Printed: 08/20/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	08/13/2010

RECEIVED Wyoming Dept of Health SEP 13 2010

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

Office of Healthcare Licensing and Surveys

(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 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: Based on record review, resident and staff	F 225	X F 225 The facility will meet this requirement by documenting, thoroughly investigating and reporting on all abuse and neglect allegations. Residents #3, 5, 8 and 10 will have a review of all incident reports up to present to insure follow up has been completed of each incident and resident. The Administrator will be notified immediately along with other officials in accordance with Wyoming law. The results of all investigations will be reported to the administrator or designee and other officials in accordance with Wyoming law within five (5) working days of the incident. If a violation is verified appropriate corrective action will be taken. All staff /volunteers involved in resident care will be in-serviced on the correct procedure for reporting and investigating allegations of abuse and neglect. A review of the procedure will be included in monthly LTC staff in-services.	X 10/1/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
x Doris Bloom	x CEO/Administrator	x 9/3/10

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.

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F 225	Continued From page 1 interview, it was determined that the facility failed to thoroughly investigate incidents of possible neglect or abuse, and report such incidents to the facility administrator for four of ten sample residents (#3, 5, 8 and 10). The findings included: 1. A review of the medical record for resident #10 was made on 8/12/10. A late entry was made in the "Nurse Notes" of the chart on 6/23/10 at 3:00 PM. The entry described that a Certifice Nursing Assistant (CNA) had asked the nurse to assess the 5 th digit of resident #10's left hand. The note described that the CNA had cut the resident's finger just below the finger nail while attempting to trim the resident's nail. The note described the cut as being "0.25 cm (centimeters) round" with a moderate amount of bleeding. The note indicated that the nurse cleaned and dressed the wound. During an interview with the Director of Nursing (DON) on 8/12/10 and 8/13/10, the DON was unable to produce any information showing that the facility had investigated this incident for possible resident neglect or abuse. There was no documentation showing that the incident was reported to the facility administrator. 2a. A review of a "Employee Warning Report" dated 8/12/10 found an allegation of improper patient care had been made on 7/23/10 against CNA (I). The report stated that CNA (I) had not toileted resident #8 on 7/23/10 from 7:00 AM until 1:00 PM. The report stated that CNA (I) had been told by the nurse on duty to toilet the resident prior to the CNA going to lunch that day. The report was not complete as of 8/12/10 and there was no evidence that the facility had conducted an investigation into this incident. b.Review of the medical record for resident #5	F 225	The facility will maintain this requirement by developing a quality indicator and will be monitored by Social Services monthly through QA/QI program.	

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F 225	Continued From page 2 was completed on 8/12/10. The review found that the resident was assessed to be totally dependent on staff for toileting. Review of a "Employee Warning Report" dated 8/9/10 found that CNA (I) was reported to have not toileted resident #5 during the day on 8/9/10. During 5:00 PM rounds on 8/9/10 another CNA found resident #5 laying in bed in a Depends incontinent brief that was fully saturated and had leaked into the bed linens. The report stated that the time of 4:30 AM had been marked on the brief, indicating the time it was last changed.. The report was not complete as of 8/12/10 and there was no evidence that the facility had conducted an investigation of this incident. c. A review of the medical record for resident #8 was completed on 8/12/10. The review found that on 8/10/10 the resident was assessed to be a total assist for activities of daily living. Progress notes in the resident's chart revealed that the resident had sustained a skin tear on 8/10/10 of approximately 1/4 inch on the right upper arm. The review found that CNA (I) had reported the skin tear to the nursing staff. Review of an "Incident Report" dated 8/11/10 found that the incident had been reported to the State Survey Agency on 8/11/10. There was on evidence that a complete investigation had taken place regarding this incident. d. In an interview with the DON on 8/12/10, the DON stated that the facility had not fully investigated these three incidents that involved the same CNA. There was no documentation in the medical records of resident # 5 or resident #8 or provided by the facility showing that the facility had identified or ruled out possible or actual neglect and/or abuse in any of the three separate incidents.	F 225		

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F 225	Continued From page 3 3. On 8/10/10 at 9:05 AM, in an interview with resident #3, the resident indicated that an EA (Environmental Aide) who had just become a Certified Nurse Aide (CNA) was rude and would not listen to the resident's directions relating to his/her care. The resident said that he/she reported this and the CNA was no longer there. This same resident revealed that he/she had reported that his/her roommate (resident #10)'s finger was injured and the roommate's physician was not notified until the resident advocated for the roommate to get care by the doctor. 4. On 8/12/10 at 1:25 PM and 1:45 PM, respectively, the DON and Chief Executive Officer (CEO) were separately interviewed about abuse, including injuries of unknown origin, investigations. Both responded that no formal investigations had occurred recently. Specifically, they were asked about the above concerns of the one resident. The following were their responses: a. The DON revealed that the CNA in the above resident's complaint had been terminated based on several problems. For resident #10, she indicated that the physician was notified and the resident was treated by the physician. She verified that she talked to staff but nothing was documented in terms of an investigation. b. The CEO said that she gets all incident reports and these are sent to the Safety committee for review. She stated that there were no recent abuse investigations. The CEO commented that the nurse has been completing the incident reports, but she wants the person who observes the incident to write the report. The facility has changed their program so that the Activity staff	F 225		

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F 225	Continued From page 4 members are keeping the residents occupied in the dining room, so that there are less incidents. In relation to the above resident concerns, the CEO says that she signed the termination paper for the CNA, but not aware of the scenario. She was not aware of the issue with resident #10 until after the fact and this information was given to her verbally. The CEO verified that she had been away from the facility 7/2 - 7/12/10 and 8/4 - 8/10/10, so she thought that may have been why she wasn't immediately aware of this scenario.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to develop, implement and follow policy and procedures for the investigation of allegations of abuse and neglect. The findings included: 1. Review of the facility's "LTC-Abuse-1" with a revision date of July 11, 2008 revealed that it listed "Abuse: Seven Key Points". The seven key points were Prevention, Screening, Training, Identification, Reporting, Protection, and Investigation. Review of the Prevention key point revealed that abuse was defined as "The willful infliction of verbal, sexual, physical and mental abuse, involuntary seclusion, failure to provide goods and services to a void physical harm, mental	F 226		

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F 226	Continued From page 5 anguish, or mental illness, and misappropriation of resident property." Review of the Identification Procedure evidenced the following: "2. Staff to be pro-active in the prevention of abuse; A. Provide interventions to defuse/distract residents exhibiting negative behaviors. B. Recognize a stressed co-worker and intervene. C. Identify situations in which abuse might occur. D. Report the above situations to the charge nurse and the ADON (Assistant Director of Nursing) and/or DON. E. ADON and/or DON to take further action as necessary to prevent reoccurrence." Review of the Investigation Procedure revealed the following: "1. The investigation will include, but is not limited to: A. Examination and assessment of the abused resident... B. Interview the alleged abuser... C. Record the names of staff on duty. Interview staff... D. Interview other residents... E. Interview contacted family members and others as appropriate. 2. All documentation of the allegation (the event, notification of agencies, investigation and final determination) will be maintained by the Social Services Director." The policy did not specify that all allegations of abuse, including injuries of unknown origin, were	F 226	F 226 The facility will meet this requirement by changing and implementing the policy and procedure for investigating and reporting abuse and neglect allegations to include injury of unknown origin. The facility will improve staffing levels to provide appropriate resident care and supervision of staff to minimize the potential for abuse or mistreatment of residents. Facility staff will be in-serviced on the change to the policy and procedure for reporting and investigating alleged abuse or neglect to residents. Staff will be trained on the appropriate procedure/timeline for reporting and investigating alleged abuse or neglect, including injury of unknown origin. The facility will maintain this requirement by developing a quality indicator to be monitored monthly by Social Services and reported to the QA/QI committee.	10/1/10

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F 226	Continued From page 6 to be investigated and reported. 2. During the staff interviews which were conducted on 8/11/10 and 8/12/10 for the Abuse Protocol review, the supervisory staff verified that oversite of their staff was not being done and there was no way to address issues such as burnout with the current staffing numbers. Two of the three supervisors reported they worked in areas of the facility or at times when they were not able to observe their staff's interactions with the residents. The shortage of nursing staff was a repeated concern. Direct care staff interviews verified that breaks were limited and long hours were being worked. The potential for abuse or mistreatment existed due to the current staffing level, the extended hours which were being worked, and the lack of supervisory oversight. The facility failed to implement its policy which required that abuse was to be reported immediately, the investigation was to include the information listed in the policy, and that the findings were to be documented. In the examples which were listed in F225, there were allegations of neglect (medical care not provided) and verbal/mental abuse (rude CNA who would not listen to care instructions which the resident provided). The Chief Executive Officer (CEO) and the Director of Nursing (DON) were not immediately notified of these allegations and/or did not investigate and document the investigation findings. (Cross Refer to F225).	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		

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F 241	Continued From page 7 full recognition of his or her individuality. This Requirement is not met as evidenced by: Based on observations, resident interviews, and staff interviews it was determined that the facility failed to ensure that the dignity and respect of individuality for two of ten sample residents (#8 and 9) and one supplemental sample resident (#11). The findings include: 1. On 8/11/10 at 9:52 AM, Certified Nurse Aides (CNAs G and R) were observed transferring resident #9 from his/her wheelchair to a recliner in the chapel. The resident was yelling and resisting the transfer. The CNAs were not heard to talk to the resident but lifted him/her and placed the resident in the recliner. CNA (D) said that the resident had had a shower and was combative earlier. 2. On 8/12/10 at 3:55 PM, CNA (J) pulled resident #8, who was seated in his/her wheelchair, backwards down the hall to the resident's room. 3. At 10:45 AM, resident #11 appeared to be asleep and was slid down in his/her wheelchair. Three staff member moved so that they were standing around the resident. They did not speak to the resident. When CNA (G) touched the resident's hand, the resident startled and jerked his/her hand upward. 4. Residents identified as being dependent on staff for care which included toileting and eating were not being provided care in a manner and in an environment that maintained or enhanced each resident's dignity . (Cross refer to F312)	F 241	F 241 The Facility will meet this requirement by in-servicing and training staff on proper staff/resident interactions to maintain or enhance each resident's dignity and respect. For Residents #8, 9 and 11, staff will be trained on appropriate communication to resident when attempting to move/transfer resident. Staff will be trained on appropriate procedure for assisting/moving resident in a wheelchair. Reference F226 – Facility will improve staffing levels to provide care to residents in manner and an environment that maintains or enhances each resident's dignity. The facility will maintain this requirement by developing a quality indicator and will be monitored by Social Services and DON monthly through QA/QI program.	10/1/10
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	Continued From page 8 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: Based on observation, record review and staff interview it was determined that the facility failed to provide maintenance services to ensure a comfortable, orderly, and cleanable environment for the residents. The findings included: 1. During the environmental tour on 8/12/10 from 10:00 AM to 11:00 AM with the Maintenance Supervisor and Administrator the following issues were identified: a. The metal shelving in the bathroom in #213 used for personal care items was rusted and needed to be replaced. There were also some holes in the wall from a bracket and a piece to a metal bracket still attached to the wall needing to be repaired and removed. b. The sink in the bathroom in #211 was cracked and pulling away from the wall. There was also a hole in the wall behind the toilet. c. The flooring in resident room #202 was cracked with chips out of the flooring. The Maintenance Supervisor was aware of the issues with the flooring and reported it was available and needed to be scheduled to get it replaced. 2. On 8/12/10 at 2:30 PM the bathing room was checked with the Maintenance Supervisor and the following issues were identified: a. The whirlpool tub was noted to have a light	F 253	F 253 The facility will meet this requirement by: 1.a. Room #213: rust has been removed from shelving. Housekeeping staff will be instructed to wipe shelving daily to prevent future problems. Holes in wall will be repaired. The metal bracket will be removed. b. Room #211: bathroom sink will be repaired and resealed to wall. The hole in wall behind toilet will also be repaired. c. Room #202: Flooring will be replaced as soon as scheduling allows for temporary placement of resident to another room. Maintenance and housekeeping staff will monitor weekly to ensure a comfortable, orderly and clean environment. 2. a-f. Maintenance staff will clean, inspect and check disinfectant line and dispensing system to make sure it is operational. Staff responsible for resident bathing will read tub operation manual, followed by employee in-servicing and	10/1/10

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F 253	Continued From page 9 green liquid running down inside the tub from one of the whirlpool jets. The disinfectant cabinet located above the tubs control panel was open. There was a gallon container of disinfectant however the tubing from the disinfectant to the tub was not attached. There was also a hemostat on a small black tube on the whirlpool inlet in the bottom of the tub. b. Interview with the Maintenance Supervisor reported that the hemostat on a small black tube on the whirlpool inlet had been checked by the company and it was the only way they could keep the tube from going back into the inlet. He reported he did not know why the green liquid was leaking or why the disinfectant was not attached. c. The bath aide (G) was then asked to come to the bathing room and was interviewed with concerns about the whirlpool. She reported and demonstrated use of the whirlpool. She would refill the tub after use and while the tub was filling turn on the disinfectant for five seconds. She was not aware of how to use the flow meter and the disinfectant wand for proper cleaning of the whirlpool. She reported she was shown how to clean the whirlpool by another staff member and she had not received any formal training on the use of the whirlpool tub. She currently had one resident who got a tub bath and occasionally the hospital would use the tub for bathing hospitalized patients. d. The Maintenance Supervisor then pulled a file which indicated the last inservice provided to staff on proper use and cleaning of the whirlpool tub was 12/19/06. The file also contained the instruction manual for the whirlpool.	F 253	sign off sheet. In-service on tub and disinfectant operation and care will be provided by maintenance staff. Monitoring of correct tub and disinfection operations will be done bi-monthly by maintenance staff. A quality indicator will be developed and will be reported to QA/QI committee. 3. a-g. Wheels on both shower chairs have been replaced. The commode bracket was replaced. A new commode bucket was ordered and has been received. Maintenance staff will monitor monthly to ensure proper condition of shower chairs and commode. A quality indicator will be developed and will be reported to QA/QI committee.	

