the lack of a system to regularly review and verify surveillance data; she added that she was working to "...catch up..." the surveillance logs after falling behind with data collection. c. Facility policies reviewed on 3/28/11 at 4:15 PM required the infection control program to "...establish goals and measurements to achieve improved infection control compliance and infection rates..." Review of infection control records and Quality Assurance (QA) committee meeting minutes on 3/29/11 at 10:10 AM failed to show evidence that either of these two requirements, i.e., improved compliance and infection rates, were monitored or reported as required by facility policy. Interview with the ICN and DON on 3/29/11 at 10:20 AM confirmed the absence of infection control findings to inform the QA committee. The one infection control entry appearing on QA meeting minutes was a quarterly summary of UTI prevalence among residents. Review of the 2010 quarterly summaries showed an increase in UTI prevalence, from 9% in the first 2 quarters to 13% in the 3rd quarter. There was no documentation to show if the increased prevalence was	F 441		

5/3/11

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F 441	Continued From page 39 recognized, determined to be significant, or resulted in actions or interventions to reduce UTIs among residents. Results for the 4th quarter in 2010 were not available. d. The ICN stated in interview on 3/28/11 at 11:05 AM she monitored hand hygiene among CNAs by conducting an annual inservice training and observing a return demonstration to show proficiency. The ICN acknowledged that annual assessments were last completed in 2009. The ICN further stated she did not routinely monitor non-nursing staff for compliance with hand hygiene practices, adding that she did not consider housekeeping, maintenance, and dietary personnel to pose a significant infection risk to residents. Facility policies reviewed 3/30/11 at 8:05 AM revealed a requirement for all employees to be assessed for hand hygiene at least once a year. 2. Regarding transmission of communicable infections by employees: a. On 3/27/11 at 4:45 PM CNA #9 was observed on the Central unit wearing a disposable mask over her mouth while providing assistance to residents on the hallway. The CNA stated in interview on 3/27/11 at 4:50 PM that she "...was sick yesterday and didn't feel good..." describing her symptoms as a sore throat, cough, nausea, vomiting, and a red tongue. The CNA's eyes appeared red and teary during the interview. During the 4:50 PM interview, the CNA stated she had worn the mask continuously since donning it at the start of her shift at 3 PM. b. At 4:50 PM, the CNA's mask was observed to be worn loosely over her mouth and positioned	F 441		

4/3/11

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F 441	Continued From page 40 below her nose. The Centers for Disease Control & Prevention (CDC) defines correct placement of a disposable mask used as a respiratory barrier as covering the mouth, nose and chin. The CDC guidelines further recommend a mask be fitted snugly to the face without gaps...to block aerosolize droplets from entering or escaping the barrier of the mask. When asked by a surveyor on 3/27/11 at 5:05 PM how she was trained to wear a mask as an infection barrier, the CNA pulled the mask over her nose, but did not tighten the straps to form an effective barrier. At 5:12 PM the mask was again observed to sag beneath the CNA's nose. c. During a 32 minute observation, from 5:12 PM to 5:44 PM, CNA #9 entered 4 separate resident rooms in the Krampert hallway to assist residents with cares, transfers, and to push residents in wheelchairs to the dining room for the evening meal. At no time was the CNA observed to change her mask, wash her hands, or reposition and tighten the mask to form an effective barrier. During a subsequent observation at 7:15 PM, the CNA was observed in the Krampert dining room, standing behind a medication cart facing toward the center of the room. It was apparent that her mask was not securely fastened when, at 7:17 PM, she sneezed toward the center of the dining room and her mask was blown away from her face, exposing her nose and the upper portion of her mouth. She realigned the mask to cover her mouth, but allowed her nose to remain exposed. The CNA did not wash her hands after handling her mask and proceeded to assist resident #91 put on a clothing protector and positioned the resident's wheelchair at a dining table.	F 441		

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F 441	Continued From page 41 d. Interview with the ICN at 5:05 PM revealed the ICN was unaware the CNA felt ill. The ICN stated she spoke with the CNA's nursing supervisor and the supervisor's assessment was that the CNA "...was not running a fever ..." and, therefore, was allowed to work. The ICN further stated it was the CNA's decision to wear a mask, the supervisor had not directed her to do so. There was no observed interaction between the ICN and the CNA to correct the improper positioning of the mask or guidance for hand hygiene or changing the disposable mask periodically. e. The CNA stated in interview on 3/27/11 at 7:25 PM she was going home as soon as a replacement arrived. Review of her time card on 3/29/11 at 9:20 AM showed CNA #9 was not replaced early and worked a shift on 3/27/11 from 2:49 PM to 10:58 PM (8 hours and 9 minutes). f. On 3/29/11 at 2:40 PM, the ICN provided infection control policies and procedures for review. These documents included a statement prohibiting "...any employee with a communicable disease..." from working. However, the documents failed to establish criteria to define communicable or infectious conditions that prohibited employees from working, nor did they establish a system for notification and follow-up by the ICN. 3. Regarding a safe and sanitary setting for passing medications: a. Observation on 3/27/11 at 11:40 AM showed a carry-out container of food (chicken and French fries) on a medication cart (Yellow #2); there was also a white plastic bag labeled	F 441		

