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

PRINTED: 07/16/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	C 07/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

(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 DON - director of nursing MDS - Minimum Data Set CNA - certified nurse aide MRSA: Methicillin-resistant Staphylococcus aureus (a drug-resistant bacterium) lap buddy - soft restraint hooked around the arm rests of a wheelchair or geriatric chair to prevent a resident from rising Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident, family, and staff interviews, and review of internal investigations, the facility failed to identify medical symptoms necessitating use of restraints, determine that the restraints applied were the least restrictive device or action which could maintain safety and independence of the residents, and/or ensure the restraints were not imposed for staff convenience for 3 of 3 sample residents (#4, #5, #19) with restraints. The	F 221	F221 The facility will meet this requirement as evidenced by providing a comprehensive assessment for any resident, including #4,5,& 19, receiving an order for restraints. The assessment will define the medical symptoms, determine the least restrictive restraint & identify safety protection & supervision for each resident. All restraint use will be appropriately toileted per facility protocol. Residents #19 and #4 will be toileted per facility protocol. Protocol will be developed for restraints during meal times.	8/15/10 Care Planned F 65

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Doris Brown — TITLE: Administrator — (X6) DATE: 8/14/10

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: FKVZ11 Facility ID: WY0009 If continuation sheet Page 1 of 85

Wyoming Dept of Health
AUG 16 2010
Office of Healthcare Licensing and Surveys

This POC accepted with all additions & corrections per phone conversation on 8/17/10 @ 1615 between Doris Brown, CEO & Betty Nilson RN, Health Care Surveyor

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F 221	Continued From page 1 findings were: 1. Review of the 6/7/10 quarterly MDS assessment and 6/14/10 care plan showed resident #19 was able to ambulate and transfer with extensive assistance. On 6/29/10 at 7:20 AM the resident was observed at a table in the dining room. The resident was seated in a geriatric (geri) chair with a lap buddy in place from until 10:30 AM (3 hours and 10 minutes) without being repositioned or allowed to get up from the chair. At 9:36 AM the resident requested scissors from the surveyor to "cut this thing off." The resident was pulling on the lap buddy during this request. Additionally, observations on 6/30/10 at 1:10 PM, 2:30 PM, and 7:05 PM and on 7/1/10 at 3 PM showed the resident in bed with full side rails raised on both sides of the bed. At no time during these observations was the resident trying to reposition him/herself. According to nursing documentation dated 6/18/10 at 4:30 PM, the resident sustained a laceration to the back of the head from an unwitnessed fall in the dining room and was taken to the emergency room. Review of readmission orders dated 6/18/10 at 5:40 PM showed the physician ordered a "lap buddy" for this resident. However, there was no description of the medical symptoms necessitating use of the restraint. Further review of two orders, each dated 8/21/10, showed "Both side rails up while in bed per family request and MD approval to aid in bed repositioning & safety" and "Resident is to have lap buddy on at all times per family request and MD permission. Resident is to sit sideways (in W/C & lap buddy) while at Dining room table." Again, a description of the symptoms requiring these restraints was lacking. The following concerns with use of restraints	F 221	The facility will have staff present in the dining room to meet the needs of residents before, during and after meals. This requirement will be maintained by in-servicing nursing staff, families and physician on facility protocol for restraint use and removal, restraint assessment and dining room supervision. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program	

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F 221	Continued From page 2 for this resident were identified: a. A specific medical symptom or condition necessitating the use of either a lap buddy or side rails was not identified. Neither was there a determination of how the use of restraints would benefit a targeted medical condition, protect the resident's safety, and maintain as much independence as possible. On 6/29/10 at 3:30 PM the DON stated the facility met with the family to explain why a physician's order and/or family request was insufficient for use of restraints. However, she further stated the facility had not made any changes prior to the survey. b. The facility failed to complete an assessment to determine if the restraints were the least restrictive devices or actions that could be implemented to assure safety for this resident and maintain his/her independence. Examples of devices could include a wedge cushion, a helmet, various protective pads, anti-tippers for the chair, or a floor mat. Examples of actions which could be taken could include positioning the back of the wheelchair or gerichair seat lower than the front, changing the wheels so the large ones would be in the front, or lowering the bed. Interview with the DON on 7/1/10 at 7 AM confirmed these or other alternative interventions had not been attempted. c. Review of the care plan revealed that neither the use of the lap buddy nor the side rails was care planned. Interview with the DON on 7/1/10 at 7 AM confirmed the care plan was current. d. There was no evidence the restraints were not being used for staff convenience. The following interviews revealed staff were not always present in the dining room when residents were brought in before meals: 1. During an interview on 7/1/10 at 8:15 AM, a family member stated staff were not always	F 221		

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F 221	Continued From page 3 present in the dining room when residents were there. 2. On 7/1/10 at 11 AM, interview with the emergency medical services (EMS) responder (a CNA actually assigned to acute care) who initially found the resident revealed facility staff were not present in the dining room on 6/18/10 when the resident fell. The responder stated she would assist with meals in the nursing home when she was not busy in acute care. The EMS responder reported she had accepted pureed foods from the dietary staff and was setting them down when she heard a crash, turned, and found the resident on the floor; however, the responder stated she did not actually observe the fall. The responder further stated she had to yell for help and instruct the CNA who answered to find the nurse. Review of the facility's internal investigation verified these statements. 3. On 7/1/10 at 6:30 PM resident #12 stated it there were frequently no staff in the dining room when they were trying to get residents up for meals. The resident stated s/he would be the only person watching other residents. 2. On 6/28/10 observation showed resident #4 was seated in a wheelchair with a lap buddy in place at 5:06 PM. Further observation showed the resident's meal was served at 5:27 PM. The lap buddy was not removed during the meal even though a CNA sat immediately next to the resident and provided one-to-one assistance. Observation on 6/29/10 at 8:37 AM revealed the same scenario during breakfast. Review of the assessment showed the facility failed to determine if a lap buddy was the least restrictive restraint which could be used to assure safety and yet maintain as much independence as	F 221		

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F 221	Continued From page 4 possible. Examples of less restrictive interventions are itemized with resident #19. 3. Review of the 6/3/10 quarterly and 3/8/10 significant change MDS assessments showed resident #5 was coded as having "other than full" side rails on both sides of the bed; use of a chair that prevented rising was not documented. Observation on 6/28/10 at 6:05 PM and on 6/29/10 from 7:27 AM until 11:44 AM showed the resident was in a gerichair with a tray table which s/he was unable to remove. The observation on 6/29/10 showed the resident was seated beside a table, but actually ate his/her breakfast from the tray table. Review of nursing documentation showed the resident fell in February 2010 and, according to information on the radiology report, may have sustained a fractured pelvis. Review of the consent form for the gerichair showed the resident had been in it since March 2010. Detailed review of the medical record revealed no assessment to determine if the gerichair and tray table was the least restrictive restraint or how it would improve the resident's quality of life. Review of the care plan last updated on 6/2/10 showed a gerichair was to be used when the resident was not in bed, but there was no documentation supporting the use of the tray table. Finally, since the resident was seated appropriately at the dining room table during the evening meal on 6/28/10, there was no evidence that the tray table was not used for staff convenience.	F 221		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents	F 244		

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F 244	Continued From page 5 and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews, and review of written correspondence from the facility to the families of residents, the facility failed to ensure grievances raised by families were addressed and the resulting decisions effectively communicated back to the families. The findings were: Four confidential family interviews took place between 6/28/10 and 7/1/10; each of the families voiced concerns regarding care and operations at the facility. Their concerns focused on a lack of "...sincerity and care..." in staff-resident interactions, rapid turnover among staff that created discontinuity and confusion, occasions when the facility appeared dirty or "...smelled bad...", and a lack of feedback from the facility (characterized by the families as "...they [facility staff] are defensive...and evasive..."). The interviewees further stated they did not have a free-flow of communications from the administrator or DON. Each of the four family interviews also cited a letter they received, signed by the social services director and dated 4/26/10, as a concern in that they interpreted some of the language as "...defensive..." or "...threatening..." Reference was made to what these families perceived as a cumbersome process for registering complaints and an offer of assistance to help relocate residents if family members felt the facility did not	F 244	F244 The facility will meet this requirement by notifying family and residents, in writing, of the reasoning for changing the complaint/concern process, appropriate procedure for filing complaints/concerns and residents and family will also be notified in writing of resolution. The facility will attempt to resolve complaints/concerns until no further options can be identified. In addition this letter will inform residents and their families of possible alternatives they could choose if their complaints/concerns ~~are not addressed~~ cannot be resolved to their satisfaction. Furthermore, all families will be informed they may meet at the facility to discuss mutual concerns with other family members, in private, if they so desire, & their concerns will be acted upon. This requirement will be maintained by educating staff on facility procedure for filing,	8/15/10