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F 253	Continued From page 10 e. The manufactures instructions included the disinfecting of the system. It included a "Warning" about the dispensing system and how it is calibrated for use with it's disinfectant. The instructions included: "1. Open disinfectant cabinet on top of the unit. 2. Ensure the disinfectant siphon tube is placed in the disinfectant container. 3. While holding disinfectant wand over the interior of the tub, turn OFF/ON valve to on position... With the liquid flowing from the disinfectant wand: 1. Turn flow meter adjustment knob until floating ball rises to level 35 cc/min.(Note: At this level, disinfectant is being mixed with water at the correct ratio.) 2. Disinfectant will begin to fill the plumbing system and will be completely full when liquid begins flowing from the disinfectant wand. 3. Spray interior of the tub, including whirlpool jets, overflow fitting and the whirlpool inlet fitting with disinfectant. (Note: Invacare recommends that you throughly scrub all interior surfaces of the tub with disinfectant ..) 4. Turn disinfectant ON/OFF valve to OFF position and return disinfectant wand to its holder. (Note: Let disinfectant remain in the loop and on the tub surfaces for ten minutes." The instructions under "Preparing the tub for use" also gave step by step instructions on how to back-flush the system until water coming from the whirlpool inlet is clear and rinsing the interior of the tub. The interviews with the Maintenance Supervisor and staff (G) confirmed that the whirlpool tub instruction were not being followed to ensure it	F 253		

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F 253	Continued From page 11 was properly disinfected. f. The Maintenance Supervisor also confirmed he was aware that there was a problem with the flow meter not working at times however it had not been checked or put on a routine maintenance check list. 3. Other issues identified on 8/12/10 at 2:30 PM when the bathing room was checked with the Maintenance Supervisor included; a. A small shower chair with rusted wheels and a broke commode. The commode bracket under the shower was broken. Observations earlier noted staff pulling a resident down the hall backwards. b. A larger shower chair with rusted wheels which was difficult to roll. c. Staff reported that the shower chairs were difficult to roll and they had to pull residents backwards to get chairs to roll. The Maintenance Supervisor reported that he has to clean the wheels intermittently but no problem had been reported.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE 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	F 274		

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F 274	Continued From page 12 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 record review and staff interview it was determined that the facility failed to identify and complete a comprehensive reassessment after a significant change had occurred for two of ten sample residents (#2 and 6). A significant change as defined in the Long Term Care Resident Assessment Instrument (RAI) User's Manual, updated by the Centers For Medicare & Medicaid Services (CMS) in December, 2002, is "a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan." "A significant change assessment is appropriate if there are either two or more areas of decline or two or more areas of improvement." A Significant Change in Status assessment is to be done "No later than: 14 days following determination that a significant change has occurred."	F 274	F 274 The facility will meet this requirement as evidenced by residents #2 and 6, 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. Staff involved in the MDS process will be trained on how to determine a significant change in resident's status and procedure/timeline to complete the reassessment process. This requirement will be maintained by developing a quality indicator and will be monitored by the Interdisciplinary team monthly through QA/QI program.	10/1/10

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F 274	Continued From page 13 The findings included: 1. Record review revealed that sampled resident #6 was admitted to the facility on 10/9/09. The resident's diagnoses included: dementia, post hepatic neuralgia, diabetes and VRE (vancomycin-resistant enterococci) colonization. [Vancomycin is an antibiotic that is often used to treat infections caused by enterococci. In some instances, enterococci have become resistant to this drug and thus are called vancomycin-resistant enterococci (VRE).] a. Review of the resident's Minimum Data Set (MDS) assessments showed an admission assessment done on 10/16/09 and quarterly assessments done 1/12/10 and 4/20/10. The two quarterly assessments showed an overall decline in the resident's condition and required that a comprehensive MDS re-assessment be completed and/or revision of the care plan. The following areas showed a decline in the resident's status: Section G. Physical functioning and structural problems: 1/12/10 Transfers as 1-1 (supervision - set up help only), 4/20/10 Transfers as 4-3 (total dependence - two person physical assist), 1/12/10 Walk in room as 1-1 (supervision - set up help only), 4/20/10 Walk in room as 8-8 (activity did not occur), 1/12/10 Dressing as 2-2 (limited assistance -one person physical assist), 4/20/10 Dressing as 4-3 (total dependence - two person physical assist),	F 274		

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F 274	Continued From page 14 1/12/10 Toileting as 1-1 (supervision - set up help only), 4/20/10 Toileting as 4-3 (total dependence - two person physical assist), 1/12/10 Personal Hygiene as 1-1 (supervision - set up help only), 4/20/10 Personal Hygiene as 4-2 (total dependence - one person physical assist), Section H. Continence in last 14 days: 1/12/10 Bowel Continence 0 (continent), 4/20/10 Bowel Continence 2 (occasionally incontinent, once a week), Section Q. Discharge potential and overall status: 4/20/10 Overall change in care needs was marked as 2. deteriorated-receives more support. These areas indicated a decline or significant change and required that a comprehensive MDS re-assessment be completed and/or revision of the care plan. The facility failed to complete a full significant change assessment for this resident to determine if any new care plan approaches were warranted. Additionally the area under J. Health conditions for pain was marked as zero on admission and the 4/20/10 assessment identified the resident as having pain as 2-2 (pain daily - moderate pain). b. Interview on 8/11/10 at 9:20 AM with nurses (T and V) confirmed an overall decline in the resident's condition with generalized weakness, being unable to walk, having falls and pain. They also reported decline in the resident's condition after having pneumonia in April (2010).	F 274		

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F 274	Continued From page 15 Nurse (T) reported that she had been doing the MDS assessment for the past few months but had not been to any type of training. Nurse V had just started and was new to long term care and the MDS process but would be doing the MDS assessments. c. The DON reported that issues with MDS assessment had been identified. She reported staff had not been sent to MDS training but would be doing to training on the new MDS 3.0. 2. Record review for sample resident #2 revealed that the resident had diagnoses that included pneumonia, urinary tract infection (UTI), edema, hypertension, depression, and dementia. Review of the resident's12/8/09 and 3/8/10 quarterly MDS assessments evidenced that the resident experienced the following declines without evidence that the facility staff had completed a full, comprehensive re-assessment for this resident to determine if any new care plan approaches were warranted: 12/09 - The resident was assessed as requiring limited assistance with transfer. 3/10 - The resident was assessed as requiring extensive assistance with transfer. 12/09 - The resident was assessed to require supervision for walking in room and in corridor. 3/10 - The resident was assessed as not walking in room and in corridor. 12/09 - The resident was assessed as requiring limited assistance with toilet use. 3/10 - The resident was assessed as requiring extensive assistance with toilet use.	F 274		

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F 274	Continued From page 16 12/09 - The resident was assessed as requiring physical help limited to transfer only with bathing. 3/10 - The resident was assessed as requiring physical help in part of bathing activity. The above changes indicated that a significant change assessment should have been completed for this resident. The failure to complete a comprehensive re-assessment when a resident experiences a significant change can result in the care plan not being updated as appropriate for the resident's changed status.	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	F 278		

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F 278	Continued From page 17 assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to make accurate assessments for four of ten sample residents (#2, 3, 6, and 9). The findings included: 1. Record review revealed that sampled resident #6 was admitted to the facility on 10/9/09. The resident's diagnoses included: dementia, post hepatic neuralgia, diabetes and VRE (vancomycin-resistant enterococci) colonization. a. The current MDS (minimum data set) assessment dated 7/14/10 under skin treatments did not identify pressure relieving devices for the chair. b. The RAP (Resident Assessment Protocol) Module for pressure ulcer identified the resident at risk for skin breakdown and that the resident was confined to a "W/C" (wheelchair). It identified pressure relieving devices utilized with "pressure pad to bed and W/C" written in. However the MDS did not identify the pressure relieving devices for chair. c. The area under G4. functional limitation in range of motion (ROM) marked arms as partial loss of limitation on one side. Review of the "ADL Functional /Rehabilitation Potential" RAP identified the resident as having problems with mobility due to loss of coordination and stiffness with movement. It identified the resident as being wheelchair bound. There was no indication on the	F 278		

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F 278	Continued From page 18 MDS of functional loss of ROM or voluntary movement with the resident's legs and feet. d. Interview on 8/11/10 at 9:20 AM with nurse (T) confirmed that the resident had a history of skin breakdown, was at risk for skin breakdown and was supposed to have a pressure relieving cushion in his/her wheelchair at all times. Nurse (T) confirmed the resident had a decline in his/her mobility, no long walked and that the current MDS did not reflect the resident's functional limitation. 2. Record review for sample resident #2 revealed that the resident had diagnoses that included pneumonia, urinary tract infection (UTI), edema, hypertension, depression, and dementia. Review of the resident's 9/4/09 admit Minimum Data Set (MDS) and 12/8/09 quarterly MDS assessments evidenced that the resident experienced a significant weight loss from153 to 141 pounds (or an 8 % weight loss in three months). This weight loss was not identified on the 12/8/09 MDS assessment. Additionally, documentation on the resident's 12/8/09 and 3/8/10 MDS assessments evidenced that the resident was provided restorative (rehab) services. On the 12/8/09 assessment, there was a check mark, instead of the number of days the resident received AROM (active range of motion). On the 3/8/10 MDS assessment, the resident was marked as receiving AROM two times in seven days. Review of the resident's Daily Program Documentation for Restorative/Rehabilitation Nursing for 12/09 revealed that the resident refused these services in December. There was no additional documentation to show that the	F 278	F278 The facility will meet this requirement as evidenced by residents #2, 3, 6 and 9 will have their assessments reviewed for accuracy and updated. All residents MDS's will be reviewed for accuracy. The MDS/care plans will be reviewed upon completion at weekly interdisciplinary team/care plan meetings by the MDS Coordinator and the team members to ensure accurate data has been recorded. This requirement will be maintained by training all staff involved in the MDS process. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	10/1/10

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F 278	Continued From page 19 resident was receiving services after December, 2009. On 8/10/10 at 11:30 AM, in an interview with the Restorative Aide (RA), she verified that the resident was not receiving restorative services. 3. Review of resident #9's physician orders included an order for Zyprexa (an antipsychotic medication), dated 9/30/09. Review of the resident's MDS assessments, including the 8/3/10 quarterly assessment, revealed that the resident was coded to be taking an antianxiety medication seven times a week. The antipsychotic was not coded on the assessments. 4. Review of resident #3's 2/28/10 Resident Assessment Protocol (RAP) Summary form evidenced that it was not correctly completed. The column for the location and date of the RAP documentation contained only "Rap Summary". The Care Plan Decision Column contained "2/28/10", instead of the care plan decision.	F 278		
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	F 280		

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F 280	Continued From page 20 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: Based on record review, observation, and staff interview it was determined that the facility failed to revise comprehensive resident plans of care for three of ten sample residents (#1, 3 and 9). The findings include: 1. A review of the medical record for resident #1 was completed on 8/12/10. This review found that the resident's current comprehensive Plan of Care (POC) had not been updated to show that the resident had been assessed to be transferred with a two person assist. The last Minimum Data Set Assessment dated 5/30/10 identified the resident as being "totally dependent" for self performance with transfers and requiring "extensive assistance" with support for transfers. A "Balance and Gait Assessment" was made of the resident on 6/21/10 with the narrative "Comments" section stating that the resident "needs assist of 2 c (with) transfers." The CNA ADL (Activity of Daily Living) Reference Sheet used by the Certified Nursing Assistant (CNA) for this resident did not code the resident for transfers, only showing a "0" (zero) marked under Physical functioning and transfer. The "Nursing Assistant ADL (Activities of Daily Living) Care Sheet", located in the resident's bathroom identified that the "Resident has a hip fracture.	F 280	F280 The facility will meet this requirement as evidenced by residents #1, #3, and #9 comprehensive care plan will be revised and updated to follow the physician orders and to reflect any changes in resident status/needs. All residents comprehensive care plans will be reviewed and updated quarterly, annually and/or when there is a significant change of status identified for resident. Nursing staff will update all care plans to reflect any changes made including discontinuing use of items or new orders/interventions to be initiated. This requirement will be maintained by in-servicing nursing staff of these procedures. A quality indicator has been developed and will be monitored by IDT through QA/QI program.	10/1/10

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F 280	Continued From page 21 Fire man carry only. No Lift.". Observation of the resident being transferred from a geri chair to his/her bed was made on 8/11/10 at 9:35 AM. The transfer was performed by two CNAs doing a total lift transfer. One of the CNAs (K) stated that the resident could not be transferred with a lift or use of a gait belt because of a previous hip fracture and fragile bones. Review of the resident's current comprehensive POC was completed on 8/11/10. The care plan had not been updated to address how transfers were to be made. The only comment made related to transfers for the resident stated under the POC problem number 02, Activity of Daily Living, "NO LIFT AT ALL." 2. Record review for resident #3 revealed that the resident was admitted to facility 4/3/07 and had diagnoses that included seizure disorder, osteoporosis, urinary tract infection (UTI), history of MRSA (methicillin resistant staphylococcus aureus), pneumonia, neurogenic bladder, history of sacral decubitus ulcers, and depression. Review of the resident's care plan evidenced a problem of "potential for continued weight gain" with a review date of 6/1/10. The approaches included 1800 ADA/High Protein/Regular texture and continuing education regarding weight loss/management. Review of the resident's CNA ADL Reference Sheet revealed that the resident's diet was 1200 diet per patient chef salad every night. Review of the resident's physician order evidenced an order for ADA/regular text/increased protein diet.	F 280		