5/3/11 AM

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F 441	Continued From page 42 "Walmart" on the cart. The food container was uncovered and RN #3 was observed to eat from the container twice between 11:50 AM and 12:05 PM. RN #3 stated in interview on 3/27/11 at 3:20 PM that the medication cart should not be used to hold staff food or personal items. She further stated she ate her lunch from the cart because she did not have time to leave the nursing station. At 5:40 PM on 3/27/11, LPN #4 was observed passing medications from the "Yellow #2" cart in the vicinity of room 121. A piece of French fry and salt was visible on top of the cart. During an interview at that time, LPN #4 stated she had not cleaned the cart prior to beginning medication pass; she further stated she was not aware that staff had used the cart to hold food or an outside shopping bag. 4. Observations and interviews from 3/26/11 through 3/29/11 revealed multiple instances in which facility staff failed to practice acceptable infection control practices. These instances included the following: a. Inadequate Handwashing: (i) Observation during lunch on 3/27/11 showed CNA #1 assisted six residents (#9, #21, #91, #69, #135, #104) without washing or sanitizing her hands between residents. All six residents required extensive or total assistance. Interview with the CNA at the time revealed she should have cleansed her hands between feeding residents. (ii) Observation on 3/28/11 at 12:28 PM revealed CNA #1 gave resident #69 a spoonful of macaroni salad, scratched her head, then without cleansing or washing her hands fed the resident another spoonful of macaroni salad. Continued observation showed at 12:35 PM, the same CNA	F 441		

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F 441	Continued From page 43 scratched her nose and again, returned to feeding residents without washing or cleansing her hands. Interview with the CNA at the time revealed she should have cleansed her hands between feeding residents and after touching her hair and nose. (iii) Observation on 3/28/11 at 10 AM showed CNA #6 provided perineal care for resident #69 whose incontinence brief was soaked with urine. Observation revealed the CNA did not remove the soiled gloves used during the perineal care prior to placing an oxygen nasal cannula into the resident's nose. Interview with the CNA on 3/29/11 at 10 AM revealed the CNA was unsure what to do regarding changing gloves after perineal care. She said in CNA training she was taught to change between dirty and clean, but the other CNAs at this facility did not change their gloves so she just did what the others did. b. On 3/27/11 at 10:10 AM resident #29 was observed to position his/her wheelchair in front of the ice machine located at the East unit nursing station. The resident raised the lid to the ice bin and used a large scoop to fill his/her drinking cup with ice. The resident displayed hand tremors and ice was observed to contact his/her left hand and drinking cup before falling back into the ice machine bin. The resident stated in interview on 3/27/11 at 10:25 AM s/he regularly filled his/her cup with ice rather than wait for staff assistance. During the interview, the resident held out his/her left hand to reveal an IV port and stated s/he was getting "medicine" for an infection. Review of the resident's medical record showed s/he was currently receiving IV gentamicin for a UTI. Interview with RN #3 on 3/27/11 at 4:10 PM revealed she was not aware a resident was getting ice from the ice machine. When asked about infection control concerns, she	F 441		

5/3/11

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F 441	Continued From page 44 acknowledged the practice "...might have some problems, especially if people don't wash their hands."	F 441		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to securely attach hallway handrails in four locations. The findings were: Periodic observations from 3/26/11 at 3:48 PM through 3/29/11 at 3 PM revealed corridor handrails were loose in the following four locations: a. Outside the resident trust/Title 19 billing office. b. Opposite resident room 11. c. Next to resident room 16. d. By the water fountain in the secure unit. Interview with the Title 19 billing clerk on 3/27/11 at 3:48 PM revealed she was unaware the rail was loose outside her office. She stated it posed a fall risk to residents and staff. In addition, interview with RN #4 on 3/29/11 at 10 AM revealed she was unaware the handrails near the resident rooms cited above were loose. She also stated they represented a fall risk to residents. Interview with CNA #7 on 3/28/11 at 2:48 PM verified the handrail was loose in the secure unit.	F 468	**F 468** **The facility must equip corridors with firmly secured handrails on each side. This will be accomplished by:** **1. The identified loose handrails in the four locations were repaired.** **2. Safety Committee will conduct monthly rounds to identify subsequent non-secured handrails.** **3. Hand rails identified as loose will be immediately repaired.** **4. The Director of Maintenance and the Safety Committee will report results to the QA team for a period of 90 days. After that time, the audits will be conducted as directed by QA until it is determined the facility has achieved compliance.** **5/8/11**	
F 496 SS=E	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING	F 496		