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F 244	Continued From page 6 meet the needs of a resident. This later item was viewed by all four interviewees as implying their family member might be moved if they continued to complain. A copy of the letter sent to family members was reviewed on 6/30/10 at 4:40 PM. The language used in the letter could be perceived as a threat because the facility left the families with no option other than relocation if they were dissatisfied. The family interviews also described attempts to meet as a family group at the facility as a "...failure..." The interviewees stated they felt as though the meetings were orchestrated by the facility to divert attention from their concerns and, instead, were limited to "...providing educational materials..." The interviewees further stated that several families chose to meet outside the facility in order to discuss their concerns. Interview with the administrator and DON on 7/1/10 at 5:10 PM confirmed several families had complained to facility staff. The administrator stated she was not aware family members felt threatened by language in the letter sent from social services, nor was the intent of the correspondence to discourage communication between facility staff and families. The DON stated she was also unaware this had been the result of the social services letter to family members.	F 244	follow-up and resolution to resident and family complaint/concerns. A quality indicator will be developed and monitored on a monthly basis by Social Services through QA/QI program. Housekeeping staff will follow deep cleaning protocol per policy on a monthly basis or as needed. Infection Control will monitor cleanliness of facility and will report through QA/QI program.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and family and staff interviews, the facility failed to maintain a clean, sanitary environment. Three of 4 fans used by residents contained a buildup of dust and debris, the bedroom and bathroom floors for 1 of 9 sample residents (#19) was dirty, several of the dining room chairs were stained and contained crumbs, and large stains were present on the carpet at the nursing station. The findings were: Observation throughout the survey and specifically with the DON on 7/1/10 at 2:55 PM revealed the following concerns: a. Resident fans in rooms #201, #202, and #216 contained a buildup of dust and debris on the protective grate and on the blades. b. Several of the dining room chairs contained crumbs in the pads placed in the each seat and upon the upholstery. In addition, stains were present on the upholstery of many chairs c. Debris was present on the floor under the bed of resident #19. Furthermore, the bathroom floor was sticky, especially around the toilet. d. Several large stains were present on the carpet at the nursing station. The DON confirmed the lack of general cleanliness during the observations. During confidential interviews, four family members also stated the facility was not as clean as it had been at one time. Specific issues raised during these interview were the dining room chairs, individual resident recliners, "fuzzy" corners, debris under the beds, "musty" smells, and just generally "doesn't look clean."	F 253	F253 The facility will meet this requirement as evidenced by performing the following housekeeping and maintenance scheduled duties: a. Monthly fan cleaning schedule b. Daily walk through of each room by LTC staff to address any housekeeping or maintenance issues c. Weekly inspection of dining room chairs and cleaning as needed d. Carpet at nurses' station will be inspected daily and shampooed as needed. This requirement will be maintained by in-servicing all LTC staff, including housekeeping and maintenance of these changes. A quality indicator has been developed and will be monitored by Housekeeping/Maintenance monthly through QA/QI program.	7/25/10
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS	F 272		

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F 272	Continued From page 8 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on review of medical records and staff interviews, the facility failed to complete comprehensive assessments in various areas for 4 of 10 sample residents (#4, #5, #9, #11). The findings were:	F 272	F272 The facility will meet this requirement by conducting a comprehensive assessment for residents #4, #5, #9. #11 and all residents will receive a comprehensive assessment, if needed due to significant change of status, quarterly and annually. ~~a. Review of each resident's current care plan for possible omissions from Triggers and RAPS~~ b. Facility will provide MDS training for MDS Coordinator and all sections will be appropriately completed. c. All assessments will be completed by admitting nurse and the information will then be used by the interdisciplinary team and the MDS Coordinator to provide complete and accurate information in all areas triggered for RAP summaries.	8/15/10

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F 272	Continued From page 9 1. According to the 4/28/10 admission MDS assessment, comprehensive assessments were required for resident #4 as s/he was completely incontinent of bowel, experienced mild pain less than daily, and was restrained with side rails and a chair which prevented rising. Observation on 6/28/10 at 5:05 PM and on 6/29/10 at 7:25 AM showed the resident was restrained with a lap buddy. Review of the "Bowel Retraining Assessment" showed a notation dated 4/8/10, "Res incont [resident incontinent] Dx [diagnosis] Dementia." The remainder of the assessment was incomplete with a line drawn diagonally across the page. Review of the 4/9/10 pain assessment showed it was also incomplete with a line drawn diagonally through most of the questions. Refer to F323 for further information regarding lack of a safety assessment for the lap buddy. Interview with the MDS coordinator on 7/1/10 at 1:20 PM confirmed the bowel and pain assessments were incomplete. Additional review of the MDS assessment revealed Section V lacked information designating the location of assessment information for cognitive loss, visual function, communication, ADL (activities of daily living) functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, pressure ulcers, psychotropic drug use, and physical restraints. Furthermore, the care planning decision was not checked for any item except ADL function and urinary incontinence. During the aforementioned interview with the MDS coordinator, she confirmed Section V was incomplete. The coordinator also stated she had been at the facility about six months, but had no education in use of this MDS.	F 272	This requirement will be maintained by in-servicing all staff involved in the MDS process. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	

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F 272	Continued From page 10 2. Review of the 3/8/10 significant change MDS assessment showed resident #5 required comprehensive assessments in the areas of communication, ADL functional/rehabilitation potential, bowel incontinence, restraints, and falls. Review of those assessments revealed a bowel assessment and a restraint assessment for use of a gerichair (a wheeled, upholstered recliner) with a lap buddy were lacking. Further review revealed the assessments for communication and ADL functional/rehabilitation potential were not comprehensive; they repeated information already in the MDS, failed to identify causes and contributing factors, and failed to describe the impact on the resident's life. Refer to F309 for further information related to the lack of a bowel management program. Refer to F323 for details related to lack of post fall assessments and restraint use. 3. Sample resident #9's medical record was reviewed on 8/29/10 at 2:15 PM. The ADL Functional/Rehabilitation Potential assessment initiated on 3/10/10 and updated on 6/4/10 was discovered to be incomplete and inaccurate. The section with the heading "Behavior Factors for Consideration" solicited information regarding behavior problems, but the staff wrote "...taking Vicodin on schedule..." and did not address specific behavorial problems. Further, where the assessment form solicited information for persistent mood problems, staff wrote "...taking Lexapro..." and failed to address any mood status or related problems. 4. Refer to F323 for details regarding lack of a siderail safety assessment for resident #11.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	C 07/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

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F 274	Continued From page 11 A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change assessment for 1 of 3 sample residents (#19) who met the criteria to have that type of assessment. The findings were: Review of the 3/11/10 significant change MDS assessment showed resident #19 required limited assistance with transfers and ambulation in the room and hallway, and was occasionally incontinent of bowel and bladder. Comparison of that assessment with the 6/7/10 quarterly MDS assessment revealed the resident had declined in all of the itemized areas; s/he was identified as requiring extensive assistance with transfers and ambulation and was frequently incontinent of bowel and bladder. Furthermore, the 6/7/10 note for falls described the resident as requiring more assistance. On 7/1/10 at 7:35 PM, the DON confirmed that a significant change assessment	F 274	F274 The facility will meet this requirement as evidenced by resident #19, will have a significant change of status assessment completed. All residents who meet the criteria to initiate the significant change of status assessment will have an assessment completed within 14 days after facility determines there has been a significant change in status. The MDS/care plan will be reviewed upon completion at weekly interdisciplinary team/care plan meeting, by the MDS Coordinator and the interdisciplinary team members to ensure accurate data has been recorded. This requirement will be maintained by in-servicing all staff involved in the MDS process. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	8/15/10

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8/17/10

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F 274	Continued From page 12 should have been completed.	F 274		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of medical records and laboratory reports, the facility failed to ensure accurate assessments for 3 (#3, #5, #32) of 10 sample residents. The findings were:	F 278	F278 The facility will meet this requirement as evidenced by residents #5, #3 and #32 will have their assessment reviewed for accuracy and updated. All residents MDS will be reviewed for accuracy. The MDS/care plan will be reviewed upon completion at weekly interdisciplinary team/care plan meetings, by the MDS Coordinator and the interdisciplinary team members to ensure accurate data has been recorded. This requirement will be maintained by training all staff involved on the MDS process. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	8/15/10 BD

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F 278	Continued From page 13 1. Medical record review on 6/29/10 and 6/30/10 revealed the following discrepancies in section I.2 ("Diseases") on the MDS form: a. The quarterly MDS completed on 6/9/10 for resident #32 failed to include the resident's current infection with a drug-resistant organism. A sputum culture submitted 6/3/10 was positive for MRSA and reported to the facility on 6/5/10. Antibiotic therapy was initiated on 6/7/10 and droplet precautions were established for the resident's room the same day. b. The quarterly MDS for resident #3 dated 5/23/10 was coded in section I.2 for infection with a drug-resistant organism. Further review of the record failed to uncover evidence to support the coding. Review of microbiology culture results with the laboratory manager on 6/30/10 at 2:10 PM failed to find any reports of drug-resistant isolates from resident #3 in the last 12 months. c. The MDS coordinator stated in interview on 6/30/10 at 3:05 PM she "...missed..." the MRSA culture results for resident #32, even though she did update the resident's care plan for the infection on 6/7/10. She further stated resident #3 was coded for infection because s/he had a history of MRSA infection and was considered colonized. She stated she was not aware section I.2 was limited to active infections. The DON stated in interview on 6/30/10 at 3:36 PM that coding for diseases was "...confusing..." and the facility was uncertainly on how to capture MRSA colonization information on MDS assessments. 2. Review of the 6/3/10 quarterly MDS assessment showed resident #5 was coded as having a fecal impaction within the 14 day period prior to the 5/30/10 MDS assessment. Detailed	F 278		