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F 280	Continued From page 22 Review of the resident's 5/23/10 quarterly MDS assessment revealed that the resident was on a planned weight loss and experienced a significant weight loss. The resident's care plan had not been updated to show the weight loss and/or change of diet. 3. Record review for resident #9 revealed that the resident was admitted to facility 2/5/08 and had diagnoses that included dementia, history of VRE and MRSA, atrial fibrillation, edema, left hip fracture, and peripheral vascular disease. Review of the resident's 8/3/10 quarterly Minimum Data Set (MDS) assessment evidenced the resident was assessed to require extensive assistance with bed mobility, toilet use, and personal hygiene and total assistance by one or two staff members for transfer, dressing, and bathing. The resident was assessed to be frequently incontinent of bowel and bladder. Review of the resident's bowel monitoring for 4/10 - 8/10 revealed that the resident was not having regular bowel movements. The facility began charting the resident's bowel monitoring on 7/24/10. However, the resident did not have a care plan problem or approaches to address the resident's constipation/bowel issues. Review of the resident's care plan evidenced a problem of potential for injury from fall related to cognitive deficit with an approach of "gait belt, walker & 2 person assist w/all (with all) transfers". Observation during the survey evidenced that the staff did not use a gait belt when transferring the resident. In interviews of the staff they indicated	F 280		

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	535029	A. BUILDING _____ B. WING _____	08/13/2010

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F 280	Continued From page 23 that the gait belt was not used because it agitated the resident more. The care plan was not updated to show that a gait belt was not to be used.	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 record review, observation, and resident and staff interviews, it was determined that the facility failed to follow professional standards and facility policies when administering medications and failed to ensure that physician orders were followed for two of ten sample residents (#1 and 2) and two supplemental sample (#14 and 25) . The findings included: 1. A review of the medical record for resident #1 was completed on 8/12/10. The review found that on 5/19/10 the resident's physician had ordered calcium 500 mg to be administered orally three times per day (at 8:00 AM, 12:00 PM, and 6:00 PM). The review found the order had been transcribed to the Medication Administration Record (MAR) for the month of May with the first dose scheduled to be given on 5/20/10 at 8:00 AM. Facility nursing staff made attempts to administer the calcium from 5/20/10 at 8:00 AM until 5/23/10 at 6:00 PM. However, during these times the calcium was not administered to the resident with the reason given that the calcium was unavailable. Review of the nursing notes and interdisciplinary notes for this time period found nothing to	F 281	F 281 The facility will meet this requirement as evidenced by residents #1, 2, 14, and 25 will have orders clarified to include dosage. Medications will be given during the appropriate time frame. All residents medications will be administered correctly. Nursing staff will be in-serviced on safe medication administration practices, including proper physician order clarification prior to implementation of the orders including dosage, route or diagnosis. In-service will discuss CMS guidelines, medication pass overview, times of administration, preparing medication of different forms, dosages, and routes and checking for expiration dates.	10/1/10

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F 281	Continued From page 24 indicate that nursing had attempted to secure the calcium to be administered as ordered. 2. On 8/10/10 during a medication pass observation from 10:20 AM to 11:10 AM, nurse (D) was administering 8:00 AM medications greater than two hours after the time the medications were scheduled to be given. The medication administration was observed for residents #2 (eight medications) and #14 (thirteen medications). These medications included Levothyroxine, Lasix, Oxybutynin, Metoprolol, Clonidine, and HCTZ. 3. On 8/10/10 during this medication pass, it was observed that the pharmacy label did not match the current physician's order for residents #2 (Metoprolol - order was for one time a day; label was for twice a day) and #14 (Norco 5/325 - order was for every 8 hours as needed; label was for every 6 hours as needed). The nurse reported that the pharmacy had not provided new labels. For the narcotic medication, the pharmacy would not change the label without a new physician prescription. 4. The pharmacy sent 60 tablets of Calcium 500 mg (milligrams)/Vitamin D (no international unit amount was noted) for resident #14. Review of the physician order for this resident revealed that the resident was to receive Calcium 600 mg/Vitamin D 400 iu. Nurse (D) recognized that the dosage was incorrect and used the stock medication to provide the correct dosage to the resident. The surveyor requested the Director of Nursing (DON) to count the number of tablets remaining in the bottle of Calcium 500 mg tablets. She counted 46 tablets, indicating that 14 tablets had been used. Fourteen incorrect doses had been given to the resident without the nurses	F 281	This requirement will be maintained by weekly observation of medication pass and monitored by MDS Coordinator or DON through QA/QI program.	

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F 281	Continued From page 25 verifying the correct dosage. 5. On 8/10/10 during this medication pass, resident #14 was asked if he/she needed pain medication. Nurse (D) did not assess the level of pain or the location of the pain before administering it. Review of the physician order showed that the resident was to receive 1 or 2 tablets of Norco 5/325 every eight hours. Review of the resident's Medication Administration Record (MAR) charting for this medication evidenced that the number (one or two) was not always noted. 6. On 8/11/10 at 10:37 AM, nurse (D) was observed preparing resident (#25)'s Aspirin and Levothyroxine for administration. The medications were crushed and placed in ice cream. Review of the resident's MAR evidenced that the medications were scheduled to be given at 8:00 AM and 7:00 AM, respectively. 7. On 8/13/10 at 8:08 AM, resident #14 stated that his/her hip was hurting and had asked for a pain pill but had not received it. The surveyor reported the resident's pain to the nurse (B) who was unaware of a request for pain medication. The nurse prepared the medication. 8. Review of resident #2's physician orders evidenced that the resident had an order dated 8/7/10 for Macrobid 100 mg twice a day for seven days to treat a UTI. Review of the resident's 8/10 MAR revealed that the medication was not started until 8:00 PM on 8/9/10. On 8/11/10 at 9:00 AM, in an interview with the DON, she revealed that if medications are	F 281		

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F 281	Continued From page 26 ordered on the weekend and the hospital does not have the medication, the resident may have to wait two days. 9. Review of the facility's policy "LTC-Meds-22" with a revised date of June 17, 2008 revealed the following in relation to the Administration of Oral Medications: "18. Take medication to resident at correct time or within 30 minutes before or after prescribed time to ensure intended therapeutic effect." The nurse failed to administer the medications in the hour time period as stated in the policy. Based on interviews and observations, the failure related to the shortage of nursing staff to perform the cares needed by the residents. The nurse was frequently observed to be assisting the CNAs and residents. (Cross refer to F353). A. STANDARD OF PRACTICE: ADMINISTRATION OF MEDICATIONS: Standards for nursing practice for administration of medication provide, in pertinent part that: The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients. Medications must be accurately administered and documented. Accurate administration includes, in the first instance, a physician order authorizing the administration of the medication; if an order is not clear, the nurse should communicate with the physician to seek clarification. Thereafter, accurate administration includes transcribing the drug order correctly, delivering the correct drug, to the correct resident, by the correct route, in the correct dose. Accurate documentation involves	F 281		

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F 281	Continued From page 27 recording information on the drug administered, including the client's response to the medication. The physician may order a drug on a PRN basis (when a client requires it). The nurse uses objective assessments, subjective assessments, and discretion in determining the client's need. When medications are administered, the nurse documents the assessment made and the time of drug administration. The nurse should make frequent evaluation of the effectiveness of the drug and record findings in the appropriate place. See generally: Lippincott, Nursing Drug Guide, 1998 (Lippincott) and Perry & Potter, Clinical Nursing Skills & Techniques; 1998, (Perry & Potter). B. FOLLOWING PHYSICIAN ORDERS Fundamentals Of Nursing, Potter and Perry, 4 th Edition, 1997, Chapter 20, pg 341, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients."	F 281		
F 309 SS=E	483.25 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 observation, record review and staff interview it was determined that the facility failed to implement the ordered bowel program for four	F 309		

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F 309	Continued From page 28 of ten sample residents (#1, 8, 3, and 9) failed to provide appropriate care for three of ten sampled residents (#6, 7 and 4) who were identified to be at high risk for skin breakdown. The findings include: BOWEL PROGRAM 1. Review of facility records found that the facility had implemented physician standing orders that physicians could sign and have implemented for residents. These orders included a bowel routine that instructed nursing staff to implement the following if constipation was assessed for an individual resident where the resident's physician had indicated the approval for the use of the standing orders: "Natural Lax 30cc (cubic centimeters) PRN (as needed) constipation Day 2 no BM (bowel movement) Milk of Magnesia 30cc PRN constipation Day 3 no BM Dulcolax Suppository PRN constipation Day 4 no BM Fleets Enema or SS (soap suds) enema if no results by Day 5" 2. A review of the medical record for resident #1 was completed on 8/12/10. The review found that the facility failed to implement orders for bowel treatment provided by the physician to relieve constipation the resident experienced. These orders included a protocol on how to treat any constipation the resident experienced that occurred for two or more days and were part of the physician standing orders signed by the resident's physician on 10/29/09. Resident #1 had been care planned to be at risk	F 309	F309 The facility will meet this requirement as evidenced by review of residents #1, 8, 3, 9, will have updated bowel protocol implemented in a timely manner. All residents will have bowel assessments completed on admission, quarterly, annually and/or significant change in status and the protocol will be implemented as indicated. Residents #6, 7, and 4 will have updated skin assessments completed and protocol will be followed. All residents will have skin assessments completed on admission, quarterly, annually and/or if significant change in status occurs and the protocol will be implemented as indicated. Training and in-service on bowel protocol, bowel assessment, skin protocol and skin assessment will be provided to nursing staff. Bowel tracking will be reviewed daily and interventions will be	10/1/10

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F 309	Continued From page 29 of constipation related to the use of narcotic pain relievers. On the monthly order sheet, beginning 9/30/09, the physician had included the use of Miralax 17 gm (grams) in 8 ounces of water to be administered daily for constipation. Review of the "31 DAY ADL (activity of daily living) RECORD" for the months of May 2010, June 2010, and July 2010 found recorded under the section titled, "Bowel movements per shift" to show the resident did not have a recorded bowel movements as follows: a. From the night shift of May 6, 2010 until the day shift of May 11, 2010, in excess of four days. b. From the night shift May 11, 2010 until the evening shift of May 21, 2010, in excess of ten days. c. From the evening shift May 27, 2010 until the day shift of June 5, 2010, in excess of seven days. d. From the night shift of June 13, 2010 until the day shift of June 17, 2010, in excess of four days. e. From the night shift of June 18, 2010 until the evening shift of June 22, 2010, in excess of four days. f. From the night shift of July 9, 2010 until the day shift of July 14, 2010, in excess of four days. Review of the resident's MAR for the months of May through July did not find that the facility implemented the ordered bowel constipation treatment program or explain why the the bowel constipation treatment program was not implemented as ordered. 3. A review of the medical record for resident #8 was completed on 8/12/10. The review found that the facility failed to implement orders for bowel treatment provided by the physician to	F 309	implemented as necessary. Assessment and findings will be incorporated into the comprehensive 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. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program	

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F 309	Continued From page 30 relieve constipation the resident experienced. These orders included a protocol on how to treat any constipation the resident experienced that occurred for two or more days and were part of the physician standing orders signed by the resident's physician on 11/13/09. The monthly order sheet for resident #8, beginning 4/27/10, included the use of Natural Lax 30 cc (milliliter)orally to be administered two times daily for constipation. Review of the "31 DAY ADL (activity of daily living) RECORD" for the months of May 2010, June 2010, and July 2010 found recorded under the section titled, "Bowel movements per shift" to show the resident did not have a recorded bowel movements as follows: a. From the night shift of May 8, 2010 until the evening shift of May 12, 2010, in excess of three days. b. From the evening shift June 1, 2010 until the day shift of June 6, 2010, in excess of four days. c. From the day shift of June 7, 2010 until the day shift of June 10, 2010, three days. d. From the night shift of June 26, 2010 until the day shift of July 2, 2010, in excess of five days. e. From the evening shift of July 5, 2010 until the day shift of July 11, 2010, in excess of four days. f. From the day shift of August 1, 2010 until the evening shift of August 4, 2010, in excess of three days. g. From the day shift of August 8, 2010 until the day shift of August 11, 2010, three days. Review of the resident's MAR for the months of May through August did not find that the facility implemented the ordered bowel constipation treatment program or explain why the the bowel	F 309		

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F 309	Continued From page 31 constipation treatment program was not implemented as ordered. 4. Record review for resident #3 revealed that the resident was admitted to facility 4/3/07 and had diagnoses that included seizure disorder, osteoporosis, urinary tract infection (UTI), history of MRSA (methicillin resistant staphylococcus aureus), pneumonia, neurogenic bladder, history of sacral decubitus ulcers, and depression. a. Review of the resident's 5/23/10 quarterly Minimum Data Set (MDS) assessment evidenced the resident was assessed to require total assistance by two staff members for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. The resident was assessed to be incontinent of bowel and continent of bladder with a catheter in place. The assessment noted that the resident had bilateral limitations in range motion and full loss of voluntary movement in his/her arms, hands, legs, and feet. b. The Director of Nursing (DON) was requested to provide the facility's bowel tracking forms for the months of 4/10 through 8/10. She indicated that she was unable to find the 5/10 and 6/10 forms. Review of the facility's bowel tracking form for the months of 4/10, 7/10, and 8/10 revealed the following dates when the resident did not have a bowel movement for three or more days with the intervention implemented: 7/6/10 - 7/8/10: 3 days; no intervention 7/15/10 - 7/20/10: 6 days; no intervention. The facility's standing orders for laxatives were not implemented. c. Review of the resident's physician orders failed	F 309		

