STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 05/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE & REHABILITATION CENTER	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on random observations, and staff and visitor interviews, the facility failed to ensure the wheelchairs for 2 sample residents (#75 and #99) were kept clean. The findings were: 1. Observation on 5/24/11 at 10 AM revealed CNAs #1 and #2 assisted resident #75 from his/her wheelchair to a sit-to-stand lift to provide incontinence care. Observation at that time showed the resident's wheelchair had dried food on the seat and right arm of the wheelchair. After the resident was provided incontinence care, the CNAs returned the resident to the wheelchair without cleaning the seat or arm of the wheelchair. 2. Observation on 5/24/11 at 8:55 AM revealed sample resident #99 had been incontinent of liquid stool which had soiled the wheelchair cushion and seat. CNA #3 assisted the resident to the toilet and wiped the top of the Roho wheelchair cushion. The CNA did not remove the cushion and clean the wheelchair seat under the cushion before assisting the resident back in the wheelchair. 3. On 5/23/11 at 1:55 PM, an anonymous visitor reported to the survey team concerns about observing soiled resident wheelchairs when s/he	F 253	**PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF STATE AND FEDERAL LAW** **F-253 – Housekeeping & Maintenance Services** **This plan of correction is the facility's credible allegation of compliance** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The wheelchairs and cushions for residents #75 and #99 were cleaned.	

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

Executive Director 06-20-11

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Accepted w/no changes doc - 7/10/11

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on random observations, and staff and visitor interviews, the facility failed to ensure the wheelchairs for 2 sample residents (#75 and #99) were kept clean. The findings were: 1. Observation on 5/24/11 at 10 AM revealed CNAs #1 and #2 assisted resident #75 from his/her wheelchair to a sit-to-stand lift to provide incontinence care. Observation at that time showed the resident's wheelchair had dried food on the seat and right arm of the wheelchair. After the resident was provided incontinence care, the CNAs returned the resident to the wheelchair without cleaning the seat or arm of the wheelchair. 2. Observation on 5/24/11 at 8:55 AM revealed sample resident #99 had been incontinent of liquid stool which had soiled the wheelchair cushion and seat. CNA #3 assisted the resident to the toilet and wiped the top of the Roho wheelchair cushion. The CNA did not remove the cushion and clean the wheelchair seat under the cushion before assisting the resident back in the wheelchair. 3. On 5/23/11 at 1:55 PM, an anonymous visitor reported to the survey team concerns about observing soiled resident wheelchairs when s/he	F 253	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by RN Unit Managers/Designees to confirm that all resident's wheelchairs are appropriately cleaned on a scheduled basis as well as checked for cleanliness throughout the day. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** RN Unit Managers/Designee will routinely audit to confirm that resident's wheelchairs are appropriately cleaned and remain clean. Based on the results of the audit, additional education will be provided as needed. Wheelchairs and cushions are cleaned weekly based on the schedule developed on each Unit. Systemic changes will include the review of the schedule for cleaning wheelchairs and confirm that the schedule is adhered to.	

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F 253	Continued From page 1 visited the facility during the past month. 4. Interview on 5/25/11 at 4 PM with the nurse manager revealed the policy was that wheelchairs were to be cleaned the night before a resident was scheduled to be bathed, but she added if the wheelchair was obviously soiled, her expectation was it would be cleaned immediately.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the care plan for 1 of 22 sample residents (#75) was revised	F 280	**F-280 – Right to Participate Planning of Care – Revise CP** **This plan of correction is the facility's credible allegation of compliance** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** The care plan for resident #75 was updated to reflect the change in their toileting program as well as their transfer status. IDT members will be educated by the Case Management Coordinator/Designee regarding the completion of comprehensive care plans based on identified resident needs and updating care plans to reflect changes.	