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F 278 SS=D	Continued From page 14 review of the resident's medical record and the DON's bowel tracking record showed no evidence of an impaction. Interview with the MDS coordinator on 6/30/10 at 3:12 PM revealed the coding was an error.	F 278	F279 The facility will meet this requirement as evidenced by resident #5 care plan will be reviewed and update. All other residents care plan will be reviewed and updated ~~quarterly, annually and/or as significant change indicates~~ as indicated.	8/15/10
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive care plan which addressed identified issues for 1 of 10 sample residents (#5). The findings were: According to the 6/3/10 MDS assessment,	F 279	Care plans will include psychotropic medications side effects and other non-medication behavioral interventions or individual resident specific techniques for behavioral modification. The MDS/care plan will be reviewed upon completion at weekly interdisciplinary team/care plan meeting, by the MDS Coordinator and the Interdisciplinary team members to ensure accurate data has been recorded and care plan updated. Care plan changes will be communicated to staff after the interdisciplinary team meeting and at stand-up meeting.	

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F 279	Continued From page 15 resident #5 was completely incontinent of urine. However, review of the care plan showed the facility failed to develop a plan addressing this issue. After reviewing the care plan on 6/30/10 at 1:35 PM, the DON confirmed the lack of a care plan to address the resident's urinary incontinence. Additionally, review of the care plan for psychotropic medications revealed it was not comprehensive. It listed the antidepressant and antianxiety medications the resident took and instructed staff to administer medications as ordered, remove the resident from excess stimuli, and to redirect, reorient, and reassure the resident as needed. Side effects of the medications were not listed; nor were any diversionary activities which might benefit the resident. Furthermore, ways or techniques to redirect, reorient, and reassure the resident were not described.	F 279	This requirement will be maintained by training all staff involved in the ~~MDS process~~ care of the residents of the importance of updating and following care plans. A quality indicator has been developed and will be monitored by IDT through QA/QI program.	
F 280 SS=E	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	F 280	F280 The facility will meet this requirement as evidenced by reviewing the plan of care and following the physicians orders for residents #5, #11, #19. All residents plan of care will be reviewed and updated in a timely manner or as significant change indicates. Nursing staff will update all care plans to reflect any changes made including discontinuing use of items or	8/15/10

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F 280	Continued From page 16 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to revise care plans to reflect the current conditions of 3 of 9 sample residents (#5, #11, #19). The findings were: 1. According to a physician's order dated 6/9/10, resident #5 was to receive milkshakes or smoothies as a liquid option at meals instead of thickened liquids which were discontinued on that date. Review of the care plan, found in the care plan book and last reviewed by the facility on 6/2/10, showed the resident received a regular diet with regular texture; however, liquids were not mentioned as either milkshakes, smoothies, or thickened liquids. Observation on 6/28/10 at 5:23 PM and on 6/29/10 at 8.37 AM showed the resident was served regular liquids. The above listed observations also showed the resident seated in a geriatric chair (an upholstered, wheeled recliner). Review of the physician's orders showed an order for physical therapy to evaluate and treat the resident. Detailed review of the medical record on 6/29/10 revealed the evaluation was not included; however, a nursing note dated 6/28/10 documented staff were to continue using the fireman's lift with this resident. Review of the care plan showed the resident required the assist of two staff at all times for turning, repositioning, and incontinence care. The fireman's lift was not included as an approach in the care plan. During	F 280	new orders/interventions to be initiated. This requirement will be maintained by in-servicing nursing staff of these procedures. Nursing staff will also be in-serviced on proper notification of non-nursing disciplines when new orders are received. A quality indicator has been developed and will be monitored by IDT through QA/QI program.	

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F 280	Continued From page 17 an interview on 6/29/10 at 2:05 PM, the DON stated that *all* care plans in the care plan book were current, and, on 6/30/10 at 1:35 PM, she stated she was unaware of the nursing note to continue using a fireman's lift. 2. Observation on 6/28/10 at 1:45 PM revealed resident #11 did not have an indwelling urinary catheter. On 6/28/10 at 3:55 PM, the DON reported that all catheters (including the resident's) except one had been discontinued. During an interview that day at 4:30 PM, the resident stated s/he had recently expelled the catheter, and it was not replaced. Review of the current care plan, last updated after the 6/13/10 annual MDS assessment, revealed it had not been revised to reflect the discontinuation of this resident's catheter. 3. Refer to F323 for information related to the facility's failure to revise resident #19's the fall care plan for falls.	F 280		
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 observation, medical record review, and staff interview, the facility failed to ensure staff followed professional standards of practice related to medication administration for 3 of 8 residents (#10, #11, #17) observed during medication passes. The findings were: 1. Observation on 6/29/10 showed LPN #4	F 281		

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F 281	Continued From page 18 prepared and administered medications and the dietary supplement, Lipoic Acid 600 milligrams (mg), to resident #10 at 9:31 AM. Reconciliation of the medication pass with the physician's orders showed the physician originally ordered Lipoic Acid on 4/27/10 but failed to specify a dose. The orders for May and June 2010 also failed to include a dose. Interview with the DON on 6/29/10 at 2:01 PM revealed the dosage was never clarified. On 7/1/10 at 9:34 AM the DON stated she had checked with the pharmacist, and the dose for blood sugar control ranged from 300 mg to 600 mg; however, neither the DON, LPN #4, nor the pharmacist was able to explain how the 600 mg dose for this resident was determined. According to Elkin, Perry, Potter in "Nursing Interventions & Clinical Skills", 2007, page 382: nurses should "check incomplete or unclear orders with the prescriber before implementation." 2. Observation on 6/30/10 at 7:20 AM showed LPN #4 prepared an injection of Lantus insulin for resident #11. During preparation of the medication, the LPN placed her fingers on the inside of the plunger, thus contaminating the syringe. Further observation showed the LPN moved the plunger back and forth to expel an air bubble in the insulin. During this process, the insulin became contaminated from contact with the inside of the syringe prior to being pushed back into the bottle and contaminating the insulin contained in the bottle for future use. When questioned about this technique, the LPN stated this was her usual practice when drawing up injectable medications. She confirmed that the sterility of the syringe was lost using this technique and that the medication was contaminated. Review of the schedule revealed	F 281	F281 The facility will meet this requirement as evidenced by resident #10 will have orders clarified to include dosage and diagnosis for the use of lipoic acid, nursing staff preparing Lantus insulin injections for resident #11 will be inserviced on safe medication administration practices, resident #17 medications will be checked for expiration date and disposed of if expired. All nurses will be inserved on safe medication practices included checking for expiration dates and proper disposal of expired medications. Medications must be administered correctly to all residents. This requirement will be maintained weekly by observing and reviewing medication passes and monitored by MDS Coordinator or DON through QA/QI program.	8/15/10

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F 281	Continued From page 19 this LPN worked fifteen of the previous days in June and would have administered insulin to the resident. According to Elkin, Perry, and Potter, in "Nursing Interventions & Clinical Skills", 2007, page 417, staff should "avoid touching" the plunger of a syringe. 3. Observation on 6/29/10 at 8:55 AM showed LPN #4 prepared medications, including Citrucel, 1 Tablespoonful, for resident #17. Prior to administering the Citrucel, the LPN checked the expiration date on the container and discovered it expired on 5/2010. She immediately discarded the medication and obtained a new container. However, she confirmed the expired medication had been used during the month of June 2010. Review of the schedule revealed this LPN worked fifteen of the previous days in June when the medication was administered. According to Elkin, Perry, and Potter, "Nursing Interventions & Clinical Skills", 2007, page 389, staff should "check expiration date on medication" before administering.	F 281		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure care plans were implemented as written for 4 of 9 sample residents (4, #5, #9, #19). The findings were:	F 282		