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F 309	Continued From page 32 to show medications that were ordered for routine bowel management and to prevent constipation/fecal impaction for this immobile resident. The resident had physician orders to take Prozac (to treat depression) daily, Dilantin (anticonvulsant) twice daily, and Baclofen (muscle relaxant) three times daily. These medications have a side effect of constipation. d. Review of the resident's CNA ADL Reference Sheet noted that for bowel function the resident "needs assist to evac (evacuate) bowels". e. Review of the resident's care plan for altered bowel elimination with the last review date of 6/1/10 listed approaches as: "Encourage fluid intake Plan BM's q2days (every two days) - setup program when res (resident) allows (supp (suppository), digital stimulation) qd (daily) and PRN (as needed)." f. Review of the resident's 7/10 Treatment Administration Record (TAR) revealed that a "Bowel Routine" started being charted on 7/20/10. 5. Record review for resident #9 revealed that the resident was admitted to facility 2/5/08 and had diagnoses that included dementia, history of VRE and MRSA, atrial fibrillation, edema, left hip fracture, and peripheral vascular disease. a. Review of the resident's 8/3/10 quarterly Minimum Data Set (MDS) assessment evidenced the resident was assessed to require extensive assistance with bed mobility, toilet use, and personal hygiene and total assistance by one or	F 309		

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F 309	Continued From page 33 two staff members for transfer, dressing, and bathing. The resident was assessed to be frequently incontinent of bowel and bladder. b. The Director of Nursing (DON) was requested to provide the facility's bowel tracking forms for the months of 4/10 through 8/10. She indicated that she was unable to find the 5/10 and 6/10 forms. Review of the facility's bowel tracking form for the months of 4/10, 7/10, and 8/10 revealed the following dates when the resident did not have a bowel movement for three or more days with the intervention implemented: 4/1/10 - 4/3/10: 3 days; no intervention 4/11/10 - 4/15/10: 5 days; MOM on 4/14/10 4/22/10 - 4/25/10: 4 days; Bisacodyl supp 4/26/10 on 5 th day 7/15/10 - 7/19/10: 5 days; Bisacodyl supp 7/20/10 on 6 th day 7/28/10 - 7/30/10: 3 days; no intervention 8/1/10 - 8/3/10: 3 days; no intervention. c. Review of the resident's "31 Day ADL Record" forms for the months of 5/10 and 6/10 revealed the following dates when the resident did not have a bowel movement for three or more days with the intervention implemented: 5/12/10 - 5/15/10: 4 days; no intervention 6/4/10 - 6/6/10: 3 days; Bisacodyl supp 6/7/10 on the 4 th day 6/12/10 - 6/14/10: 3 days; no intervention 6/20/10 - 6/24/10: 5 days; no intervention 6/26/10 - 6/29/10: 4 days; no intervention. The facility's standing orders for laxatives were not implemented. d. Review of the resident's physician orders	F 309		

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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 _____	08/13/2010

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

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F 309	Continued From page 34 revealed orders for Miralax daily and Bisacodyl supp prn. The resident was ordered to take Zyprexa (antipsychotic) daily and Lasix (diuretic) daily. These medications have a side effect of constipation. e. Review of the resident's 7/10 Treatment Administration Record (TAR) revealed that a "Bowel Routine" started being charted on 7/24/10. f. Review of the resident's CNA ADL Reference Sheet noted that for bowel function the resident was incontinent and needed to be checked every two hours. g. Review of the resident's care plan evidenced that the resident did not have altered bowel elimination identified as a problem. Reference for BOWEL MANAGEMENT A. The Merck Manual of Geriatrics, Chapter 110 "Constipation, Diarrhea, and Fecal Incontinence," some medications, low dietary fiber, inadequate hydration, and reduced caloric intake are common causes of constipation. Functional impairment from immobility, muscular weakness, some neuromuscular disorders, altered mental status or depression may also contribute to constipation. Dietary approaches begin with adequate hydration, a cornerstone to treating constipation. B. A presentation, entitled Management of Diarrhea and Constipation (2005), given by David R.P. Guay, Pharm.D., F.C.P, F.C.C.P, F.A.S.C.P listed "Complications of Constipation in the Elderly." This list included fecal impaction and sigmoid volvulus.	F 309		

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F 309	Continued From page 35 C. Medical Update November, 2001 [Update 01-11], Office of the Ombudsman for Mental Health & Mental Retardation, Minnesota, Bowel Obstruction Alert indicated the following: "Factors that may contribute to constipation: Dietary factors - low residue (low fiber) diet, not drinking enough liquids Inactivity and immobility.... Environmental factors... Structural abnormalities... Smooth muscle or connective tissue disorders... Depression Neurological disorders... Metabolic/endocrine disorders... Medications "This list is intended to give common examples and cannot include all current or future medications that can cause constipation. Opioid analgesics... Nonsteroidal antiinflammatory drugs... Antacids... Anticholinergic drugs... Antidepressants - particularly lithium and tricyclics (like Elavil, Anafranil, desipramine, Pamelor, Tofranil/imipramine) Antipsychotics... Antihypertensives... Inderal... Antiarrhythmics... Diuretics... Anticonvulsants... Dilantin... Antihistamines - Benadryl Anti-ulcer medications... Antilipidemics... Monitoring bowel function:	F 309		

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F 309	Continued From page 36 It is important for every facility and home health care program to have an established procedure for monitoring bowel function and responding to changes. Clients should be asked on a daily basis whether they have had a bowel movement. The information needs to be documented in order to learn what the individual's normal routine is and to monitor for the development of problems." 6. Record review revealed that sample resident #6 was admitted to the facility on 10/9/09. The resident's diagnoses included: dementia, post hepatic neuralgia, diabetes and VRE (vancomycin-resistant enterococci) colonization. a. Review of the resident's MDS assessments done on 7/14/10 showed an overall decline in the resident's condition. It identified the resident being totally dependent on staff for transfers, dressing, toileting and personal hygiene. It also identified the resident as frequently being incontinent of urine. b. Review of the "Wound Assessment and Care Tool" dated 4/8/10 showed the resident was at skin risk and had a history of open areas on buttock and coccyx. c. Review of the "Interdisciplinary Progress Notes on 7/19/10 identified the resident having a small open area of breakdown to the left buttock. d. Interview with staff (S) during tour on 8/9/10 identified the resident skin as closed with protective barrier being applied. The resident was noted to have a red cushion in his/her wheelchair. e. Observation of resident #6 on 8/10/10, 8/11/10 and 8/12/10 the resident did not have a cushion or pressure relieving device in his/her	F 309		

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F 309	Continued From page 37 wheelchair chair. The resident was noted to spend most of the day up in his/her wheelchair in the dining room and/or hallway. f. Observation of resident #6 on 8/11/10 from 8:00 AM until 11:45 AM identified the resident was not toileted during this 3 hour and 45 min time period. The resident was positioned in a wheelchair without a cushion in the dining room during this time frame. g. Interview on 8/12/10 at 2:30 PM with nurse (T) accompanied the surveyor to check the residents wheelchair and confirmed a cushion was not in place. The nurse reported that the resident was supposed to have a gel cushion in place at all times. 7. Record review revealed that sample resident #7 was admitted to the facility on 4/9/08. The resident's diagnoses included: COPD (chronic obstructive pulmonary disease), PVD (peripheral vascular disease), hital hernia, diverticulosis hypertension, squamous cell skin cancer and recent hospitalization 8/2/10 due to dehydration. a. Review of the resident's MDS assessments done on 7/8/10 and 4/12/10 showed the resident being totally dependent on staff for transfers, dressing, toileting and personal hygiene. It also identified the resident as frequently being incontinent of urine and bowel. On 4/12/10 the resident was identified with a blister to the left heel and having fragile skin. b. Review of the physician's orders on 4/23/10 identified the resident having a C&S (culture and sensitivity) of the right scrotum. It included treatment orders and instructions to clean perineum very thoroughly with each brief change.	F 309		

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F 309	Continued From page 38 c. Observation of resident #6 on 8/11/10 from 8:00 AM until 11:30 AM identified the resident was not toileted during this 3 hour and 30 min time period. When the resident was toileted by staff the resident's perineum was red. The resident grimaced and moaned when staff wiped over the rectum and scrotum The resident was not provided thorough cleaning of the perineum and groin creases. The resident foreskin was not retracted to ensure proper cleaning of the glans penis. d. The resident's Plan of Care (POC) identified the problem of "Impaired skin integrity R/T (related to) pressure ulcer stage 2 to coccyx, breakdown to right scrotum and open areas on buttocks, and blister to left heel. The approaches included: turn and reposition q (every) 2 hrs. (hours), keep resident clean and dry after each incontinence episode which was not being followed. 8. Review of resident #4's medical record identified the resident at risk for skin breakdown. and use of a geri chair. a. Review of the MDS Assessment dated 6/5/10 did not identified the resident being at skin risk due even though the resident was incontinent of bowel and bladder, urinary tract infections, dependent on staff for personal hygiene, repositioning and immobility. The resident's Plan of Care (POC) did not identify the resident's potential for skin breakdown. b. Observation of resident #4 on all days of survey identified that the geri chair used by the resident did not contain a cushion to protect the resident's skin or provide pressure relieving	F 309		

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F 309	Continued From page 39 devices. c. Interview on 8/12/10 at 2:30 PM with nurse (T) identified the resident #4 at risk for skin breakdown. 9. Review of the medical record for resident #8 was completed on 8/12/10. The review found that the facility failed to provide protection of the resident's skin integrity related to the use of a geri chair. The resident's Minimum Data Set Annual Assessment dated 5/14/10 identified the resident for being at risk for pressure sores. The Pressure Ulcer Resident Assessment Protocol (RAP) sheet, dated 5/20/10, identified the resident as using a geri chair for mobility. The resident's Plan of Care (POC) identified the problem of "Potential for skin breakdown R/T (related to) immobility, incontinence and diabetes." Observation of resident #8 on 8/11/10 at 9:45 AM during a transfer from a geri chair to bed, identified that the geri chair used by the resident did not contain a cushion to protect the resident's skin integrity when using the geri chair. Review of the resident's POC found nothing that addressed the use of the geri chair relative to the protection of the resident's skin integrity and providing pressure relief when the resident was seated in the geri chair.	F 309		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This Requirement is not met as evidenced by:	F 311		

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F 311	Continued From page 40 Based on observation, record review, resident and staff interview it was determined that the facility failed to provide care and services that would maintain and improve the activity of daily living for three of ten sample residents (#2, 6 and 9) and nine supplemental sample residents (#11, 12, 13, 14, 15, 16, 21, 22, and 23). The findings include: 1 a. Observation was made of the evening meal on 6/10/10 at 5:00 PM. Supplemental sample resident #11 was observed to be seated a table with three other residents. The resident appeared to be sleeping at times during the meal service. Staff were not observed to attempt to assist or que the resident to eat his/her meal. Resident #26 attempted to get resident #11 to eat with little success at various times during the meal. At one point a resident at an adjoining table got up and said , "There's never staff around when you need 'em. I'll see if I can find the nurse." A facility nurse came shortly after this and took the resident back to his/her room. Resident #11 ate less than 5% of his/her evening meal. 1 b. Observation was made of the noon meal on 8/11/10 at 12:00 PM. Resident #11 was observed to be sitting at the same table. During this meal a CNA was observed to be seated next to the resident assisting and queing the resident to eat. The resident was interactive with the CNA and others at the table. The resident was observed to eat almost 100% of the meal. 2. On 8/10/10 during the noon meal, resident #9 was observed sleeping during the meal. Resident #15's food was served without the resident being in the dining room.	F 311	F 311 The Facility will meet this requirement by residents #2, 6, 9, 11, 12, 13, 14, 15, 16, 21, 22 and 23 will be assisted to eat or qued to eat during meal times by increasing the number of staff members available throughout meal times. Staff will be directed on all residents and their specific needs for assistance with meals. Dietary staff will ask residents if they would like an alternative to what they have been served and if the residents are satisfied with the meals. Dietary staff will remain present throughout the meal to assist with queing the residents when needed. The facility will maintain this requirement with a quality indicator and will be monitored by the Charge nurse or DON monthly through QA/QI program.	10/1/10

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F 311	Continued From page 41 3. On 8/10/10 during the evening meal which was observed from 5:15 PM to 6:30 PM, the following observations were made: a. The residents (#2, 22, 21, 14, 15, 16, 9, 12, 13, and 23) were not offered any assistance once their meals were set-up at the beginning of the meal service. No staff were observed to interact with these residents to offer alternates or more food. b. Resident #15 dropped part of a pear on the floor and spent several minutes trying to reach it with his/her fork. The resident was successful picking it up and he/she questioned the surveyor about whether or not the pear was good. It was decided that it was not good and the pear was placed on the resident's plate. Observation at the end of the meal revealed that the resident had consumed the pear. c. Resident #16 ate 100 % of his/her meal and then scraped the plate and bowl with his/her fingers and napkin for at least 10 minutes. No staff intervened to determine if the resident needed or wanted more food. d. Resident #12 was observed sleeping at the table at 6:24 PM. e. Resident #21 consumed all of his/her food except the carrots. The resident stated that "we get too many carrots". No staff offered an alternate vegetable to the resident. f. At 6:25 PM, resident #6 had taken his/her lower denture of his/her mouth. It was lying on the table. The resident tried unsuccessfully to put it in a pocket. No staff were present or intervened, so the surveyor requested that CNA (O) assist the	F 311		

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F 311	Continued From page 42 resident. g. During this meal, the soft.serve machine was running and noisy. No staff intervened to move the machine out of the dining room. h. On 8/11/10 at 8:45 AM and at 9:55 AM, residents #16 and #12 were asleep in their room. Resident #16's breakfast was sitting on the table in the dining room and was disposed of by the dietary staff at 9:30 AM. At 9:25 AM, a breakfast tray for resident #12 was placed on the counter at the activities desk by a dietary staff member, who left the tray without notifying nursing staff. At 9:48 AM, the DON picked up the tray and returned it to the kitchen. Neither resident received breakfast. It was not clear who was responsible to ensure that these and other residents were given their meals. 2. On 8/11/10 during the noon meal from 12:07 PM to 1:25 PM, the following observations were made: a. At 12:07 PM, resident #2 was served his/her food. The resident ate the chicken, but then did not eat any of the rest of the food. The resident was leaning to the right side with his/her head down. The resident was not encouraged to eat or offered any alternates. b. At 12:07 PM, resident #14 was not seated at the table when his/her food was placed on the table. At 12:08 PM, the resident was taken out of the chapel to the bathroom. At 12:13 PM, the resident was assisted to the table. At 12:40 PM, the resident requested that the surveyor pass him/her the salt shaker as no staff was available. c. At 12:08 PM, resident #16 was not seated at the table when his/her food was placed on the	F 311		