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F 253	Continued From page 1 visited the facility during the past month. 4. Interview on 5/25/11 at 4 PM with the nurse manager revealed the policy was that wheelchairs were to be cleaned the night before a resident was scheduled to be bathed, but she added if the wheelchair was obviously soiled, her expectation was it would be cleaned immediately.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the care plan for 1 of 22 sample residents (#75) was revised	F 280	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the RN Unit Managers /Designee to confirm that the current care plan for all residents is accurate and revised if needed. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Systemic changes will include an on-going audit of care plans by the Case Management Coordinator/MDS Coordinator/ Designee per the MDS schedule to identify that changes in resident's status have resulted in changes in the care plan.	

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F 280	Continued From page 2 after the most recent assessment to reflect the current status of the resident. The findings were: 1. Review of the 3/28/11 significant change MDS assessment for resident #75 showed s/he was always incontinent of urine, frequently incontinent of bowel and was not on a toileting program. The assessment also showed the resident required extensive assistance for toilet use, and transfers for this resident required at least two persons. Observation on 5/24/11 at 10 AM showed staff used a sit-to-stand lift to check and change the resident for incontinence. However, review of the care plan, last updated 1/11/11, showed it did not reflect the resident's current status. The care plan showed the resident required limited assistance for transfers and was on a prompted voiding schedule. Interview with MDS coordinator #1 on 5/25/11 confirmed the care plan did not reflect the current status of the resident and needed to be updated.	F 280	**Monitoring the Corrective Action(s) Performance to Make Sure Systems are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is July 10, 2011.	7/10/11
F 309 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and family interview, the facility failed to ensure early assessment and intervention for 1 of 7 sample	F 309	**F-309 – Providing Care/Services for Highest Well Being** **This plan of correction is the facility's credible allegation of compliance.** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #124 discharged from the facility on 01/31/11.	

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F 309	Continued From page 3 residents (#124) who had a urinary tract infection (UTI). The findings were: Review of the nursing notes dated 1/19/11 at 9:05 PM showed resident #124 had a fever of 101.9 degrees Fahrenheit and was given Tylenol. Review of the 1/21/11 nursing note, timed 5 PM, revealed a urinalysis (UA) and culture and sensitivity (C&S) was requested by the family and an order was obtained. Interview with a family member on 5/25/11 at 7:10 PM revealed the family requested the tests because the resident was "lethargic and staring off." Also, they had noticed a strong urine odor in the resident's room. The family member stated these same symptoms had been displayed when the resident had previous UTIs. Review of the 1/21/11 at 6 PM (Friday evening) physician orders showed an order for a UA and C&S, if indicated. However, according to the nurses notes the urine was not actually collected until 1/24/11 (three days later). Results of the urine culture were received on 1/26/11 and the sensitivity report on 1/28/11. Review of the nurses notes dated 1/28/11 at 4 PM showed treatment with oral antibiotics was started for a UTI, nine days after the onset of symptoms. Further review of the untimed nursing notes dated 1/29/11 revealed the resident was not eating or drinking well and was very drowsy. On 1/30/11 at 12 PM-12:30 PM nursing notes showed the resident's blood pressure was low at 71/49, and pulse rate was increased at 137. Intervenous (IV) fluids were started and the nurses note written at 7 PM showed an order was received for IV antibiotics. On 1/31/11 at 9:23 AM the resident had to be transferred to the hospital.	F 309	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** RN Unit Manager/Designee will conduct an audit of laboratory orders received within the most recent 30 days to confirm that lab testing was performed as ordered. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** Licensed Nurses will be educated by the Staff Development Coordinator/Designee regarding: • Facility policy and procedure related to laboratory services; • Process for ordering unscheduled or urgent lab tests; • Communicating the resident's status to the physician to facilitate obtaining lab orders appropriately; and • Signs and symptoms of Urinary Tract Infections (UTI).	