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F 282	Continued From page 20 1. Review of nursing documentation dated 6/18/10 at 4:30 PM showed resident #19 was found on the floor in the dining room with a laceration to the back of the head. Review of the care plan for falls dated 6/18/10 showed the following interventions should be implemented: a. Maintain record of falls...evaluate for patterns b. Falling Star or other symbol on door c. Gripper socks d. PT (physical therapy) evaluation for strength training, gait, or transfer e. Non-skid strips on floor f. Wedge in chair g. Chair alarm h. Bed in lowest position, with side rails down i. Half side rails to assist with transfer Observation from 6/28/10 at 5 PM through 6/30/10 at 3 PM revealed these interventions were not implemented. Interview with the DON on 6/30/10 at 3:30 PM confirmed the lack of implementation. The DON stated the care plans were generic, and the interventions had not been individualized as appropriate for the resident. 2. According to the 3/2/10 assessment information for falls, resident #6 fell on 2/21/10 and, per information on the radiological report, may have sustained a fractured pelvis. According to the 6/2/10 care plan, located in the care plan book, the resident was to have the assistance of two staff members at all times for repositioning and incontinence care. Observation on 6/29/10 at 10:30 AM showed the resident was transferred to the toilet by CNA #9. This CNA also independently completed incontinence care and transferred the resident back to the geriatric chair.	F 282	F282 The facility will meet this requirement as evidenced by residents #4, 5, 9 and #19 care plan interventions will be implemented and individualized for these residents. All resident care plan interventions will be individualized and implemented as written. Furthermore, temporary or generic care plans will primarily be implemented for antibiotic use. Nursing staff will be updated as needed regarding care plan interventions at stand-up meetings. The facility will maintain this requirement with weekly resident care observations and will be monitored by IDT with follow up through QA/QI program.	8/15/10

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F 282	Continued From page 21 During both transfers the resident stood beside the toilet with his/her knees bent and held onto the grab bar while the CNA helped him/her pivot. On 6/29/10 at 2:05 PM, the DON confirmed the care plan was current. 3. Resident #9 was observed on 6/28/10 from 4:45 PM to 5:50 PM during the evening meal. The resident was observed to drink a cup of cappuccino prior to moving his/her wheelchair to the dining table; staff brought him/her 2 additional cups of cappuccino during the meal, but did not offer the resident any cueing or assistance to eat. The resident ate his/her pudding cup, but did not consume any of the meat, vegetables, or bread served to him/her. At 5:25 PM the resident left the table, rolled his/her wheelchair to the nurse's station, and was given a fourth cup of cappuccino. The resident's current care plan was based on assessments developed from an admission MDS assessment dated 9/14/10; it was modified following a quarterly MDS dated 5/31/10. According to it, the resident required cuing and assistance at meals to ensure s/he ate. Interview with the DON on 7/1/10 at 4:40 PM revealed she was aware this resident required assistance. The DON stated she did not know staff failed to offer assistance during the observed meal, nor that the resident consumed four cups of cappuccino in lieu of the observed meal. 4. According to the incontinence care plan, resident #4 was to be toileted per the toileting schedule while the falls care plan instructed staff to toilet the resident every two hours. Observation on 6/29/10 showed the resident was not toileted from 7:20 AM until 11:44 AM, a time period of 4 hours and 24 minutes. On 7/1/10 at 1:13 PM the	F 282		

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F 282	Continued From page 22 DON confirmed the resident's toileting schedule was every two hours.	F 282		
F 309 SS=E	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 staff interview, medical record review, and review of the bowel tracking records and protocol, the facility failed to implement their bowel protocol for 4 of 4 sample (#3, #4, #5, #19) and 2 non-sample (#16, #18) residents in order to prevent possible fecal impactions or painful, constipated bowel movements. The findings were: Review of the bowel tracking record for June 2010 indicated that after two days without a bowel movement, residents were to receive a dose of natural laxative; after three days, Milk of Magnesia; after four days, a suppository; and after five days, an enema. In addition, the physician was to be notified on day five. The following concerns with failure to implement this protocol were identified: a. Review of the 6/3/10 quarterly MDS assessment showed resident #5 was coded for a fecal impaction within the fourteen days prior to 5/30/10. After reviewing the MDS assessments on 6/28/10 at 3:30 PM, the DON confirmed that	F 309	F309 The facility will meet this requirement as evidenced by residents #3, 4, 5, 16, 18, and #19 will have an updated bowel protocol in a timely manner. All residents will have bowel assessments completed on admission, quarterly, annually and/or significant change. Training and in-service on bowel protocol and bowel assessment will be provided to nursing staff. Assessment and findings will be incorporated into the care plan and will include resident specific interventions The MDS/care plan will be reviewed upon completion at weekly interdisciplinary team/care plan meeting, by the MDS Coordinator and the interdisciplinary team members to ensure accurate data has been recorded.	8/15/10

implemented by

the protocol will be implemented as indicated. by

The bowel tracking form will be reviewed daily. Interventions implemented as necessary by

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F 309	Continued From page 23 the coding was correct. However, she stated she was unaware of any impaction. Although detailed review of the resident's medical record and the bowel tracking record revealed no evidence of a fecal impaction during that time period, review of the June 2010 bowel tracking record showed the resident went four days without a bowel movement twice during the month. The record also showed the resident once went five days without a bowel movement during June. Review of June's medication administration record (MAR) showed the resident received a suppository the morning after each four or five day event, but there was no evidence earlier interventions were implemented. The tracking record indicated a bowel movement did occur each time the resident received a suppository, but there was no indication if the resident was constipated or impacted. b. According to the 4/28/10 admission MDS assessment, resident #4 was totally incontinent of bowel, but there was no documentation to indicate constipation, diarrhea, or fecal impaction. Review of the bowel tracking records from May 1st through June 28th of 2010 showed the resident went without a bowel movement for four consecutive days during May and once for five consecutive days during June. In addition, there were three times during the two months where the resident went three days without a bowel movement. Review of the MARs and the nursing documentation for those months showed no evidence any interventions were implemented during these time periods. c. Although the 6/7/10 quarterly MDS assessment showed no documentation that resident #19 was constipated, review of the June 2010 bowel tracking record revealed two times where the resident had no bowel movement for	F 309	A quality indicator will be developed and monitored by IDT monthly through QA/QI program	

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F 309	Continued From page 24 three days and once for five days. According to the June 2010 MAR, the resident received a suppository the morning after the five day occurrence, but there was no documentation other interventions were implemented at an earlier time per the protocol. d. Review of the bowel tracking records showed resident #3 went four days without a bowel movement once in May 2010 and once for five days in June 2010. The resident was also documented as going without a bowel movement for a two day period on seven different occasions during May and June 2010. Review of the medical record provided no evidence the facility's protocol had been implemented. On 6/29/10 at 5 PM the DON confirmed that the interventions listed on the bowel tracking record constituted the facility's bowel protocol. She further stated evidence was lacking that staff followed the protocol for the two non-sample residents, #16 and #18, whose records she was asked to review. Finally, the DON reported there was no evidence staff were following the bowel protocol for all residents without a bowel movement for two or more days. According to the June 2010 bowel tracking record, this involved 27 of the 32 residents residing in the facility.	F 309		
F 323 SS=G	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.	F 323	F323 The facility will meet this requirement as evidenced by residents #5, #11, #19, #21, #31, will have appropriate assessment, monitoring and supervision in place for residents injured or at risk for	8/15/10

to prevent/minimize injury

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F 323	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident, family, and staff interview, and review of internal reports and investigations, the facility failed to appropriately assess, monitor, or supervise 3 of 9 sample (#5, #11, #19) and 2 non-sample (#21, #31) residents who were injured or were at risk for injuries. In addition, staff failed to report injuries to residents #21 and #31 so that investigations could be conducted and further injuries be prevented. As a result, residents #19, and #21, experienced avoidable harm. The findings were: 1. Review of the 3/11/10 significant change MDS assessment revealed resident #19 required limited assistance with transfers and ambulation in the room and corridor. The documentation also indicated the resident's sitting and standing balance was unsteady, and that s/he had fallen within the past 31 to 180 days. Review of the comprehensive assessment for falls showed the resident had a diagnosis of osteoporosis, showed a decline in cognition, was walking less, and had fallen on 1/8/10. Review of the 6/3/10 quarterly assessment showed the resident's status had declined; s/he required extensive assistance with transfers and ambulation in the room and corridor and had fallen twice during the past 30 days, as well as the past 31 to 180 days. The resident's balance had also declined while standing and s/he required assistance to complete the test. The 6/7/10 note on the comprehensive assessment form for falls documented the resident fell twice during the past quarter due to poor balance. Review of the 6/7/10 "Balance and Gait Assessment" revealed the resident had recently had a "marked" change in mobility, lost	F 323	injury. All residents will be assessed for the need of adequate supervision and assistive devices upon admission, quarterly, annually and/or a significant change of status for safety concerns. The information gathered from assessments will be used by IDT and the MDS Coordinator to provide complete and accurate information. When an incident occurs the charge nurse on duty will begin a post fall assessment during her shift and document in the nurses notes the interventions s/he has assessed, other staff will complete appropriate reports, new orders from physician and the information will be passed on to all staff and documented.. Interdisciplinary team will complete the review and assess for further interventions as needed at the next IDT meeting. All incidents will be investigated & reported as required and residents will receive appropriate treatment in a timely manner. BD	