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F 311	Continued From page 43 table. At 12:21 PM, the food was covered. At 12:53 PM, an EA took the resident's food to his/her room without heating the food. The resident refused to eat. d. At 12:09 PM, resident #15 was not seated at the table but his/her food was placed on his/her assigned table. At 12:21 PM, the food was covered and staff indicated that the resident was not coming to lunch. e. At 12:10 PM, resident #9's food was placed on the table. The resident was sleeping in a recliner in the chapel. The food was covered at 12:17 PM. At 12:28 PM, the sleeping resident was transferred to the wheelchair by two CNAs (J and R) and placed at his/her place at the table. At 12:44 PM, the resident opened his/her eyes and reached for a glass of water. At 12:52 PM, CNA (G) attempted to assist the resident. At 12:53, EA (V) offered the resident food, but the resident refused. At 1:00 PM, the resident began to eat and consumed 100 % of the food. f. At 12:10 PM, resident #12 was not seated at the table when his/her food was placed on the table. At 12:21 PM, the food was covered. At 12:25 PM, the resident was brought into the dining room. g. At 12:27 PM, resident #13 was brought into the dining room. The resident was served his/her food at 12:29 PM. The CNA (K) oriented the visually impaired resident to the location of the food on the plate. The resident's oxygen concentrator was running but the nasal cannula was not placed on the resident. At 1:08 PM, when the surveyor observed that the resident was pale and had dusky colored lips, the nurse (V) was requested to check the resident's oxygen level.	F 311		

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F 311	Continued From page 44 The resident was taken to his/her room and oxygen was put on the resident. The pulse oxygen saturation was 70 %. CNA (K) said that she forgot to put the oxygen on the resident. The oxygen level improved to the low 80s. The nurse checked the resident's baseline in his/her medical record and found that the low 80s was normal for the resident. h. During this meal, several residents were observed to leave the zucchini and summer squash untouched. These residents commented "don't like zucchini and won't eat it" and "don't like that squash - can't eat it". i. No staff were observed encouraging/cueing/assisting residents to eat or offering alternate foods when residents disliked foods. No dietary staff were present once the meal service was completed until it was time to record the intakes and clean the tables. Review of the residents' tray cards evidenced that the dislike of squash was not listed. j. At 4:44 PM, in an interview with the Certified Dietary Manager (CDM), the topic of squash was discussed. She indicated that they were serving less squash as some residents did not like it. She said that there were alternates available. These alternates were not offered and no staff checked on the independent residents.	F 311		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 45 This Requirement is not met as evidenced by: Based on observation, record review, and staff interview it was determined that the facility failed to assist six of ten sample residents (#2. 3, 4, 6, 7, and 8) and eight supplemental sample residents (#11, 14, 17, 18, 19, 20, 24, and 26) with appropriate and adequate incontinence care, bathing assistance, and meal assistance. These residents were facility assessed and/or were observed to be unable to perform these Activities of Daily Living (ADLs) and required extensive/total assistance. The findings included: MEAL ASSISTANCE: Observations during the meal service and staff interview confirmed that dependent residents were not being provided timely assistance with eating. 1. On 8/10/10 the evening meal which was observed from 5:03 PM to 6:30 PM. Staff identified tables F2 and F1 as "resident needing to be fed". There were 3 residents (#7, #4 and #17) seated at table F2. Resident #26 was identified as in his/her room due to illness. There were 4 resident (#8, #18, #19, and #20) seated at table F1. The meal service started at 5:05 PM with the food being served to tables F1 and F2 by 5:09 PM. The food for residents at table F2 were in mugs and set on the table in front of the residents. There was not staff available to assist with eating until all residents had been served. At 5:20 PM CNA (O) returned to the table to feed these residents. The feeding of these resident was intermittent as the CNA was called out of the dining room to assist residents in their rooms	F 312	F 312 The facility will meet this requirement as evidenced by residents #2, 3, 4, 6, 7, 8, 11, 14, 17, 18, 19, 20, 24, and 26 will be provided timely assistance with appropriate and adequate incontinence care, bathing assistance and meal assistance. All residents will be provided timely assistance with appropriate and adequate incontinence care, bathing assistance and meal assistance. The facility will increase staffing to ensure all residents receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. Staff will be trained and in-serviced on proper toileting and infection control protocol for residents. Meal times will be completed in a timely manner. Staff will be available to assist with residents activities of daily living needs after meal times are complete.	10/1/10

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	535029	A. BUILDING _____ B. WING _____	08/13/2010

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F 312	Continued From page 46 leaving the residents at this table unattended. Examples included: a. (Table F2) Resident #7 started to eat at 5:22 PM being fed by staff and helped for three minutes, CNA (O) then returned at 5:55 PM and helped for 5 minutes, left and returned at 6:10 PM for 4 minutes. This resident was noted to try to reposition in his/her self in the wheelchair and was leaning to the left. The resident was also noted to have mucous dripping from his nose and food on his chin thorough most of the meal. Resident #4 started to eat at 5:38 PM (29 minutes after meal was served) and staff left at 5:40 PM, returned at 5:50 PM for five minutes, left and returned at 6:15 PM. This resident was still being fed at 6:30 PM. Resident # 17 was started at 5:20 PM and helped for two minutes, staff returned at 5:46 PM for 4 minutes. Then a second CNA (M) assisted the resident at 5:38 PM. b. At Table F1 the resident's food had been served by 5:15 PM. CNA (K) was assisting residents #18 and #8 from 5:5 PM to 5:25 PM when she left the dining room to answer a call light and did not return until 5:38 PM. Resident #18 was noted to have behaviors during this time and escalated while the CNA was gone. CNA (M) was assisting resident #18 and #19 from 5:20 PM to 5:38 PM and was also noted to leave the dining room intermittently to assist with call lights. The residents at this table finished eating by 6:20 PM. 2. Interview with staff at 6:30 PM reported that it was a common occurrence to only have two CNAs in the dining room to feed and assist the residents. There was a resident who ate in his/her	F 312	The charge nurse, Social Services and DON will monitor weekly the meal assistance, toileting assistance/ peri-care and ADL's provided to residents. Quality indicators will be developed and will be reported monthly to QA/QI committee.	

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F 312	Continued From page 47 room that needed to be fed and call lights needed to be answered leaving two CNAs in the dining room. There was not enough help to give the residents timely assistance in the dining room. 3. On 8/11/10 during the noon meal which was observed from 12:02 PM to 1:30 PM, there were two CNAs assisting four residents at each table F1 and F2. However the staff was noted to frequently move between residents and the tables. The last resident finished eating was at 1:30 PM. 4. On 8/11/10 during the noon meal which was observed from 12:07 PM to 1:25 PM, resident #3 who was totally dependent on staff assistance with eating was observed. This alert, interviewable resident was present in the dining room when his/her food was served at 12:10 PM. No cover was placed over the food. The resident was first provided assistance at 12:27 PM by CNA (G). The resident finished eating at 12:46 PM and had consumed approximately 75 % of the meal. TOILETING ASSISTANCE & PERI CARE: 1. There were two residents #7 and #6 who were observed on 8/11/10 in the AM not receiving timely assistance to meet their toileting needs. They included: Resident #7 who was left in the dining room from 8:00 AM until 11:30 AM (3 hour and 30 minutes time period) without being toileted. Resident #6 went from 8:00 AM until 11:45 AM (3 hour and 45 minutes) without being toileted. 2. Record review revealed that sample resident	F 312		

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F 312	Continued From page 48 #7 was admitted to the facility on 4/9/08. The resident's diagnoses included: COPD (chronic obstructive pulmonary disease), PVD (peripheral vascular disease), hiatal hernia, diverticulosis hypertension, squamous cell skin cancer and recent hospitalization 8/2/10 due to dehydration. a. Review of the resident's MDS assessments done on 7/8/10 and 4/12/10 showed the resident being totally dependent on staff for transfers, dressing, toielting and personal hygiene. It also identified the resident as frequently being incontinent of urine and bowel. On 4/12/10 the resident was identified with a blister to the left heel and having fragile skin. b. Review of the physician's orders on 4/23/10 identified the resident having a C&S (culture and sensitivity) of the right scrotum. It included treatment orders and instructions to clean perineum very thoroughly with each brief change. The resident was identified as having a MRSA infection. c. Observation of resident #7 on 8/11/10 from 8:00 AM until 11:30 AM identified the resident was not toileted during this 3 hour and 30 min time period. When the resident was toileted by staff (K and R) the residents perineum was red. The resident was placed on the toilet by using a full mechanical lift. CNA (K) donned gloves to remove the resident's brief with was saturated with urine. The resident was also noted to have a bowel movement. When finished the resident was suspended in the lift to provide peri care. The resident grimaced and moaned when staff wiped over the rectum and scrotum with disposable wipes. Then with the same gloves Staff (K) put on a new brief and was observed to touch the resident, the lift, the wheelchair and her watch	F 312		

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F 312	Continued From page 49 before removing the soiled gloves. The resident was not provided through cleaning of the perineum and groin crease. The resident foreskin was not retracted to ensure proper cleaning of the glans penis before new brief was put on. f. The resident's Plan of Care (POC) identified the problem of "Impaired skin integrity R/T (related to) pressure ulcer stage 2 to coccyx, breakdown to right scrotum and open areas on buttocks, and blister to left heel. The approaches included: turn and reposition q (every) 2 hrs. (hours), keep resident clean and dry after each incontinence episode which was not being followed. 3. Record review revealed that sample resident #6 was admitted to the facility on 10/9/09. The resident's diagnoses included: dementia, post hepatic neuralgia, diabetes and VRE (vancomycin-resistant enterococci) colonization. a. Review of the resident's MDS assessments done on 7/14/10 showed an overall decline in the resident's condition. It identified the resident being totally dependent on staff for transfers, dressing, toileting and personal hygiene. It also identified the resident as frequently being incontinent of urine. b. Review of the "Interdisciplinary Progress Notes on 7/19/10 identified the resident having a small open area of breakdown to the left buttock. c. Interview with staff (S) during tour on 8/9/10 identified the resident skin as closed with protective barrier being applied and high risk for skin breakdown.	F 312		

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F 312	Continued From page 50 f. Observation of resident #6 on 8/11/10 from 8:00 AM until 11:45 AM identified the resident was not toileted during this 3 hour and 45 min time period. The resident was positioned in a wheelchair without a cushion in the dining room during this time frame. 4. Observation of resident #8 on 8/11/10 at 9:45 AM with CNA (J and K) providing care. The resident was placed on the toilet using the standing lift. After the resident had finished the CNA (J) donned gloves to wipe the resident's buttocks. There was fecal smearing noted on the wipes and the resident was placed back down on the toilet. Staff was noted to touch the lift with soiled gloves before removing her gloves. The resident was again lifted up and the CNA donned gloves to wipe the resident from standing behind the resident. Two wipes were used over the rectum. The buttocks and groin crease were not wiped before transferring the resident in to bed. 5. Interview with staff during the survey who wished to not be identified reported that residents were not getting the assistance in the dining room they needed. They also reported issues with resident were not being toileted timely or briefs being changed. There were two examples of other residents not getting a briefs changed for an extended period of time. The residents which staff had identified were dependent on staff for care. ACTIVITIES OF DAILY LIVING THAT DID NOT OCCUR SINCE RESIDENTS REMAINED IN THE DINING ROOM AFTER THE BREAKFAST MEAL 1. On 8/11/10, the following observations were made on the residents in the dining room:	F 312		

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F 312	Continued From page 51 a. At 8:45 AM, residents who ate in the dining room were seated at their assigned tables. b. At 10:00 AM, residents #4 and #17 were still in the dining room, sleeping at their table. Resident #7 was still in the dining room at the table, wiggling in his/her wheelchair and reaching for the hand sanitizer which was in the middle of the resident's table. Residents #11, #24, and #6 were still in the dining room sitting at their table. c. At 10:07 AM, resident #7 continued to wiggle in his/her wheelchair. Resident #17 woke up and stayed awake briefly. d. At 10:10 AM, the Social Service (SS) staff member asked resident #6 how he/she liked the new wheelchair. e. At 10:20 AM, resident #17 was moved out of the dining room. Resident #6 was talking to visitors in the dining room. Resident #7 continued to be seated at the table, wiggling in the wheelchair and reaching for items in the center of the table. Residents #11 and #24 were still sitting at the table and had been joined by the SS staff member who was attempting to involve resident #24 in a table top game. f. At 10:26 AM, seven of the eight residents seated in the chapel area were sleeping. The one resident (#14) who was awake called the surveyor to reach him/her a magazine. The resident stated "I have been waiting for someone to come along." g. At 10:30 AM, the minister arrived and resident #18 was removed from the chapel. Resident #24 was moved into the chapel area.	F 312		