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F 309	Continued From page 3 residents (#124) who had a urinary tract infection (UTI). The findings were: Review of the nursing notes dated 1/19/11 at 9:05 PM showed resident #124 had a fever of 101.9 degrees Fahrenheit and was given Tylenol. Review of the 1/21/11 nursing note, timed 5 PM, revealed a urinalysis (UA) and culture and sensitivity (C&S) was requested by the family and an order was obtained. Interview with a family member on 5/25/11 at 7:10 PM revealed the family requested the tests because the resident was "lethargic and staring off." Also, they had noticed a strong urine odor in the resident's room. The family member stated these same symptoms had been displayed when the resident had previous UTIs. Review of the 1/21/11 at 6 PM (Friday evening) physician orders showed an order for a UA and C&S, if indicated. However, according to the nurses notes the urine was not actually collected until 1/24/11 (three days later). Results of the urine culture were received on 1/26/11 and the sensitivity report on 1/28/11. Review of the nurses notes dated 1/28/11 at 4 PM showed treatment with oral antibiotics was started for a UTI, nine days after the onset of symptoms. Further review of the untimed nursing notes dated 1/29/11 revealed the resident was not eating or drinking well and was very drowsy. On 1/30/11 at 12 PM-12:30 PM nursing notes showed the resident's blood pressure was low at 71/49, and pulse rate was increased at 137. Intervenous (IV) fluids were started and the nurses note written at 7 PM showed an order was received for IV antibiotics. On 1/31/11 at 9:23 AM the resident had to be transferred to the hospital.	F 309	The RN Unit Managers/Designee will conduct an audit to confirm that physician ordered UA's and subsequent C&S laboratory testing are conducted timely and in accordance to the physician's order with specific attention being given to weekend C&S testing. The RN Unit Managers/Designee will conduct an audit to confirm that residents exhibiting signs and symptoms of an urinary tract infection are treated appropriately and timely. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is July 10, 2011.	7/10/11

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F 309	Continued From page 4 Interview with the DON on 5/25/11 at 4:00 PM revealed the reason for the lack of timeliness in collecting the UA was due to the agreement that laboratory tests were not performed during the weekend unless the physician ordered them STAT (immediately). Routine labs ordered by the physician on Friday evening or on the weekend would not be done until the following Monday. Review of the laboratory service agreement showed routine courier services were provided by the laboratory on a routine basis, during normal business hours Monday through Friday. STAT services were provided at an additional charge. According to Smeltzer, Bare, Hinkle and Cheever in " Textbook of Medical-Surgical Nursing," eleventh edition, 2008, pages 1573, 1575: "Elderly patients often lack the typical symptoms of UTI and sepsis...nonspecific symptoms such as altered sensorium, lethargy, anorexia, new incontinence, hyperventilation, and low-grade fever, may be the only clues ...early recognition of UTI and prompt treatment are essential to prevent recurrent infection and the possibility of complications such as renal failure and sepsis."	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 observations, medical record review,	F 312	**F-312 – ADL Care Provided for Dependent Residents** **This plan of correction is the facility's credible allegation of compliance** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Residents #27, #75, and #99 were provided appropriate incontinence care.	

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F 312	Continued From page 5 staff interview, and review of the facility's policy and procedure, the facility failed to ensure adequate incontinence care for sample residents (#27, #75, #99) during 3 of 6 random observations of incontinence care. The findings were: According to Hegner, Acello, and Calwell in "Nursing Assistant A Nursing Process Approach," 9th edition, 2010: "Always wipe from clean to dirty with a single wipe, then turn or discard the cloth." Failure to follow this standard of practice was identified during the following observations: 1. Review of the 3/21/11 annual MDS assessment for resident #99 showed the resident needed extensive assistance with toileting and bathing. Observation on 5/24/11 at 8:55 AM revealed CNA #3 provided the resident with incontinence care. The resident had been incontinent of liquid stool. The CNA assisted the resident in changing clothes, cleaned the back of the residents legs, buttocks, and rectal area, but did not clean the resident's anterior pubic area. Review of the facility's incontinence/perineal care policy and procedure showed cleaning the anterior pubic area was included in the procedure. 2. Review of the 3/28/11 significant change MDS assessment for resident #75 showed the resident needed extensive assistance with toileting and bathing. Observation on 5/24/11 at 10 AM revealed CNAs #1 and CNA #2 assisted the resident with incontinence care. CNA #1 removed the resident's incontinent brief which was saturated with urine. The CNAs cleaned around the resident's rectum and buttocks, but did not	F 312	An in-service will be conducted by the Staff Development Coordinator/Designee with facility staff to educate on the proper practice of providing adequate incontinence care which includes the anterior peri area. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** Observations/audits will be conducted by the RN Unit Managers/Designee to confirm that residents are provided appropriate incontinence care. This will include confirming that the anterior pubic area is cleaned and that staff are wiping from clean to dirty. Education will be provided immediately on an as needed basis.	