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F 323	Continued From page 26 stamina as the day progressed and then used a wheelchair, and had fallen on 4/9 and 4/26/10. The assessment also documented "POC [plan of care] updated." Review of the 6/7/10 "Fall Risk Assessment" revealed the resident "is a high fall risk. Note several falls this last six months...POC updated." Review of the POC to prevent falls, dated 6/14/10, showed the resident's blood pressure was to be monitored daily and the physician was to be notified if it was elevated, medications were to be administered as ordered, a personal alarm was to be in place, and staff were to anticipate the resident's needs. "Res [resident] ambulates with walker, monitor closely for unsteady gait" had been crossed through. Although the resident had declined, was known to have a history of falls, was increasingly unsteady, and the care plan had been "updated" by removing information about the walker, no other interventions to prevent falls were implemented. Review of nursing documentation dated 6/18/10 at 4:30 PM showed the resident was found lying on the floor bleeding from a laceration to the back of the head. The following concerns related to the facility's failure to prevent an avoidable injury resulting in harm to the resident were identified: a. Even though the resident was assessed as a high fall risk, and the documentation indicated s/he was weaker, particularly in the evening, additional interventions were not devised and implemented. b. Comparison of the 6/14/10 care plan with the previous one showed that, with the exception of removing information about the walker, the interventions had not been changed. c. Although the resident was assessed as weaker with decreasing stamina throughout the day, physical therapy was not involved to	F 323	Smoking assessments will be completed on all smoking residents and will be placed in their chart. Assessments will be reviewed as needed and residents will be instructed to smoke in designated areas only. Policy will be changed to reflect areas as the safest designated area for the residents and still support resident independence. The board will be informed per the Administrator. Safety of devices used will be determined by IDT and recommendations sent to physician as needed. Nursing staff will be in-serviced on smoking assessments, fall assessments and the importance of proper documentation and reporting of incidents. A quality indicator has been developed and will be monitored monthly by IDT through QA/QI.	

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F 323	Continued From page 27 determine if strengthening exercises would be beneficial. d. Review of the incident report and internal investigation showed facility staff were not present in the dining room when the resident fell. e. On 6/30/10 at 3:30 PM the DON confirmed appropriate interventions had not been included on the 6/14/10 care plan. She also confirmed that the new care plan was not put in place until after the resident's fall on 6/18/10. 2. Review of nonsample resident #21's medical record showed a nursing note dated 6/25/10 stating the resident's left 6th finger was swollen, red, and warm to the touch. Continued charting on 6/25/10 through 6/28/10 confirmed the resident's finger was infected and antibiotic therapy was initiated on 6/25/10. However, the record lacked clear information to show how the resident's finger was first injured. The DON stated in interview on 6/30/10 at 4:10 PM that a CNA was trimming the resident's fingernails on 6/23/10 and accidentally cut the resident's finger. A subsequent interview with the nursing unit coordinator revealed her impression the resident's finger was caught between his/her wheelchair and a door frame. Neither description was documented in the medical record, nor was there any information to show the initial injury was assessed. The DON reaffirmed in interview on 7/1/10 at 10:25 AM the injury was caused by nail clippers. She further acknowledged there was no incident report to document the injury, nor was there any documentation of the event in the medical record until the cut became infected and required antibiotic treatment. 3. During an interview on 6/29/10 at 8:55 PM, a	F 323		

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F 323	Continued From page 28 family member stated non-sample resident #31 had recently experienced unexplained injuries to his/her head and knee. The injury to the resident's head involved a walnut sized lump on the forehead at the hairline. The family member further stated that when s/he asked staff about the lump on the resident's forehead, no one knew what had happened, nor had the resident been assessed. The family member further stated that a CNA who no longer works at the facility later told her she was alone while pulling the resident's pants up in the bathroom when the resident fell forward, striking his/her forehead against the wall. According to the family member the CNA had not reported the injury. According to the family member, the injury to the resident's knee occurred after the head injury and involved a large amount of swelling and bruising. Review of the medical record showed no documentation of the injury to the resident's head. However, there was a notation dated 2/12/10 at 10:45 AM that the resident had "...an egg sized lump" on the right knee with some bruising on top. "Resident showing s/s [signs and symptoms] severe pain upon contact." There was no documentation indicating how the injury occurred. The following deficient practices related to these avoidable injuries that resulted in harm were identified: a. Review of incident reports revealed neither injury was reported and investigated. Interview with the DON on 7/1/10 at 2:35 PM revealed she questioned the staff that day (7/1/10), and CNA #6 remembered that a traveling CNA was dressing the resident when s/he fell forward and struck his/her forehead against the wall. The DON confirmed the lack of documentation, incident reports, and investigation. Review of the falls care plan, initiated on 2/5/08 and due for	F 323		

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F 323	Continued From page 29 re-evaluation on 2/10/10, revealed the resident was at high risk for falls and was to have "1 or 2" staff assisting during transfers. The number/word "1 or" had been crossed off at some undated and unknown time. Additionally, the DON stated no one knew how the resident's knee was injured, and she confirmed an incident report and investigation had not been completed. b. Due to the lack of reporting, the resident was not assessed for a head injury. In addition, there was no evidence the resident's risk for falls was reviewed or that the care plan was revised, if necessary. On 7/1/10 at 1:13 PM the DON stated the facility did not complete post fall assessments so that the actual reason a resident fell was never determined. She further stated the only assessment that was completed after a fall was a neurological (neuro) check if the resident hit his/her head. She confirmed neuro checks were not performed for the resident after this fall. c. Due to the lack of reporting, neither the resident's family nor the physician were informed of the injury to the resident's head. 4. On 6/29/10 at 6:50 AM resident #11 was observed to drive his/her electric wheelchair out the front door of the facility and maneuver across a two-lane road to an area adjacent to a residential garbage can. S/he then smoked a cigarette. Interview with the resident at 7 AM the same morning revealed s/he routinely used this area for smoking. S/he further stated the facility designated a smoking area "...out the back door..." but s/he preferred the observed location because it allowed him/her to retain independent movement. The resident stated the back door had a lock that s/he could not open from the outside and, therefore, required staff assistance to reenter the building.	F 323		

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F 323	Continued From page 30 The resident stated in a subsequent interview on 6/30/10 at 11:45 AM that s/he sometimes had to "...wave cars down..." driving on the street in order to cross the street; s/he further stated the Sheriff's car came down the street "...kind of fast..." at times. The resident stated s/he spoke with the administrator and DON about her smoking location and was told s/he should use the designated area. Besides loss of independence and freedom of movement, the resident further stated she liked to smoke a cigarette "...in the middle of the night..." and staff were not always able, or willing, to assist her with the back door. The resident then revealed that at night s/he went to a different location further down the street to an area with a street light because s/he did not like to smoke in the dark. The interview ended with the resident's comment that there were snakes in the grass by the smoking area s/he used. This resident's medical record and associated assessments were reviewed on 6/30/10 at 4:20 PM and again on 7/1/10 at 7:12 AM. The record failed to show evidence staff completed a smoking assessment and determined the resident could safely exit the facility and smoke independent of staff assistance. The resident was observed on multiple occasion between 6/28/10 and 7/1/10 to exit the facility in his/her electric wheelchair, cross the street, and smoke. Furthermore, review of the 8/20/09 "Physical Restraint and Siderail Safety Assessment" showed it was incomplete. The areas that determined if it was safe for the resident's use were blank. The DON stated in interview on 7/1/10 at 3:20 PM that a safe smoking assessment had not been completed for resident #11. The DON acknowledged she was aware the resident exited	F 323		

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F 323	Continued From page 31 the facility and smoked across the street. Interview with the maintenance director on 6/30/10 at 3:20 PM revealed he was concerned about the resident's safety when crossing the street and affirmed s/he was independent and "...determined..." He acknowledged a small snake was killed in the area on 6/29/10. The administrator stated in an interview on 7/1/10 at 3:30 PM that she had talked with the resident about using the designated smoking area behind the facility and the resident resisted, citing her desire to be independent. The administrator stated she had approached the hospital board for approval to allow the resident to smoke under a covered entry way by the front door, but her request had been denied by the board. On 6/30/10 at 2:36 PM, three individuals were observed smoking in the prohibited area described by the administrator. When interviewed by the surveyor on 6/30/10 at 2:50 PM, they stated they were visiting a friend in the hospital (co-located with the long-term care facility), saw cigarette butts on the ground, and assumed it was "OK to smoke here...." 5. Observation on 6/29/10 at 1:46 PM showed resident #5 was transferred to bed by CNAs #1 and #10. After completing care, the CNAs raised both half side rails and left the room. Review of the 6/3/10 quarterly and 3/8/10 significant change MDS assessments showed the resident was totally dependent on staff for bed mobility and that two staff members were required to move the resident. Further review showed the resident used half side rails which were coded and assessed appropriately. However, review of the "Physical Restraint and Side Rail Safety Assessment" dated 3/10/10 showed the safety	F 323		

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F 323	Continued From page 32 assessment had not been completed for the side rails. Review of nursing documentation dated 6/22/10 at midnight revealed the resident's alarm sounded, and the resident was found kneeling on the floor impact mat beside the bed. The resident was assisted up by staff, toileted, and put back to bed. Review of incident reports revealed the unwitnessed fall was not reported or investigated. At 5 PM on 6/30/10 the DON stated she was unaware of the resident's fall on 6/22/10, and she confirmed neither a post fall assessment nor an investigation was done.	F 323		
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	F329 The facility will meet this requirement as evidenced by residents #5, #19, will have medication regiments reviewed and tracked by nursing staff and physician with documentations to support use or discontinuation of the medication. All residents will have nursing staff, pharmacist, and physician review quarterly, annually and/or ^ significant changes of status and as needed with documentation to support use.	8/15/10