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F 312	Continued From page 52 h. At 10:40 AM, an Activities staff member (U) was observed turning resident #7's wheelchair so that the resident faced the chapel. The resident continued to move and wiggle in his/her chair. The staff member moved the resident to another side of the same table, such that the table was in front of the resident. The staff member sat with the resident. i. At 10:45 AM, resident #11 appeared to be asleep and was slid down in his/her wheelchair. Three staff member moved so that they were standing around the resident. They did not speak to the resident. When CNA (G) touched the resident's hand, the resident startled and jerked his/her hand upward. At 10:48 AM, CNAs (G and K) moved the resident out of the dining room and toileted the resident. The resident was taken back to the dining room. 2. On the morning of 8/11/10, resident #2 was observed throughout the morning in his/her nightgown sitting in his/her room doorway and then later wheeling up and down the hallway. Staff indicated that the resident was waiting for a shower. At 11:38 AM, nurse (A) was observed toileting and dressing the resident, as it was lunch time. The resident had not been showered. In an interview with the nurse, she was not aware that the resident was waiting for a shower.	F 312		
F 323 SS=E	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	F 323		

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F 323	Continued From page 53 prevent accidents. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to provide adequate supervison to prevent accidents and to ensure that the environment was as free of accident hazards as possible. The findings included: POTENTIAL BURN RISK: 1. Observations on 8/10/10 at 6:30 PM were made of an open coffee pot coffee maker with a hot water dispenser and a hot cocoa/latte dispensing machine located at the nurses station. The temperature of the hot water dispenser from the coffee maker measured 170.4 degrees Fahrenheit. The temperature of the coffee from the open coffee pot measured 159.8 degrees Fahrenheit. The temperature of the cocoa dispensed from the cocoa/latte dispensing machine was 158.5 degrees Fahrenheit. 2. Observation was made of resident #2 on 8/10/10 at 6:40 PM. The resident had been given a cup of hot cocoa. The resident was seated in a wheelchair and was wheeling up and down the hallway using his/her feet and one hand to move the wheelchair while using the other hand to hold the hot cocoa. There was nothing to stabilize the cup of hot cocoa. This created the potential for the resident to spill the cooca and potentially burn the resident. 3. Observations made throughout the survey found resident #6 to frequent the area at the coffee maker and hot cocoa/latte machine. The area at the nurse's station was not always supervised. Review of the resident's oognitive	F 323	F323 The facility will meet this requirement by residents #2 and #6 will be provided an area as free of potential burn risk as is possible. The coffee pot/maker and hot cocoa/latte dispensing machine will be moved to a location that is not easily accessible to those residents. Resident #2 will be provided a travel mug with sealing lid for any hot drink and a cup holder will be attached to the wheelchair. All residents will be provided an area as free of potential burn risk as is possible. Resident #21 will be provided an appropriate hot pack when needed, for knee pain. Staff will be in-serviced on appropriate procedure using aqua-therma or waterproof heating pad when any resident requires use of a hot pack. All chemical hazards, including bleach will be stored in a locked area, not accessible to	10/1/10

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F 323	Continued From page 54 status found that the resident did have dementia and did not have clear thought processes. The openess of the coffee maker and cooca/latte machine created the potential for this resident and other with cognitive imparment to be exposed to hot fluids from the coffee maker and cocoa/latte machine. 4. On 8/10/10 and throughout the survey time, resident #2 was observed wheeling his/her wheelchair close to the coffee maker which was located at the Activities Desk. Sometimes no staff were present in the area to monitor the resident. 5. During the morning of 8/11/10, resident #2 was observed wheeling up and down the hallway. The resident wheeled around the coffee maker several times and was given hot chocolate to drink as he/she wheeled about. 6. On 8/10/10 at 3:56 PM, nurse (A) was observed wetting a towel and heating it in the microwave. She revealed that she was going to use it as a hot pack for resident #21 and that she does this to help with the resident's knee pain. Observation evidenced that the wet towel was wrapped in another towel and was placed on the resident's right knee. 7. Review of the facility's policy "LTC-App-04 revised June 16, 2008 revealed that the equipment for Applying Warm Compresses listed "Aqua-therma or waterproof heating pad". The procedure did not include the use of a microwave, which has the potential to cause burns. CHEMICAL HAZARDS: 1. During the initial tour on 8/9/10 with staff (S) from 2:45 PM to 3:45 PM issues with unlocked chemicals was identified with a gallon container	F 323	residents. Staff will be in-serviced on proper storage of chemical hazards. Residents #1 and #4 will be provided appropriate side rails with a gap no larger than 3 inches allowed between the bed and the siderails. All residents beds using siderails, will be assessed for appropriate safe siderail usage. Residents #1, 2, 3, 4, 6, 7, 8, 9, 11, and 17 will be provided safe transfers and appropriate supervision to ensure minimum exposure to possible accidents and safety risks. All residents will be provided appropriate supervision and safe transfers when needed. The facility will provide adequate staffing to meet the needs of residents in a safe environment. Staff will be trained and in-serviced on proper transferring techniques and appropriate supervision of residents to provide as safe an environment as possible. Nursing staff and maintenance will check all equipment routinely to provided safe, sound equipment for residents	

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F 323	Continued From page 55 of beach found on the counter in the soiled utility room. 2. During the environmental tour on 8/12/10 from 10:00 AM to 11:00 AM with the Maintenance Supervisor and Administrator the following issues with chemical storage was identified .The soiled utility room was found unlocked with the gallon container of beach still accessible to anyone entering the room. SIDERAILS: 1. During the initial tour on 8/9/10 with staff (S) from 2:45 PM to 3:45 PM issues with residents having side rails with gaps were identified. a. During the tour staff (S) reported that resident #4 did not move in the bed. Resident #4 was observed to be lying in bed asleep with half siderails up. There were two half rails in the up position at the head of the bed and two rails on the foot end of the bed in a lowered position. Each siderail had three areas or sections which measured approximately 7 1/2 inches square. All three areas were large enough to allow a residents head through the rail itself. These areas had a potential for resident entrapment. b. Resident #1 was observed to be lying in bed asleep with half side rails on the outside of the bed and another up against the wall. This side rails was noted to be loose and created a gap between the bed and the siderail to the open side of the bed. This gap was approximately 5 to 6 inches in width. 2. During the environmental tour on 8/12/10 from 10:00 AM to 11:00 AM with the Maintenance Supervisor and Administrator issues with side rail	F 323	needs. The facility will maintain this requirement by developing quality indicators to ensure the environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. The IDT, DON and Maintenance staff will monitor monthly and report to the QA/QI committee.	

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F 323	Continued From page 56 risk for resident #4 and #1 were confirmed. UNSAFE TRANSFERS AND LACK OF SUPERVISION: 1. Observation of resident #8 on 8/11/10 at 9:45 AM with CNAs (J and K) providing care. The resident was transferred to bed by using a two person lift. Staff lifted the resident by lifting under the resident's arm and pulling up on the back of the resident's pants. The resident's legs remained bent and did not assist staff in the transfer. A difficult lift was observed and a gait belt was not used. [A later interview with CNA (K) on 8/12/10 at 6:00 PM confirmed a gait belt should have of been used during the transfer of this resident.] Staff then decided to get the resident on to the toilet. A standing lift was placed at the edge of the bed after the resident was brought to a sitting position. The sling was placed around the resident and as the resident was lifted the resident's knees remained bent. The resident's weight was supported by his/her arms. Due to the concern of unsafe transfer the DON was asked to observe the resident in the lift. As the staff removed the resident from the toilet the DON identified the resident was not appropriate for the standing lift and instructed staff a full lift should be used. The resident was noted to have an OpSite over a skin tear on the back of her right upper arm where the sling had been positioned. 2. Resident #4 was observed during a transfer on 8/11/10 at 10:00 AM using the full lift. The resident's head was not supported during the transfer and was noted to be hyperextended. Staff reported that they did not have a sling small enough for this resident which supported the resident's head. This presented an unsafe	F 323		

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F 323	Continued From page 57 transfer for this resident. 3. Resident #17 was observed on 8/11/10 at 10:08 AM with CNA (J and R) providing toileting. The resident was transferred using a standing lift. The residents knees remained bent, toes were position on the bolts at the front of the foot platform and weight supported by the resident's arms. Staff reported that sometimes the resident helps more than others. The transfer observed was unsafe for this resident. 4. Observation on 8/11/10 at 12:38 resident #9 was observed to be transferred from the recliner in to a wheelchair. A two person under arm lift without a gait belt was observed. Staff used the back of the resident pants to assist with the transfer. 5. On 8/10/10 at 10:10 AM, nurse (D) was observed cleaning and applying a dressing to resident #8's skin tear which was located on the resident's right upper arm. The resident's arm had numerous purple bruises on it. The nurse said that CNA (I) reported this skin tear to her. When the nurse was asked if the resident was just transferred to bed, she indicated that the resident had been in bed for a while. CNA (I) was interviewed at 10:13 AM. She said that the resident had just been transferred to bed. She commented that this transfer was done using a two man transfer with the resident pivoting. The CNA said that CNA (N) was the second person for the two man transfer. 6. On 8/10/10 at 10:40 AM, resident #11 was observed in his/her wheelchair. The resident was sleeping, stretched straight out with his/her head resting on the top of the wheelchair and his/her	F 323		

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F 323	Continued From page 58 buttocks at the edge of the chair. The surveyor questioned nurse (D) about if the resident was going to slide out of the chair. The Director of Nursing (DON) and nurse (D) sat the resident up in the chair and indicated that a CNA would put the resident to bed so he/she could rest before the meal. However, observation revealed that the resident was not placed in bed, but remained sleeping in his/her wheelchair. The resident was moved to the table for the noon meal without being toileted. He/she continued to sleep at the table. 7. On 8/11/10 at 10:48 AM, CNAs (G and K) moved resident #11 out of the dining room and toileted the resident. The resident was transferred to and from the toilet without the use of a gait belt and without the wheelchair wheels being locked. One CNA held the resident up while the second one provided peri-care. During this process, the resident's knees bent so much that the resident was in a sitting position and the CNA indicated that the second CNA needed to hurry. They quickly moved the resident into the wheelchair. The resident was taken back to the dining room, where he/she was left without the TAB alarm being re-attached. The surveyor notified the nurse (D) and the CNA re-attached the alarm. 8. On 8/11/10 at 11:00 AM, CNAs (J and K) were observed transferring resident #3 from his/her bed, using a Hoyer lift, to a shower chair. The resident was transported backwards down the hallway to the shower. The resident and staff explained that this was the resident's preference since his/her feet would drag on the floor if the chair were pushed forward down the hall. They commented that the shower chair did not work well.	F 323		

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F 323	Continued From page 59 9. At 11:38 AM, nurse (A) was observed toileting and dressing resident #2. In the bathroom, the resident was stood at the grab bar without the use of a gait belt. During the transfers, the wheelchair wheels were not locked. 10. On 8/11/10 at 12:28 PM, the sleeping resident (#9) was transferred to the wheelchair by two CNAs (J and R). They did not use a gait belt, but lifted the resident under his/her arms and with the resident's pants. 11. Review of the facility policies "LTC-M&L-13" and "LTC-M&L-14" revised on July 16, 2008 provided procedures for transferring a nonambulatory resident back to bed from a wheelchair or chair and into a wheelchair or arm chair from the bed. Policies state that staff need to lock the wheels on the bed and/or the brakes on the wheelchair. Both policies reference gait belts as equipment needed or to "Place the gait belt around the resident's waist." 12. On 8/13/10 at 7:45 AM, resident #7 was observed in the dining room at his/her assigned table. The resident was leaning to the left side and his/her left hand was wedged under the wheelchair bar. The resident was moaning. The surveyor notified the nursing staff who took him out of the dining room to the area next to the Activity desk. The staff moved the resident and pushed his/her hand out from under the bar. The resident's two fingers and knuckles were bright red. The staff used a pillow to position the resident in an upright position. On 8/10/10 at 10:00 AM, resident #6's wheelchair arm was observed to be cracked. This created the potential for skin tears.	F 323		

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F 323	Continued From page 60 On 8/10/10 at 10:00 AM, resident #1 was observed in the dining room, trying to climb out of his/her geri-chair.	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This Requirement is not met as evidenced by: Based on the observations, record review, and resident, family, and staff interviews, it was determined that the facility failed to provide sufficient, qualified nursing staff to meet the needs of the residents. The facility had a census of 32 residents. The direct resident care was provided by certified nurse aides (CNAs) with the nurses passing medications and doing treatments. The failures were evidenced by the deficient practices cited in this survey report and	F 353	F353 The facility will meet this requirement by providing adequate staffing to meet the needs of resident #5 and all other residents. The facility will monitor staff for possible burnout, frustration and stress. Staff will be in-serviced on the suggestion box located in the employee dining area where concerns/issues may be addressed anonymously, if staff so choose. This requirement will be maintained by developing a quality indicator to monitor appropriate staffing levels to adequately provide care to residents. Social Services will monitor on a monthly basis and report to the QA/QI committee.	10/1/10

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F 353	Continued From page 61 residents, family, and staff who complained about the shortage of staff to assist the residents with their activities of daily living (ADLs). The findings included: 1. During an interview with a family member on 8/12/10 at 6:30 PM the family member stated that he/she had concerns with the facility having enough staff on during the evening and nights. The family member stated that during the night they had personally been in the facility and verified that only two staff were present to take care of the residents. 2. During an interview with a family member on 8/10/10 at 6:35 PM the family member stated that he/she believed that the facility could use more staff at times. The family member stated that the facility seemed to have lost some staff over the past year or so and that it seemed that the acuity of care for residents had increased without an increase in staff. 3. During an interview with resident #5 on 8/11/10, the resident stated that at times staff were not always available when she needed them to go to the bathroom or for other needs. The resident stated that on several occasions during evenings and at nights she would activate the call light and not get a response from staff. The resident stated that he/she would then begin yelling in order to get staff to come to the room to attend to his/her needs. 4. On 8/10/10 in a confidential interview with a staff member, she revealed that her 12 hour shifts usually meant working 14 to 15 hours. 5. On 8/10/10 during the resident group meeting,	F 353		