5/3/11

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
	535042	A. BUILDING _____ B. WING _____	C 03/29/2011

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F 496	Continued From page 45 Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, the facility failed to verify information with the state CNA registry for 3 of 3 CNA (#1, #2, #3) employee records reviewed. The findings were:	F 496	**F 496** **Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. This will be accomplished by:** current staff 1. **All newly hired C.N.A.'s will be verified on the registry before beginning employment.** 2. **The Staffing Coordinator has been inserviced to the above deficiency as has his supervising Nurse.** 3. **The ADON will review any new C.N.A. hires to assure that compliance is maintained.** 4. **Compliance will be monitored the Director of Human Resources. Any deficient practices will be noted with immediate correction and**	

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F 496	Continued From page 46 Review of employee records for CNA's #1, #2, and #3 showed there was no documentation for verification of information with the state CNA registry. During an interview with the administrator on 3/29/11 at 9:30 AM, she confirmed that the facility did not verify information with the state CNA registry when hiring CNAs.	F 496	**reported to the QA team for a period of 90 days. After that time, the audits will be conducted as directed by QA until it is determined the facility has achieved compliance.**	**5/8/11**
F 503 SS=E	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's instructions, the facility failed to correctly annotate expiration dates for 5 of 5 vials	F 503	**F 503** **If a facility provides its own laboratory services, the services must meet the applicable requirements for laboratories. This will be accomplished by:** **1. All glucometer test strips that did not meet the manufacturer's 90 day open-vial stability limit were discarded.** **2. Nursing Staff been inserviced to the above deficiency.** **3. The Infection Control Nurse will conduct random audits of test strips to assure compliance. Any deviation from the policy will be immediately addressed.** **4. Results of audits will be reported to the QA team for a minimum of 90 days at which point the team will determine appropriate reporting until ongoing compliance is established.** **5/8/11**	

5/8/11

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F 503	Continued From page 47 of glucose reagent test strips inspected for expiration. The findings were: On 3/27/11 at 8:45 AM RN #3 was observed to perform glucose testing on a resident. The RN stated at this time each resident had their own glucose testing kit ("glucometer"). Five kits were selected at random for closer inspection; in addition to a glucometer, each kit included a vial of reagent test strips (50 test strips per vial). During the observation, the RN stated each vial of reagent strips was labeled with an expiration date. Review of the manufacturer's package insert for the reagent test strips on 3/27/11 at 9:10 AM revealed the open-vial stability (i.e., expiration after opening) was 90 days. The manufacturer's instructions stated test strips should not be used beyond the 90 day limit after opened. The RN stated she was not aware of the expiration date for opened vials and could not remember when the vials were opened. The RN stated an assumption that the contents of a vial would be consumed within 90 days, but added she was not sure if that were true for all residents. The Clinical Laboratory Improvement Amendment (CLIA) requirements for laboratory testing contained in the Code of Federal Regulations (CFR) 42, Part 493, prohibit facilities from using expired reagents. CLIA further requires testing personnel to follow the manufacturer's instructions.	F 503		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		

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F 520	Continued From page 48 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 review of quality assurance performance improvement (QAPI) program information, and staff interview, the facility failed to ensure an effective QAPI program was being implemented. The findings were: 1. Review of the QAPI information showed a lack of adequate information to identify focused areas that needed correction. In addition, there were no plans as to how systems or corrections would be made. The information included some data that was being collected; however, this data was not analyzed and there seemed to be no plan in place as to when or how the data would be used.	F 520	**F 520** **If 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. This will be accomplished by:** **1. The Quality Assurance Program was updated to include issues/trends/action plans discussed and documented in a formalized process. Agenda, reports, and minutes will be maintained.** **2. The QA Team will meet monthly until such time that the program is understood and efficiently administered.** **3. The process will be monitored by the Corporate Director of Operations and the Administrator with corrections/amendments incorporated, ongoing.**	**5/8/11**

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F 520	Continued From page 49 2. Interview with the DON and the quality assurance (QA) coordinator on 3/29/11 at 10 AM revealed they were aware of several areas that needed work, and stated they were continually working to correct deficiencies. The QA coordinator verified nothing was being done with the data at that time. She further revealed there were many changes in process with a new service agreement, and they were "just getting by." She stated there was not enough time to keep up the QAPI program, and they were hopeful for the new changes that were planned to take place in May 2011. Both staff members verified there was not a QAPI program in place at that time.	F 520		

5/3/11 pm