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F 329	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimes for 2 of 9 sample residents (#5, #19) were free of unnecessary drugs. The findings were: 1. Review of physician's orders and the medication administration records (MARs) showed resident #6 had received the antidepressant Lexapro 10 milligrams (mg) since 9/30/09. Detailed review of the medical record provided no evidence of a physician's rationale for not attempting a dosage reduction of the antidepressant. On 6/29/10 at 4:40 PM the DON verified the lack of a rationale. She further stated she was unaware that a gradual dose reduction should be attempted with antidepressant medications or that physician's should document the risks versus the benefits if it was felt the current dosage was appropriate for continued use. 2. According to the physician's orders and the MARs, resident #19 had received Zoloft (an antidepressant) 100 mg since 9/29/09. Review of the medical record provided no evidence of a physician's rationale for not attempting a dosage reduction. On 7/1/10 at 7:55 PM the DON stated a physician's rationale was "probably not done" as she (the DON) was unaware of the need to review antidepressant medications and attempt a dosage reduction or document the rationale for continued use at the current dose.	F 329	It will be reviewed by the interdisciplinary team and any recommendations will be given to the physicians as indicated for each resident. This requirement will be maintained by monthly monitoring of quality indicator by IDT through QA/QI.	
F 332	483.25(m)(1) FREE OF MEDICATION ERROR	F 332		

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F 332 SS=E	Continued From page 34 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, review of medical records, and staff interview, the facility failed to maintain a medication error rate under five percent. Observation of various medication passes revealed the occurrence of 3 errors out of 43 opportunities for error, resulting in an error rate of 6.9 percent. The findings were: 1. Observation on 6/29/10 showed LPN #4 prepared and administered medications for resident #13 at 9 AM. Reconciliation of the medication pass with the physician's orders revealed the LPN omitted Xanax which had been ordered to be given every 8 hours. When interviewed at 10:50 AM that morning, the LPN stated the medication was only given on an as needed (prn) basis. After reviewing and confirming the 6/4/10 signed order, the LPN found a verbal order dated 4/27/10 that changed the routine medication to prn, but she stated it had evidently not been included on the May or June 2010 order forms, thus resulting in the error of omission. 2. Observation on 6/30/10 at 9:22 AM showed LPN #4 prepared and administered medications for resident #28. Reconciliation of the medication pass with the physician's June 2010 order form showed Zofran and Meclizine were ordered for routine administration, but had not been given. At	F 332	F332 The facility will meet this requirement as evidenced by residents #13 and 28 will have: a. Review of all monthly order sheets and any updated information will be noted. b. Nursing will continue to review to ensure accuracy of recap before being sent to medical staff. c. The nurse administering medication will check each of the 5 rights of medication administration (right resident, right time, right medication, right dose and right route) prior to administering a medication. Nursing staff will be in-serviced on safe medication practices. This requirement will be maintained by weekly observation of medication pass. A quality indicator has been developed and will be monitored by DON and MDS Coordinator through QA/QI program.	8/15/10

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F 332	Continued From page 35 7:35 PM that evening the LPN stated both medications were only given on a prn basis, even though they were ordered for routine administration on the current order form. These omissions resulted in two errors.	F 332		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete an ordered physical therapy (PT) evaluation in a timely manner for 1 of 4 sample residents (#19) who required this evaluation. The findings were: Medical record review showed resident #19 fell and sustained a scalp laceration on 6/18/10. Further review showed a physician's order dated 6/21/10 for PT to "evaluate and treat" the resident for "balance and weakness" as s/he he was a "high fall risk." Medical record review on 6/30/10 showed no evidence the evaluation had been completed nine days after being ordered. Interview with the DON on 7/1/10 at 1:13 PM confirmed the evaluation had been delayed due to incomplete paperwork.	F 406	F406 The facility will meet this requirement by documentation on resident #19's follow up from Physical Therapy states family refused physical therapy. All new orders for residents for any specialized rehab services will be implemented by requiring nursing staff to notify specialized rehab services the day an order is written via fax machine with a return copy requested and signed by the person receiving the fax or by telephone. If by telephone, the conversation will be noted in the nurses' notes. Nursing will provide specialized rehabs with a copy of the order and responsible party information, while all other forms will be filled out by therapist. If a therapy discipline fails to respond the Nursing unit coordinator will follow up with the therapy discipline by fax/telephone. All attempts of communication will be documented in the resident's chart.	8/15/10

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to implement a system to ensure the availability of routine medications in a timely fashion for 1 of 9 sample residents (#5). The findings were: According to the medication administration records (MARs) for May 2010, Calcium 500 milligrams three times daily was to be started for resident #5 on 5/20/10. However, the medication was circled from 8 AM on 5/20/10 until 5/24/10 at 12 PM; a total of 13 doses were not administered. Review of the documented rationale showed the	F 425	F406 continued This requirement will be maintained and monitored by Restorative Therapy ~~monthly~~ through chart audits and reported through QA/QI program. monthly as required 8/15/10 F425 The facility will meet this requirement for resident #5 as evidenced by obtaining ordered medication from resident's primary pharmacy. All residents will receive ordered medication. If medication is not available within standard of practice time frame for the medication through resident's primary pharmacy, the nursing staff will contact hospital pharmacy to check availability. If medication is still not available another pharmacy will be contacted. If a medication is ordered from a pharmacy other than resident's primary pharmacy, family will be notified and given reason	8/15/10

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F 425	Continued From page 37 medication was "unavailable." Interview with the nursing unit coordinator on 7/8/10 at 7:50 AM revealed the physician ordered the medication on the 19th of May. The coordinator confirmed the rationale for not administering the medication was "unavailable." After conferring with the nurse on duty, the coordinator reported the facility pharmacist was unable to obtain the medication. She further stated the reason the pharmacist did not obtain the medication was not known.	F 425	medication was obtained at a different location. If medication is not available from any surrounding pharmacy within the standard of practice time frame physician will be notified for a new order.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure that irregularities in the medication regimens for 3 of 9 sample residents(#5, #11, #19) were identified and reported as required. The findings were: 1. Review of physician's orders and the medication administration records (MARs) showed resident #5 had received the antidepressant Lexapro 10 milligrams (mg) since 9/30/09. Review of the pharmacist's monthly medication regimen reports (MRRs) showed no	F 428	This requirement will be monitored monthly by nursing staff. A quality indicator has been developed and will be reported through QA/QI program. F428 This requirement will be met as evidenced by performing a drug regimen review on residents #5, 11 and #19 by a licensed pharmacist. All residents will have a monthly drug regimen review. The pharmacist will report any irregularities to the attending physician and the DON. Nursing staff and all current pharmacists will be in-serviced on CMS regulations and any	8/15/10

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F 428	Continued From page 38 evidence the irregularity had been identified and reported as required. On 7/1/10 at 1:13 PM the DON confirmed she had not received a report from the pharmacist identifying the continued use of Lexapro at the same dose as an irregularity. 2. Review of the MRRs for resident #11 revealed the pharmacist identified an irregularity on 3/31/10 and recommended that a kidney function test be completed. Review of the laboratory test results showed no evidence the test was ever done performed. During an interview on 6/30/10 at 6:15 PM, the DON stated she was never notified of the irregularity and the recommendation from the pharmacist. She confirmed the kidney function test was never ordered. 3. According to the physician's orders and the MARs, resident #19 had received Zoloft (an antidepressant) 100 mg since 9/29/09. Review of the MRRs completed by the pharmacist from January through June 2010 showed continued use of the medication at the same dose had not been identified as an irregularity. On 7/1/10 at 1:13 PM the DON stated there were no other reports to review.	F 428	new pharmacists will be given the same information. A communication sheet will be placed in the review book for the pharmacist to complete upon regimen review completion ~~for each physician~~ for them to fax to physician and a copy will be given to the DON to ensure follow up, on recommendations made. This requirement will be maintained by monthly audits. A quality indicator has been developed and will be monitored by nurse unit coordinator through QA/QI program.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F431 The facility will meet this requirement as evidenced by residents #5, #17 will have new labels. All residents will have new labels as orders change.	8/15/10

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F 431	Continued From page 39 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure medications for 2 of 8 residents (#6, #17) contained appropriate labels which included accurate dosage instructions. The findings were: 1. Observation on 6/29/10 at 9 AM showed LPN #4 prepared and administered medications, including Seroquel one-half of a 25 milligram (mg) tablet, for resident #17. Review of the label on the medication bottle showed the instructions were for the resident to take 25 mg, or one whole	F 431	Nursing staff and current pharmacist will be inserviced on CMS regulations for updating medication labels when orders are changed by the physician. The pharmacists will be given a copy of the CMS regulations. Any new pharmacist will be given the same information. Nursing staff will request a new label from every pharmacy used for every dosage change made by the physician. The pharmacist will be asked to make the new label and place it on the medication. If any pharmacist refuses, the Administrator will be notified for appropriate action to maintain compliance. This requirement will be maintained by monthly audits. A quality indicator has been developed and will be monitored by DON through QA/QI program.	