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F 353	Continued From page 62 three resident commented that the facility could use more staff. Other residents agreed with these residents. 6. On 8/11/10 in a confidential interview with a staff member, she revealed that staff, especially working 12 hour shifts, are lucky to get one break. 7. On 8/12/10 in a confidential interview with a staff member, she made the following statements: "Residents are not toileted as planned; we try to prioritize and toilet everyone when they are gotten up in the morning, before lunch, and before supper." "Residents are not getting the quality of care they deserve." "We need help in the dining room - three staff can't feed all the residents who need help." "There are a lot of two person assists - heavy lifts." "CNAs are very short staffed - have to work 12 - 16 hours." "We are lucky to get 1/2 hour break." 8. On 8/12/10 at 9:23 AM, in an interview with nurse (D), she was questioned about how the evening (8/11/10) went. She indicated that she was here until 10:30 PM (from 6:00 AM) or 16 1/2 hours. This nurse was scheduled to work a 12 hour shift on 8/12/10. 9. During the interviews which were conducted on 8/11/10 and 8/12/10 for the Abuse Protocol	F 353		

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F 353	Continued From page 63 review, the shortness of nursing staff was a repeated concern. The staff indicated that cares did not get done as planned, such as every two hour toileting, and that a lot of the residents required two staff assists for transfers and cares. The residents were identified as requiring increased time and staff to meet their needs. The supervisory staff verified that oversite of their staff was not being done and there was no way to address issues such as burnout with the current staffing numbers. 10. Based on staff interview and observation, the facility was asked to provide the actual hours that nursing staff had worked from 4/25/10 to 7/31/10, as noted on their payroll print-outs. The following were examples of nursing staff and the hours that they worked in each two week (80 hour base) pay period: Nurse (D) - 103; 92.25; 112.5; 89.25; 121; 121.5; and 92.75. Nurse (B) - 77; 71.75; 69.5; 91.25; 84.25; 74.5; and 114. Nurse (E) - 94.75; 85.5; 98.5; 87; 101.75; 93.75; and 79.5. CNA (R) - 90.75; 92.5; 87; 89.75; 90.5; 99.5; and 96.75. CNA (F) - 98.5; 92; 97; 93; 96.5; 85.25; and 80. CNA (G) - none; 106.25; 93.5; 97.25; 109.5; 93.75; and 98. CNA (P) - 80; 105.75; 91.75; 109.25; 136.5; 103.75; 124.5.	F 353		

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F 353	Continued From page 64 CNA (Z) - 83.75; 71.5; 71.5; 96.5; 96.75; 94.25; and 61.25. Contract Nurse (C) - none; none; 74; 88; 72.5; 55; and 110.2. Contract CNA (N) - 110.5; 142.5; 103.5; 96; 135.5; 75.5; and 118. There was no evidence to show that the facility was monitoring signs and symptoms of staff burnout, frustration and stress which has a potential to lead to neglect and potential abuse.	F 353		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This Requirement is not met as evidenced by: Based on observation, staff interview and record review it was determined that the facility failed to follow ordered menus and provide servings based on those menus. The findings include: 1. On 8/10/10 at 4:07 PM, an observation of dietary staff member (Q) preparing the pureed textured foods for four residents revealed the following: Four 6 ounce portions of turkey tetrazzini were placed in the blender with approximately one cup of 2 % warm milk (as described and estimated by the staff member).	F 363		

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F 363	Continued From page 65 Four 4 ounce portions of peas and carrots plus liquid from the vegetables and approximately 3/4 cup of hot water. No bread or margarine were prepared or added to the pureed texture foods. Note: The pears had already been pureed. The dietary staff member confirmed the ingredients that she used to prepare the pureed texture foods. Review of the menu for this meal evidenced the following: Turkey tetrazzini 6 ounces Peas and Carrots 1/2 cup Bread Forest Pears 2 Milk 1/2 cup. 2. On 8/10/10 during the evening meal which was observed from 5:15 PM to 6:30 PM, residents seated at facility designated tables 1 and 2 had bread placed in a basket in the center of the tables. The bread was wrapped in sandwich bags. Residents were not observed to be offered or to take any of the bread. No bread basket was present on table 3. The residents were not served bread on their plates. 3. On 8/11/10 during the noon meal which was observed from 12:07 PM to 1:25 PM, residents seated at facility designated tables 1 and 3 had bread placed in a basket in the center of the tables. The bread was wrapped in sandwich bags. Resident #2 was the only resident observed to have bread on his/her plate.	F 363	F363 The facility will meet this requirement as evidenced by menus will be prepared in advance and followed to meet the residents needs. Dietary staff will be in-serviced on proper pureed menu preparation to assure all menu items are present. The CDM will perform weekly monitoring of pureeing techniques and plating to assure compliance. This will be reported by the CDM monthly to QA/QI committee. Residents will receive all items listed on the menus to assure nutritional adequacy. Buttered bread will be placed on the plate by dietary staff during meal service as the tray is prepared, when bread is listed on the menu. This will be monitored by the CDM and reported monthly to the QA/QI committee.	10/1/10

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F 363	Continued From page 66 No bread basket was present on table 2. The residents were not served bread on their plates.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to store, prepare, and distribute food in a manner that minimized the potential for the spread of food-borne illness. The findings included: 1. On 8/9/10 at 3:40 PM, during the initial tour the kitchen in the presence of the Certified Dietary Manager (CDM), the following observations were made: a. In the walk-in refrigerator, there was a broken egg sitting the partially used carton of eggs. b. In the reach-in refrigerator, there were five cases of Mighty Shakes thawing. Three of the cases were dated 8/9 and two 8/13. c. There were containers of chemicals stored under the clean side of the dishwashing area. d. There was no garbage disposal in the	F 371	F371 The facility will meet this requirement by procuring, storing, preparing and distributing food under sanitary conditions Dietary staff will be in-serviced on proper food storage and handling, as well as sanitation guidelines. Food will be stored properly including only intact eggs being stored. Compliance to this will be monitored and recorded during daily food rounds performed by the Cook. All items, including mighty shakes thaw dates, will be appropriately dated to assure proper storage. Chemicals will be stored in a separate labeled location to prevent cross contamination risk.	10/1/10

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F 371	Continued From page 67 dishwashing room. Under the sink where the garbage disposal had been located, there was a "food trap". The CDM indicated that not all of the food particles were being caught, so there was another food trap under the dish machine. Both of these traps still contained food particles. e. In one of the cupboards, several insulated cereal dishes were observed to have caked on food debris on them. There were wet glasses and small bowls stacked in the cupboards. In the drawer where the adaptive silverware was stored, there were crumbs in the plastic silverware holder. f. There were five large cookie sheets stored on the shelf. These baking sheets had bake-on food on them and the edges had built-up, black grease on them. g. In the freezer section of the refrigerator, bags of food were dated but not labelled to indicate what the food items were. A small jar of Silvadene ointment (for staff to apply if they are burnt) and several tubes of tooth whitening solution, which belonged to a staff member. 2. On 8/10/10 at 4:07 PM, the following observation was made in the kitchen: a. In the walk-in refrigerator, there were several packages of different cooked meats thawing on the same tray. Some of the packages were not labelled as to their content. One large, unlabelled package which appeared to contain raw meat was thawing on the same pan. Staff indicated that it was cooked beef. b. Additionally, the sanitizing bucket was observed sitting in the sink in the food preparation	F 371	Food catch trays will be emptied after each batch of washes and as needed during the washes to prevent food particle build up. Dishes will be inspected for food debris and properly dried before storage. A cleaning schedule will be posted and followed. Pots and Pans will be thoroughly washed and sanitized prior to storage. Used equipment unable to be fully cleaned will be replaced. All products will be labeled for content when removed from the original packaging and dated. Staff items will be stored in a separate designated area from facility items. Staff will be in-serviced on sanitation techniques including proper preparation, testing and use of sanitizing solutions. Dietary staff will test and record on a concentration log the PPM twice a day, the	

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F 371	Continued From page 68 area with the solution hose touching the water which was in the bucket. Staff verified that this bucket was for used for wiping off counters. The surveyor requested to have the sanitizing water tested for strength of sanitizer. When the test strip indicated that there was less than 100 ppm (parts per million), the staff member said that she thought the roll of test stripes had been wet. She was unable to find more strips, but another staff member found QT-10 stripes and tested the water to be 100 ppm. The staff member said that the goal was 150 - 400 ppm. The OASIS 146 Multi-QUAT chart which was posted indicated that the test strip should be QT-40. 3. On 8/10/10 at 5:50 PM, in an observation of the residents' refrigerator which was located in the dining room, there were five undated (no thaw date) Mighty Shakes and four dated 7/28. 4. On 8/12/10 at 9:30 AM, in an observation of the residents' refrigerator, there were five undated (no thaw date) Mighty Shakes and four dated 7/28. The four shakes which were dated 7/28 were expired as these had been thawed for more than 14 days. 5. On 8/12/10 at 9:30 AM, in interviews with two dietary staff members (X and Y), they stated that the Mighty Shakes are dated when they are taken out of the freezer to thaw. 6. On 8/12/10 at 9:45 AM, in an interview with the consultant Registered Dietitian (RD), the concerns related to labelling foods, dating Mighty Shakes, the food traps under the sinks, the ice cream machine, diet list on weight tracking not being current, resident dislikes, such as zucchini/squash, and the availability of the alternate/substitutes. The RD verified that tray	F 371	concentration of the automatically dispensed quat sanitizing solution to assure the appropriate concentration is available. Dietary staff will review daily the Residents refrigerator in the resident dining area to assure no undated or outdated items are present. Items will be discarded when appropriate. This requirement will be maintained by developing quality indicators and will be monitored by the CDM and reported monthly to the QA/QI.	

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F 371	Continued From page 69 cards are used and dislikes are listed on these cards. 7. On 8/12/10 at 2:00 PM, in an interview with the CDM, she stated that the cartons labelled 8/13 were actually placed in the refrigerator on 8/3 as noted on the back of the carton. The expired and undated Mighty Shakes in the dining room refrigerator were discussed.	F 371		
F 425 SS=E	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 observation, record review, and staff interview it was determined that the facility failed to provide pharmaceutical services which ensured accurate acquiring, receiving, dispensing, administering, and labeling of drugs.	F 425	F425 The facility will meet this requirement for resident #2 as evidenced by receiving all ordered medication in a timely fashion from resident's primary pharmacy, if medication is not available within a reasonable time frame (depending on the medication) through resident's primary pharmacy, the nursing staff will contact hospital pharmacy to check availability. Furthermore 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 medication was obtained at a different location. If medication is not available from any surrounding pharmacy within the standard of practice timeframe physician will be notified for a new order. All residents will receive	10/1/10

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F 425	Continued From page 70 The findings included: Review of resident #2's physician orders evidenced that the resident had an order dated 8/7/10 for Macrobid 100 mg twice a day for seven days to treat a UTI. Review of the resident's 8/10 MAR revealed that the medication was not started until 8:00 PM on 8/9/10. On 8/11/10 at 9:00 AM, in an interview with the Director of Nursing (DON), she revealed that if a new medication order was received at night and it was available on the acute care side (hospital), the medication would be obtained from the hospital. She confirmed that there was no emergency box of medications in the nursing home. She verified that there were four pharmacies from which the facility received medications and the local pharmacist was the facility's consultant. The DON said that if a medication is ordered on the weekend, the resident may need to wait two days before the medication is received. Cross refer to F281 for issues related to medications not being correctly labelled, correctly dispensed, and available for use.	F 425	ordered medications within an acceptable standard of practice timeframe. This requirement will be monitored monthly by nursing staff. A quality indicator has been developed and will be reported through QA/QI program.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	Continued From page 71 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 (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 record reviews, observations, and staff interviews, it was determined that the facility failed to implement an infection control program through which all infections were identified and tracked. The facility's Infection Control Program failed to provide complete and follow-up information related to individual resident infections, review preventative measures to prevent the spread of infections related to those individuals, and identify a system to track clusters	F 441	F441 This requirement will be met by updating and reviewing the current LTC infection control policy for residents with known infections. This will include investigating, tracking and follow-up of infections. Policies regarding active MDRO and colonized MDRO will be reviewed and updated to include procedures for isolation and plan of action per individual resident. All LTC employees will be in-serviced quarterly on proper hand washing , PPE, equipment disinfecting, infection transmission prevention and isolation procedures, proper linen handling, storage and transport. This requirement will be met by reviewing, updating and implementing policies for the infection control program including prompt investigation, identification of infectious organisms, prevalence/trends, treatment, follow-up, control and prevention of further and/or spread of infection. A	10/1/10

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F 441	Continued From page 72 of infections within the facility. The findings included: 1. During the initial tour on 8/9/10 with staff (S) from 2:45 PM to 3:45 PM issues with residents having MDRO (Multidrug-resistant organisms) infections were identified. A CNA (certified nurse aide) worksheet provided during the tour identified and staff interview confirmed 10 residents with colonized MRSA (Methicillin Resistant Staphylococcus aureus) and 2 residents with colonized VRE (Vancomycin-resistant enterococci) infections. Staff reported that were no residents currently in isolation due to infections. [Colonization means that the organism is present in or on the body but is not causing illness, and infection means that the organism is present and is causing illness/symptoms.] INFECTION CONTROL PROGRAM: 2. Review of the infection control program revealed there was not a system in place under which it - timely investigated, controlled, and prevented infections in the facility. The findings included: a. Interview with the DON on 8/9/10 and 8/12/10 at 4:15 PM revealed that she kept the individual tracking sheets for residents started on antibiotics. Reportedly nursing staff starts the tracking form and the DON was responsible for completion of the tracking sheet and identifying the number of resident infections for the month. The designated ICC (Infection Control Coordinator) was a nurse from the hospital who was supposed to be reviewing the tracking sheets. The DON revealed she was not aware of a monthly log tracking sheet being done or follow up being done by the ICC. The DON also	F 441	maintenance record for prevalence, trends, location and potential transmission and corrective actions related to the infections will be kept and updated monthly and as needed. Incomplete infection control log and tracking for June and July will be brought up to-date. Nursing staff will be in-serviced on these policies and updates. Nursing staff will be in-serviced on proper peri-care and urinary catheter care, to prevent cross contamination and the spread of infection. Nursing staff will be in-serviced on proper whirlpool and shower cleaning and disinfection procedure per policy. A policy will be written for whirlpool cleaning, disinfection and proper storage and care of bathing supplies to prevent the spread or transmission of microorganisms.	