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F 312	Continued From page 5 staff interview, and review of the facility's policy and procedure, the facility failed to ensure adequate incontinence care for sample residents (#27, #75, #99) during 3 of 6 random observations of incontinence care. The findings were: According to Hegner, Acello, and Calwell in "Nursing Assistant A Nursing Process Approach," 9th edition, 2010: "Always wipe from clean to dirty with a single wipe, then turn or discard the cloth." Failure to follow this standard of practice was identified during the following observations: 1. Review of the 3/21/11 annual MDS assessment for resident #99 showed the resident needed extensive assistance with toileting and bathing. Observation on 5/24/11 at 8:55 AM revealed CNA #3 provided the resident with incontinence care. The resident had been incontinent of liquid stool. The CNA assisted the resident in changing clothes, cleaned the back of the residents legs, buttocks, and rectal area, but did not clean the resident's anterior pubic area. Review of the facility's incontinence/perineal care policy and procedure showed cleaning the anterior pubic area was included in the procedure. 2. Review of the 3/28/11 significant change MDS assessment for resident #75 showed the resident needed extensive assistance with toileting and bathing. Observation on 5/24/11 at 10 AM revealed CNAs #1 and CNA #2 assisted the resident with incontinence care. CNA #1 removed the resident's incontinent brief which was saturated with urine. The CNAs cleaned around the resident's rectum and buttocks, but did not	F 312	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The RN Unit Managers/Designee will routinely observe staff providing incontinence care to confirm that it is performed in an acceptable manner. Based on the results of the observations, education will be provided immediately on an as needed basis. **Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is July 10, 2011.	7/10/11

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F 312	Continued From page 6 clean the anterior pubic area. Interview on 5/25/11 at 10:50 AM with CNA #1 revealed when she performed perineal care she was taught to "clean front to back and all crevices." 3. Review of the 2/14/11 quarterly MDS assessment and corresponding care plan for resident #27 showed the resident required extensive assistance with incontinence care. On 5/24/11 at 8:40 AM, CNA #4 and RN #1 were observed providing fecal incontinent care for the resident. During the observation, the CNA cleansed the resident with back to front strokes.	F 312		
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 by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure 1 of 1 sample residents (#27) with pressure ulcers received the necessary care, assessments and treatment in a timely manner to promote pressure ulcer healing. The findings were: Review of the 12/1/10 re-admission MDS assessment and corresponding CAA for resident	F 314	**F-314 – Treatment/Services to Prevent/Heal Pressure Sores** **This plan of correction is the facility's credible allegation of compliance** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #27 is routinely followed by the Wound Team for treatment recommendations and progress toward healing. The care plan for Resident #27 will be updated to include repositioning. The wheelchair cushion for Resident #27 was replaced on 05/24/11.	