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F 431	Continued From page 40 tablet. When questioned during the observation, the LPN stated that the VA (Veteran's Administration) would not send a new label. The VA had instructed the facility to use the medication until it was gone, then reorder at the correct dose. Reconciliation of the medication pass with the physician's orders revealed the order for Seroquel was changed to 12.5 mg on 2/2/10, more than four months prior to the survey. 2. Observation on 6/30/10 showed LPN #4 prepared and administered medications for resident #5 at 8:52 AM. The medications included one-half tablet of potassium 20 milliEquivalents (mEq). Review of the label on the medication bottle revealed the instructions were for the resident to receive 20 mEq, or one whole tablet. Interview with the LPN during the observation revealed the pharmacy would not send new labels when the dosage was changed. Review of the physician's orders showed the dose was decreased to 10 mEq on 9/30/09, nine months prior to the observation.	F 431		
F 441 SS=E	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; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 This requirement will be met as evidenced by resident #32 and all residents will have care provided by staff utilizing appropriate PPE. In-servicing all LTC staff on proper hand washing technique and use of gloves including rational for changing gloves	8/15/10

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F 441	Continued From page 41 (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, review of facility policies and procedures, and review of nationally recognized infection control standards, the facility failed to implement and maintain an effective infection control program. The cumulative effects of this failure were evident in 4 critical areas: a. The facility failed to require staff to comply with infection control precautions established for 1 of 1 residents (#32) known to be culture positive for MRSA in a sputum specimen. b. The facility failed to require staff to comply with facility policies and infection control practices	F 441	when appropriate and related to precautionary measures being taken. Policy and procedures for infection control including appropriate precautions will be reviewed with staff. The infection control officer with the interdisciplinary team will monitor for adherence to precautions and the recommended practices of the CDC. Staff will not have personal food and drink in work areas and have been in-serviced. All nurses will be in-serviced on safe medication administration practices, including CMS guidelines, medication pass overview, times of administration, preparing medication appropriately to prevent possible contamination, preparing medication of different forms, dosages, and routes and checking for expiration dates.	

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F 441	Continued From page 42 regarding placement of drinking items in an area subject to contamination from an adjacent hand washing sink. c. The facility failed to ensure staff practiced appropriate infection control standards when administering medications during medical pass. d. The facility failed to ensure staff practiced appropriate hand hygiene techniques during 1 random observation of resident care. The findings were: 1. Regarding compliance with posted infection control precautions: Observation on 8/28/10 at 1:25 PM showed a small table outside the room of resident #32 containing disposable gloves, masks, disinfectant wipes, and hand hygiene gel. Interview with CNA #9 at 1:12 PM revealed the precautions were necessary because a resident in the room was identified with MRSA in his/her sputum. The CNA further stated the resident was considered potentially infectious and the DON put "...droplet isolation..." in effect. a. Continued observation of the room showed CNA #9 donned gloves and a mask at 2:10 PM and entered the room with a hydraulic lift. The CNA exited the room with the lift 19 minutes later, still wearing the same gloves and mask. She then used a disposable wipe to clean high touch areas on the lift, but repeatedly handled these same areas with the gloves she wore while in the room. b. The CNA removed her gloves and mask at 2:35 PM, donned a new pair of gloves and pushed the lift to an alcove further down the hallway. She proceeded to the nurse's station, removed and discarded the second pair of gloves at the nurse's station, and then washed her	F 441	A quality indicator has been developed and will be monitored by MDS Coordinator or DON monthly through QA/QI program.	

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F 441	Continued From page 43 hands. c. CNA #9 was again interviewed at 2:45 PM and she stated she assisted the resident to the bathroom while in the room. She acknowledged the gloves she wore out of the room were the same pair she initially donned and, further, were used while assisting the resident with care. The CNA stated she did not think about recontaminating the lift with dirty gloves. When asked what items of personal protection equipment (PPE) were required by facility policy when entering a room with droplet precautions, she stated "...a mask and gloves; we don't have to wear gowns because it gets too hot in here some times..." The CNA was wearing shorts and a short-sleeved scrub top when observed on 6/30/10. The shorts left her legs exposed from mid-thigh to her ankles; her arms were similarly exposed while providing care for the resident. d. The DON stated in interview on 6/28/10 at 5:50 PM that staff should remove and dispose of PPE in the trash can immediately outside the resident's room. She further stated she talked with the physician who provided infection control consultation, and they agreed gowns would not be necessary in the case of this resident. When asked by the surveyor, the DON acknowledged staff should not be wearing clothes that left substantial areas of skin exposed when entering a room with infection control precautions. e. Review of laboratory reports for resident #32 on 6/28/10 at 7:10 PM showed s/he was culture positive for MRSA on 6/5/10 from a sputum specimen submitted on 6/3/10. A second sputum culture was ordered by the attending physician on 6/21/10 and was again reported as positive for MRSA on 6/23/10. f. The infection control physician stated in an interview on 6/30/10 at 7:10 AM that she was	F 441		

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F 441	Continued From page 44 unaware staff were wearing shorts into the room designated with droplet precautions. She further stated this was not an acceptable practice (from an infection control standpoint). g. The infection control policies and procedures were reviewed on 8/29/10 at 5:10 PM. These documents showed a requirement for staff to observe contact precautions in the event of a MRSA infection. The facility's requirements for contact precautions included gloves, gowns, and strict adherence to hand hygiene practices. The policies further clarified droplet precautions as contact precautions with the addition of aerosol barriers, such as disposable masks. The policies & procedures did not address the relaxation of PPE requirements for the comfort of staff. h. The Center for Disease Control & Prevention (CDC) publication, Management of Multidrug-Resistant Organisms in Healthcare Setting, 2006, is a nationally-accepted guideline for preventing the transmission of multidrug-resistant organisms (MDROs) among patients/residents, facility staff, and visitors. Specific recommendations include: (1) Implement a multidisciplinary process to monitor and improve healthcare personnel adherence to recommended practices for Standard and Contact Precautions. Hand hygiene is stressed as a critical component of Standard and Contact Precautions throughout the CDC guideline. (2) Provide education and training on risks and prevention of MDRO transmission during orientation and periodic educational a. organizational experience with MDROs and prevention strategies. (3) Use masks according to Standard Precautions when performing splash-generating procedures (e.g., wound irrigation, oral	F 441		

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F 441	Continued From page 45 suctioning, intubation); when caring for patients with open tracheostomies and the potential for aerosol secretions. 2. Regarding drinking glasses at a hand washing sink: a. At 7:45 AM on 6/30/10 observation revealed dirty items placed immediately next to and on the clean tray containing pitchers of water and iced tea for resident consumption. The dirty items consisted of three cups containing liquid, numerous empty soda cans, and four empty cups. In addition, an open bag of chips was located on the tray containing fluids for the residents. At that time LPN #4 confirmed the dirty items were not to be on the clean counter. The LPN began removing them as an unidentified CNA stated one of the cups was hers and that she brought it from home. The CNA further stated she was unaware the cup should not be on the counter. b. On 6/30/10 at 4:05 PM three drinking glasses were observed immediately adjacent to a hand washing sink by the nurses' station. The glasses were perched on a narrow strip of open countertop and two of the three glasses contained liquid. Over a 23- minute period, four staff were observed to use the sink: three to wash their hands and one to empty a resident's water glass. Closer observation of the glasses at 4:28 PM showed all three had been splashed by the activity at the sink. Interview with LPN #4 on 6/30/10 at 4:35 PM revealed the drinking glasses belonged to staff and, according to the LPN they were "not supposed to leave their drinks there [by the sink]...I tell them all the time..." The LPN acknowledged the infection control problems when food and drink are kept in, or near, a dirty	F 441		

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F 441	Continued From page 46 area such as a hand washing sink. The LPN further stated there was a cabinet where staff were supposed to leave their drinking cups/glasses and snack foods. 3. Regarding unsafe infection control practices when administering medications: LPN #4 was observed preparing medications on 6/29/10 prior to administering them to resident #17 at 9 AM. During preparation, the LPN obtained a new bottle of Naproxen which had a seal over the new tablets. Instead of peeling off the seal, the LPN punched the cap of her pen through it; the cap remained inside the bottle - possibly in contact with the clean tablets. Prior to this breech of technique, the LPN had been observed with the cap of the pen in her mouth. 4. Regarding hand hygiene practices while performing resident care: Observation on 6/29/10 at 10:30 AM revealed resident #6 was toileted by CNA #9. During the observation, the CNA donned gloves, then noticed liquid on the floor in front of the commode. The CNA cleaned the floor with paper towels, but failed to remove the contaminated gloves before providing perineal care and a clean disposable brief for the resident. The CNA then assisted the resident to dress and transfer to the geriatric chair [a wheeled, upholstered recliner] while wearing the same gloves. Immediately after the observation, the CNA stated she did not know what was on the floor when she cleaned it.	F 441		
F 496 SS=C	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse	F 496		