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F 314	Continued From page 7 #27, showed the resident had the following risk factors for developing pressure ulcers: immobility due to left sided weakness, chair-bound, urinary and bowel incontinence, severe pulmonary disease, diabetes, congestive heart failure, oxygen use, daily doses of diuretics, and recurrent pressure ulcers. Review of the 2/14/11 quarterly MDS assessment showed the resident was cognitively intact, required extensive assistance with mobility and continued to be at risk for developing pressure ulcers. According to the medical record, the resident was hospitalized for treatment of pneumonia on 4/18/11 and readmitted to the facility on 4/21/11. Further review showed the resident did not have pressure ulcers prior to admission to the hospital, but returned to the facility with a stage I pressure ulcer on the coccyx that deteriorated to a stage II pressure ulcer by 5/6/11. Review of the 5/13/11 quarterly nursing assessment showed the pressure ulcer was pink and measured 1 centimeter (cm) by 0.5 cm by less than .01 cm. This review also showed the pressure ulcer wasn't undermined and had no drainage. Review of the 5/20/11 weekly skin assessment showed the pressure ulcer began to have serosanguineous (serum and blood) drainage with a scant amount of exudate (cloudy fluid), remained pink, and measurements were unchanged. Observation of the pressure ulcer on 5/23/11 at 4:40 PM verified that it appeared as documented on 5/20/11. According to Rehabilitation Nursing, Vol. 36, No. 3, May/June 2011, "A Nurse-led Approach to Preventing Pressure Ulcers, Multidisciplinary Strategies to Consider to Reduce Risk Factors for Pressure Ulcer", there are prevention standards for specific risk factors. For the risk factor	F 314	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** An audit will be conducted by the RN Unit Managers /Designee to identify other residents to determine if the appropriate wheelchair cushion is placed and to identify residents with positioning needs. Based on the results of the audit, wheelchair cushions will be replaced as needed.	

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F 314	Continued From page 8 "exposure to pressure/reduction in mobility and activity" the prevention standard included: "Develop and implement a repositioning/turning/movement plan of care based on complete skin assessment. Reposition bed-bound patients at least every two hours and chair-bound patients every hour. Teach chair-bound patients who can do so to shift weight every fifteen minutes. use appropriate pressure-redistributing devices." For the risk factor "exposure to moisture", the prevention standard included: "Perform a daily head-to-toe skin assessment. Establish a bladder/bowel program for patients with incontinence." The following concerns with providing effective treatment for this resident's pressure ulcer were identified: a. During an interview on 5/23/11 at 2:45 PM, the resident stated s/he knew s/he needed to reduce the time s/he sat in the wheelchair due to the pressure ulcer. The resident stated that s/he had only one functional hand and leg due to a stroke and independent repositioning was not possible. S/he added that staff had not talked about or attempted scheduled repositioning at times when s/he was in the wheelchair. The resident also talked about the pressure relieving cushion in the wheelchair and described it as, "flat and uncomfortable." S/he stated staff had been telling him/her for weeks that they would get a new one, but it had not been done. b. Review of the care plan, updated 5/19/11, showed the resident required extensive assistance with personal hygiene care, incontinent care, transfers and toileting. Further review showed the resident liked to sit up for prolonged periods of time and refused to lie down periodically. However, review of the interventions	F 314	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Staff Development Coordinator/Designee will provide education to nursing staff regarding: • Facility policy and procedure related to repositioning; • Communicating need for evaluation to PT/OT as appropriate; and • Periodic evaluation of interventions to determine effectiveness and to make changes as needed. Systemic changes will include on-going audits of residents in wheelchairs to identify those that need new wheelchair cushions and repositioning schedules/care plan updates. These audits will be conducted by the RN Unit Managers /Designees.	

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F 314	Continued From page 9 for preventive skin care failed to show interventions that addressed repositioning when the resident was in the wheelchair. The review showed interventions for prompted voiding and incontinence care, but interventions for a bowel program were lacking. c. With the exception of nutritional intervention, review of the pressure sore monitoring system showed no documentation of periodic assessments regarding the effectiveness of the interventions that had been implemented. According to the April and May 2011 treatment record, the treatment was to apply Calazime paste and leave open to air. Further review of the treatment record showed this treatment remained unchanged from 4/21/11 to 5/26/11. d. Interview with the physical therapist on 5/25/11 at 3:30 PM revealed he replaced the resident's Contour Plus pressure relieving cushion with a RoHo cushion on 5/24/11. The physical therapist also stated he had not been informed about issues regarding the resident's pressure relieving cushion prior to 5/23/11. Interview with the DON on 5/26/11 at 11:05 AM revealed the Contour Plus pressure relieving cushion was provided in November 2010. The DON also stated the resident developed recurrent pressure ulcers due to noncompliance in limiting the hours s/he sat in the wheelchair. e. Observations of the resident revealed the following: On 5/23/11, s/he was in bed from 2:15 PM until 4:40 PM. On 5/24/11, s/he told staff that s/he wanted to go to bed after breakfast, and at 8:40 AM CNA # 4 and RN #1 transferred the resident to bed. The resident remained in bed until lunchtime that day. On 5/25/11 from 7 AM until 10 AM the resident was observed to sit in the wheelchair without repositioning.	F 314	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designees will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is July 10, 2011.	7/10/11

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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 medical record review, observation and staff interview, the facility failed to ensure 1 of 4 residents (#75) were evaluated and monitored for safety with mechanical lift use. The findings were: Review of the medical record for resident # 75 showed s/he had diagnoses that included muscle weakness, diffuse atrophy (wasting) and arthritis. Further review showed the resident received Tylenol three times daily for pain. Observation on 5/24/11 at 10 AM revealed CNAs #1 and #2 assisted the resident from a sitting position in a wheelchair to a standing position with a sit-to-stand mechanical lift. During the observation, the resident did not bear much weight on his/her legs and appeared to be hanging from the lift's sling which was positioned underneath the resident's arms. Throughout the time the CNAs performed incontinence care while the resident was in the lift, the resident displayed facial grimacing. When the CNAs started to lower the resident back into the wheelchair, the resident was pulled to the left in order to be in the correct position. At that time, the resident cried out in	F 323	**F-323 – Free of Accident Hazards/Supervision/Devices** **This plan of correction is the facility's credible allegation of compliance** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #75 has been assessed for the safest transfer method and is currently being transferred in the appropriate manner. **Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The RN Unit Manager/Designee will conduct audits/observations to confirm that residents requiring transfer via a mechanical lift have been assessed for the safest transfer method, documented accordingly, and are currently using the safest transfer method. Education will be provided immediately on an as needed basis.	

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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 medical record review, observation and staff interview, the facility failed to ensure 1 of 4 residents (#75) were evaluated and monitored for safety with mechanical lift use. The findings were: Review of the medical record for resident # 75 showed s/he had diagnoses that included muscle weakness, diffuse atrophy (wasting) and arthritis. Further review showed the resident received Tylenol three times daily for pain. Observation on 5/24/11 at 10 AM revealed CNAs #1 and #2 assisted the resident from a sitting position in a wheelchair to a standing position with a sit-to-stand mechanical lift. During the observation, the resident did not bear much weight on his/her legs and appeared to be hanging from the lift's sling which was positioned underneath the resident's arms. Throughout the time the CNAs performed incontinence care while the resident was in the lift, the resident displayed facial grimacing. When the CNAs started to lower the resident back into the wheelchair, the resident was pulled to the left in order to be in the correct position. At that time, the resident cried out in	F 323	**Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Staff Development Coordinator/Designee will provide education to the nursing staff regarding safe transfers. The RN Unit Managers/Designee will routinely observe residents being transferred via a mechanical lift to confirm that the appropriate lift is being used, that the transfer is safe and as pain-free as possible, and that the staff is using the lift properly.	