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F 496	Continued From page 47 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 staff interview and review of personnel records, the facility failed to consult the CNA registry to verify that 3 of 3 recently hired CNAs had no substantiated findings of abuse or neglect of long-term care residents. The findings were: Personnel records for three CNAs hired within the	F 496	F496 The facility will meet this requirement by verifying, receiving and maintaining a copy of the state registry information on all CNA's. This copy will be retained in the CNA's personnel file, by Human Resources and made available upon request. A quality indicator has been developed and will be monitored by Human Resources monthly through QA/QI.	8/15/10

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F 496	Continued From page 48 last 6 months were reviewed on 7/1/10 at 9:30 AM. These records failed to include any evidence to show the CNA registry maintained by the state survey agency (SSA) was reviewed for prior allegations of resident abuse or neglect. The human resources (HR) director stated in an interview on 7/1/10 at 9:50 AM that she was not aware there was a specific registry for long-term care CNAs. Interview with the administrator on 7/1/10 at 5:35 PM revealed she was aware of the CNA registry; she further stated she thought the HR director was using the registry as part of the pre-hire screening process.	F 498		
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of incident reports, the facility failed to ensure staff demonstrated the necessary skills and techniques required to provide competent care for residents for 6 of 6 agency, or traveling, CNAs who worked in the facility during the months of May and June 2010. Furthermore, demonstrated competencies had not been completed for the permanent staff, and yearly evaluations were incomplete. The findings were:	F 498	F498 The facility will meet this requirement by completing competency forms for any agency personnel within the first week of starting work. The charge nurse working with the agency personnel will readily observe and record the agency personnel's competency. The DON will also insure that the facility staff be evaluated upon completion of orientation and annually within the anniversary month of the employee's hires date.	8/15/10

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F 498	Continued From page 49 Interview with the administrator and DON on 7/1/10 at 3:43 PM revealed the agency providing traveling CNAs was responsible for completing competency checks for their staff. Although the facility is always responsible for care provided by the staff, the DON stated they had no system in place to verify the agency staff's competencies. The DON further stated she was unaware of the system used by the agencies to evaluate staff competencies, and she did not know that this was frequently a self-evaluation. Additionally, there was no system in place for permanent staff to demonstrate competencies in skills necessary for providing safe resident care. Furthermore, the DON and the administrator stated the facility provided a yearly four-hour in-service covering required topics, but they were unsure if any of the traveling staff attended it or the monthly educational in-service programs. Finally, the DON stated she was behind in completing yearly evaluations for "at least 4 or 5" of the permanent nursing staff, and the agency staff had never been evaluated. Refer to F282 for details related to failure to follow the care plans. Refer to F309 for information related to failure to report concerns related to residents' bowel status to the charge nurse. Refer to F323 for failure to appropriately report incidents to the charge nurse and/or complete incident reports. Refer to F441 for identified problems with staff carrying out appropriate infection control precautions and safety procedures.	F 498	This requirement will be monitored by implementing a quality indicator and will be monitored by Social Services monthly through QA/QI.	
F 503	483.75(l)(1)(i-iv) LAB SVCS - FAC PROVIDED,	F 503		

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F 503 SS=D	Continued From page 50 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 quality control logsheets, the facility failed to remove expired quality control material from use. The facility further failed to maintain accurate logsheets to monitor control performance and reagent lot numbers used to test residents' blood glucose levels. The findings were: A whole blood glucose monitoring device ("glucometer") was observed on 6/30/10 at 3:55 PM. According to LPN #4 in an interview on	F 503	F503 The facility will meet this requirement by maintaining control logs for the facility glucometers to include expiration dates of the control material and the corresponding lot number for the control material. This will be checked each time the nursing staff performs control tests on the glucometers and every 24 hours. The log sheets will also specify the lot numbers of the testing strips. All expired control solutions will be discarded. Out of range results will be corrected per manufacturers instructions DJ This requirement will be maintained by in-servicing nursing staff on log sheet use, control results, and the importance of maintaining ~~them~~. This will be monitored by DON monthly through QA/QI accurate documentation DJ	8/15/10

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F 503	Continued From page 51 6/30/10 at 4:10 PM, the glucometer was tested with quality control material every night. Two vials of control material were inspected on 6/30/10 at 4:25 PM in the presence of the LPN and one vial (low level control) was discovered to have expired on 6/21/10. The LPN stated there were 4 residents routinely monitored with the glucometer. Quality control logsheets for the glucometer were reviewed on 6/30/10 at 3:45 PM. These documents were keyed to a specific lot number of reagent test strips and included a section for listing the acceptable range of control values. Further review of the glucometer reagent strips showed they were from a different lot number than that listed on the logsheet. It was further discovered that the manufacturer's established range of acceptable control values were different between the two lot numbers of reagent test strips. Interview with LPN #3 on 6/30/10 at 7:05 PM confirmed she was responsible for performing quality control checks on the glucometer in the evenings. She stated she was not aware the control material had expired, nor that the lot numbers on the logsheets were incorrect. She stated the lot number changed "...maybe the middle of the month..." and acknowledged the quality control logsheets had not be updated.	F 503		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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	F 520		

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F 620	Continued From page 62 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interviews, review of the Quality Assurance/Quality Improvement (QA/QI) program and minutes, medical record review, and review of nationally recognized infection control standards, quality control logs, and policies, procedures, and protocols, the facility failed to assure the QA/QI committee included all required personnel and that the program was effective in identifying problems and implementing actions to resolve those problems. The failure specifically affected 4 non-sample residents (#16, #18, #21, #31,) and 5 of 9 sample residents (#3, #4, #5, #11, #19) whose care was deficient in areas cited during previous surveys. In addition, the facility failed to identify and implement action plans to correct other issues that were identified by the	F 520	F520 The facility will meet this requirement by the DON, a physician and three other LTC staff members attending quarterly QA/QI meetings. If the medical director cannot attend the QA/QI meeting, s/he will designate an alternate physician or provider to attend in their place. The ~~DON~~ appropriate personnel will implement plans of action to correct all quality problems identified in the survey process and by the committee. Implementation will include tracking/monitoring plans of action with identification of the root cause and solutions to implementing plan of action to include deficiencies cited by the survey team in this survey ~~and in previous surveys~~. Acceptable standard levels will be identified to meet the goals of the plans and will be reported to the committee at each meeting.	8/15/10

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F 520	Continued From page 53 survey team as ongoing or demonstrated a pattern of deficient practice during this survey. The findings were: 1. During an interview with the administrator and DON regarding their QA/QI program on 7/1/10 at 4:10 PM, they stated the QA/QI committee was composed of the DON, the medical director or designee, and the social services director; no other long term care (LTC) facility staff were included. Review of the minutes verified the composition of the committee. In addition, the interview revealed the facility's QA/QI program did not identify the root cause of problems or potential problems, nor develop, implement, monitor, and revise solutions to resolve those problems. Review of the QA/QI program and committee minutes confirmed the facility lacked a specific plan for the LTC facility which proactively identified and monitored specific concerns, implemented action plans, and developed benchmarks for tracking the level of success of the action plans. In addition, the facility failed to implement a method to review and revise action plans if they were ineffective. 2. During the entrance conference on 6/28/10 at 1:13 PM, both the administrator and DON stated they were familiar with the quality indicators/quality measurements QI/QM's (information sent to the State office by the facility). However, they did not express understanding of the gravity of the situation regarding the fact that 9 of the 17 (52.9%) QI/QM's were flagged as potential areas of concern with 2 sentinel events being indicated. They did state that none of the areas were specifically included in their QA/QI program.	F 520	This will be monitored by DON, Administration and Department Heads of LTC and will be reported to the Board of Trustees through the QA/QI program.	

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F 520	Continued From page 54 3. During the survey, ongoing deficient practice was identified in the following care areas: a. Refer to F323 for information regarding the facility's failure to provide adequate evaluation and assistance to prevent accidents for residents #5, #11, #19, #21, and #31. b. Refer to F329, also written during three of the last four surveys, for details related to failure to ensure residents' #5 and #19 had medication regimens that were free of unnecessary drugs. 4. Other deficient practice was identified in the following care areas: a. Refer to F309 for details related to the facility's failure to implement their bowel management protocol for six residents: #3, #4, #5, #16, #18 and #19. b. Refer to F332 for information related to the facility's failure to maintain a medication error rate under 5%. c. Refer to F334 regarding the facility's failure to implement their policies and procedures for immunizations. 5. Due to failure to correct deficiencies previously cited within the past 4 surveys at F253 (2/4), F272 (4/4), F279 (2/4), F281 (3/4), F428 (3/4), and F441 (3/4), deficiencies in these areas were also written on this survey. Refer to these specific F tags for details of current non-compliance. 6. Deficiencies identified at a pattern level (E) during this survey included F221, F244, F280, F282, F496, and F498. These deficiencies were not in care areas but affected the residents' quality of life. Refer to these specific F tags for details of current non-compliance.	F 520		