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F 323	Continued From page 11 pain. The following concerns with the use of the lift were identified: a. Interview with the physical therapist on 5/24/11 at 2:35 PM revealed the resident was not evaluated for the sit-to-stand lift by the therapy department. Further, he stated they rely on nursing to contact physical therapy (PT) if an evaluation should be needed or if there was a question concerning the appropriateness of a lift. After describing the observation of the resident during his/her transfer, the therapist questioned the safety of the sit-to-stand lift for this resident's functional status and pain issues. b. Interview with unit manager #2 on 5/25/11 at 1:15 PM revealed, after review of the resident's medical record, no documentation was found related to an evaluation for the use of the sit-to-stand lift by nursing or PT. c. Review of the PT evaluation for the sit-to-stand lift, dated 5/25/11, showed the resident had "facial grimace" and complained of pain during lift use. S/he supported weight but "leaned backward" and bore "considerable weight through axilla [armpit]." Further, the PT evaluation revealed the justification for services was to "assess safest transfer method."	F 323	**Monitoring the Corrective Action(s) Performance to Make Sure Solutions are Sustained:** The Director of Nursing/Designee will report outcomes of audits to the Performance Improvement Committee monthly times 3 for their review, recommendations, and direction as needed. Date of compliance is July 10, 2011.	7/10/11
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 502		

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F 323	Continued From page 11 pain. The following concerns with the use of the lift were identified: a. Interview with the physical therapist on 5/24/11 at 2:35 PM revealed the resident was not evaluated for the sit-to-stand lift by the therapy department. Further, he stated they rely on nursing to contact physical therapy (PT) if an evaluation should be needed or if there was a question concerning the appropriateness of a lift. After describing the observation of the resident during his/her transfer, the therapist questioned the safety of the sit-to-stand lift for this resident's functional status and pain issues. b. Interview with unit manager #2 on 5/25/11 at 1:15 PM revealed, after review of the resident's medical record, no documentation was found related to an evaluation for the use of the sit-to-stand lift by nursing or PT. c. Review of the PT evaluation for the sit-to-stand lift, dated 5/25/11, showed the resident had "facial grimace" and complained of pain during lift use. S/he supported weight but "leaned backward" and bore "considerable weight through axilla [armpit]." Further, the PT evaluation revealed the justification for services was to "assess safest transfer method."	F 323		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 502	**F-502 - Administration** **This plan of correction is the facility's credible allegation of compliance** **Corrective Action(s) for Those Residents Found to Have Been Affected by the Deficient Practice:** Resident #97's CBC has been completed. Blood glucose monitoring strips bottles have been audited to confirm that they are appropriately labeled with an expiration date and that they have not expired.	

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F 502	Continued From page 12 interview, the facility failed to ensure an ordered laboratory test was completed for 1 (#97) of 22 sample residents. In addition, observation revealed the facility failed to ensure the test strips for glucometers were not outdated in 1 of 3 glucometer testing kits. The findings were: 1. Medical record review for resident #97 revealed on 4/12/11, the physician ordered a complete blood count (CBC) and a comprehensive metabolic panel (CMP) to be done on 4/18/11. Review of laboratory tests showed results of a CMP done on 4/18/11, but there were no results for the ordered CBC. Interview on 5/25/11 at 10:35 AM with the nurse manager revealed the CBC was not done as ordered. 2. Observation on 5/25/11 at 1200 PM showed a bottle of blood testing glucose monitoring strips were open and available for use, but not dated as to when they were opened. Interview with the unit manager #2 at that time revealed she was not aware of the expiration date of the monitoring test strips. Review of the label instructions showed the test strips were good for 4 months once opened. The unit manager acknowledged the strips needed to be labeled with the date and time once opened.	F 502	**Identification of Other Residents Having the Potential to be Affected by the Same Deficient Practice:** The RN Unit Managers/Designee will audit all physician order requests for laboratory tests to confirm that the tests were performed as ordered. The RN Unit Managers/Designee will audit all blood glucose strips bottles to confirm that they are appropriately labeled with an expiration date and that they have not expired. **Measures Put into Place/Systemic Changes Made to Ensure that the Deficient Practice(s) Does Not Recur** The Staff Development Coordinator/Designee will provide education to licensed nurses regarding facility procedure for obtaining and tracking laboratory tests and for dating blood glucose monitoring strips.	

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