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F 441	Continued From page 73 provided a "Monthly Infection Report" for the infection control committee at the hospital which then went to the QA committee which was done quarterly. b. Review of the "Monthly Infection Report" and the individual tracking forms for residents having infections for the month of June and July were reviewed and found to be incomplete. The examples included: 1) "Monthly Infection Report" for June 10 identified 10 total infections with 7 "Nosocomial" (facility acquired) infections. The types of infections were listed however organisms were not identified. 2) The individual tracking forms for the seven resident having infections were incomplete. The examples included: Resident #4 who had a history MRSA was started on three different antibiotics 6/2/10, the front of the form was to supposed to include: diagnosis, nature of infection, onset, culture done, treatment, and precautions taken to prevent transmission but was blank. Resident #6 who had a history of VRE was started on three different antibiotics on 6/15/10, 6/20/10 and 6/21/10 and had three sheets, which were incomplete. Review of the Laboratory sheet for resident #6 dated 6/15/10 for sputum culture identified Klebsiella Oxytoca and Haemophilus Influenzae with growth of gram positive rods sent to another hospital for identification. There was no evidence of follow up on the results of this culture. There was no indication the resident was put in isolation until lab cultures were verified.	F 441	Nurses will be in-serviced on proper infection control procedures for medication pass including hand washing and maintaining sanitary technique. This requirement will be maintained by developing quality indicators and will be monitored by Infection Control Coordinator and reported monthly via the QA/QI program.	

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F 441	Continued From page 74 Interview with the DON 8/12/10 at 4:15 PM revealed she was unaware the resident having Haemophilus Influenzae and that the resident should of been in droplet precautions until lab results were verified or the resident was asymptomatic. Resident #7 was identified as having had an MRSA (Methicillin Resistant Staphylococcus Aureus) . The individual tracking sheets did not address "Precautions initiated against cross-contamination". c. Interview with nurse (N), the ICC (Infection Control Coordinator), from the hospital at 7:00 PM revealed she had not been involved with the infection control program for the long term care facility. She reported she had only been in the position a few months and the DON had been doing infection control. There was no evidence that the current ICC program was looking at trends and clusters of infections, residents with repeated infections, tracking of infections by organisms or that timely actions and interventions were being implemented to prevent potential spread of infections in the facility. INFECTION CONTROL ISSUES PERI CARE: 3. Observations of residents #7 and #8 receiving peri care identified staff did not provide care in a manner to prevent cross contamination and possible spread of infections. (Cross refer to F312) On 8/11/10 at 11:38 AM, nurse (A) was observed toileting and dressing the resident #2. After the	F 441		

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F 441	Continued From page 75 resident voided in the toilet, he/she was stood up and peri-care was done. The nurse wiped from behind reaching between the resident's legs. The wipe was observed to have fecal smearing on it on the first wipe. The same wipe was used and the front to back perineal area was wiped again (with the soiled peri-wipe). CLEANING OF EQUIPMENT: 4. The interviews with the Maintenance Supervisor and staff (G) confirmed that the whirlpool tub instruction were not being followed to ensure it was properly cleaned and disinfected between resident use. This has the potential for cross contamination and spread of infections. Cross refer to F253 5. On 8/10/10 during a medication pass observation from 10:20 AM to 11:10 AM, nurse (D) was administering thirteen medications to resident #14. The nurse was spooning a couple of medications into the resident's mouth at a time. One of the pills fell on the resident's blanket and rolled down the blanket. The nurse used the spoon, picked up the medication, and gave the medication to the resident. 6. On 8/11/10 at 11:00 AM, CNAs (J and K) were observed transferring resident #3 from his/her bed, using a Hoyer lift, to a shower chair, and transporting the resident to the tub room. While the resident was being showered in the lift sling, the resident's catheter bag was observed to be lying on the shower floor next to and on the floor drain with the dirty, soapy water running over it. The CNA (J) placed the resident's wet puffy (used to wash the resident) into the resident's carry bag. This bag with the wet puffy and the resident's bathing supplies was placed on the resident's	F 441		

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F 441	Continued From page 76 closet shelf. References: MRSA: CDC (Center for Disease Control) Antimicrobial Resistance - Multi-drug Resistant Organisms in Non-Hospital Healthcare Settings: They are bacteria and other microorganisms that have developed resistance to antimicrobial drugs. ... MRSA (Methicillin Resistant Staphylococcus aureus) and VRE (Vancomycin-resistant enterococci) are the most commonly encountered multidrug-resistant organisms in patients residing in non-hospital healthcare facilities. Non-hospital healthcare facilities can safely care for and mange these patients by following appropriate infection control practices. Current prevention methods is an ongoing investigation. No single prevention approach is likely to work alone. Careful handwashing is important for prevention of spread of many infections including Staph aureus..."	F 441		
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide functioning ventilation in resident bathrooms in order to minimize odors. The findings included: 1. During the initial tour on 8/9/10 with staff (S) from 2:45 PM to 3:45 PM issues with mechanical ventilation were identified. The bathroom mechanical ventilation in the	F 467		

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F 467	Continued From page 77 resident rooms #203 and #212 were found not working. Each room was occupied by two residents. The vents were checked by holding a one ply tissue paper up to the vent which was not drawn upward. Room #212 was noted to have urine odors when checked. 2. During the environmental tour on 8/12/10 from 10:00 AM to 11:00 AM with the Maintenance Supervisor and Administrator issues with the mechanical ventilation were confirmed. The bathroom ventilation was checked in resident room 213 and the soiled utility room was also found not working. Interview during this tour with the Maintenance Supervisor confirmed he was aware the mechanical ventilation was not working in some of the resident bathrooms due to a lighting strike. He reported that there were 8 units not working and that he had recently put in a work order to get 6 replacement motors and or parts for repair.	F 467	F467 The facility will meet this requirement as evidenced by ventilation motors will be replaced to ensure adequate ventilation in the facility. This requirement will be maintained by monthly monitoring performed by maintenance staff to inspect for proper ventilation. A quality indicator has been developed and will be reported through QA/QI program.	10/1/10
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: Based on observation, record review, resident interview, family interview, and staff interviews it was determined that the facility's administrative staff failed to ensure that the facility was administered in such a manner that there was adequate qualified staff to meet the residents' needs, maintain an effective infection control	F 490		

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F 490	Continued From page 78 program, and to provide adequate, qualified supervision for the staff. The findings included: 1. Twenty regulations were found to be out of substantial compliance in ten general requirement areas: Resident Behavior/Facility Practice, Quality of Life, Resident Assessment, Quality of Care, Nursing Services, Dietary Services, Pharmacy Services, Infection Control, Physical Environment, and Administration. §483.13 Resident Behavior & Facility Practice: a. The facility failed to initiate and completely investigate allegations of neglect and possible abuse to residents for injuries and improper care. (Cross Reference F225). b. The facility failed to develop and implement abused policies and procedures related to resident care and inappropriate staff treatment. (Cross Reference F226) §483.15 Quality of Life: a. The facility failed to insure that staff treatment of residents respected the dignity of residents in activities of daily living. (Cross Reference F241). b. The facility failed to maintain and provide adequate services related to housekeeping and maintenance of facility equipment and plant to provide adequate Quality of Life for residents. (Cross Reference F253) §483.20 Resident Assessment: a. The facility failed to assess residents for changes in condition when the changes were found to be significant. (Cross Reference F274)	F 490	F490 This requirement will be met by ensuring substantial compliance with regulations by administering in such a manner that there will be adequate qualified staff to meet the residents' needs, maintain effective infection control program and provide adequate, qualified supervision for the staff. The facility will implement and maintain a quality assessment and assurance program to assure the facility identifies issues related to the quality of care and quality of life for every resident in the facility. Quality indicators will be developed by appropriate staff and will be monitored by the Administrator to ensure appropriate reporting in a timely fashion by all staff involved in the QA/QI process. Results of QA/QI will be reported to the facilities Board of Trustee's quarterly.	10/1/10

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F 490	Continued From page 79 b. The facility failed to accurately complete resident assessments. (Cross Reference F278) c. The facility failed to revise individual comprehensive resident care plans when assessments indicated that changes had occurred requiring different approaches to providing care. (Cross Reference F280) d. The facility failed to follow professional standards related to the acquiring and dispensing medications and following physicians' orders. (Cross Reference F281) §483.25 Quality of Care: a. The facility failed to implement appropriate bowel programs as ordered by resident physicians and failed to provide for appropriate skin treatments for residents assessed to be at high risk for skin breakdown. (Cross Reference F309) b. The facility failed to provide services and treatment to maintain or improve resident ' s activities of daily living. (Cross Reference F311). c. The facility failed to provide services and treatment to residents who were unable to carry out activities of daily living and needed total assistance. (Cross Reference F312) d. The facility failed to maintain an environment that was free of accident hazards. (Cross Reference F323). §483.30 Nursing Services: The facility failed to provide sufficient, qualified	F 490		

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F 490	Continued From page 80 nursing staff to meet the needs of the residents. There was a lack of nursing leadership and oversight as evidenced in the deficient practices cited in this survey and the complaints of shortage nursing staff to meet the residents' needs. (Cross Reference F353) §483.35 Dietary Services: a. The facility failed to follow, prepare and serve meals using established menus. (Cross Reference F363) b. The facility failed to store, prepare, and distribute food in a manner which minimized the potential for food-borne illness. (Cross Reference F371) §483.60 Pharmacy Services: The facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administrating all medications. (Cross Reference F425) §483.65 Infection Control: The facility failed to implement an effective infection control program to identify and track infections throughout the facility. (Cross Reference F441) §483.70 Physical Environment: The facility failed to provide adequate ventilation in resident bathrooms in order to minimize odors. (Cross Reference F467) §483.75 Administration:	F 490		

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F 490	Continued From page 81 a. The facility failed to maintain clinical records in an accurate and orderly manner for resident medical records and Minimum Data Set Assessments.(Cross Reference F514) b. The facility failed to implement and maintain a quality assessment and assurance program to assure that the facility identified issues related to the quality of care and quality of life for every resident in the facility.(Cross Reference F520)	F 490		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This Requirement is not met as evidenced by: Based on record review and staff interview it was determined that the facility failed to maintain clinical records in an accurate and orderly manner. Records for ten of ten sampled residents (#1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) were found to be incomplete, unreadable or maintained in a manner that would allow improper revisions to be made of resident medical records. The findings include: 1. Review of medical records for residents #1	F 514	F514 The facility will meet this requirement by residents #1, 2, 3, 4, 5, 6, 7, 8, and 10 medical records will be reviewed and updated to ensure complete and readable records that do not allow improper revisions to be made. This will include appropriate documentation on meal intake. All residents medical records will be maintained in an accurate and orderly manner. Staff will be trained and in-serviced on appropriate documentation method to ensure sufficient, accurate and complete clinical records are maintained in accordance with accepted professional standards and practices and will be readily accessible and systematically organized. This requirement will be maintained by developing a quality indicator and the IDT and DON will monitor each resident's medical record as needed for review recommendations quarterly, annually and/or if a significant change in status is indicated. This will be reported to the QA/QI committee.	10/1/10

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F 514	Continued From page 82 through 10 were completed on 8/12/10. This review found that the Interdisciplinary Progress Notes (IPN) in each of the charts were used by staff to chart notes related to care, assessment and outcomes for each resident. a. Numerous pages in the IPN pages in each residents medical record were observed to have hand written notes or "Resident Weekly Skin Assessment" forms taped onto the IPN pages over blank areas. This created the potential for documentation related to patient care and assessment to be removed or altered after the fact. b. Numerous pages were found to have areas that were left totally blank without a continuation of the next note or block to prevent the IPN from being altered after the fact. 2. Review of the medical records for residents #1, 2, 3, 5, 6, and 8 were completed on 8/12/10. This review found Minimum Data Set (MDS) Assessment pages used by the facility to document assessments and determine the appropriate plan of care for each resident on a annual and quarterly basis and when a significant change had occurred in physical and mental status for each resident. Review of the MDS pages for each resident found numerous handwritten entries in the MDS for each resident that were either written over or scribbled out and written illegibly to the side margin. This made it difficult or impossible to determine the exact assessment code determined by the facility for that area of assessment and allowed for alteration of the assessments after the fact without clear documentation as to who made the changes and when they were made.	F 514		

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F 514	Continued From page 83 3. Review of medical record for resident #5 was completed on 8/12/10. A review of the "Food Intake Record" was made for the months of May 2010, June 2010, and July 2010. The record provided information as to how much food a resident was consuming at each meal. This assisted with the facility's assessment to assure that resident nutrition was adequate and that the resident did not develop weight loss problems. Observation throughout the survey found the facility served the resident's meal to the resident on a room tray in the resident's room rather than in the dining room. This was per the resident's request. Review of the resident's "Food Intake Record" found that the facility failed to record the meal intake for this resident on numerous days during the three months the record was reviewed. The facility also failed to record the actual amount of intake on the record in numerous instances over the three months of record reviewed and instead recorded a letter "R" to indicate that the resident had a room tray. 4. Meal observations during the survey revealed that resident #3 ate in his/her room for some meals and in the dining room at other meals. Review of resident's food intake records evidenced that the meal intakes for the evening meal which the resident ate in his/her room were not documented.	F 514		
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	F 520		

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F 520	Continued From page 84 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview it was determined that the facility failed to maintain an effective quality assessment and assurance program that identified issues related to the quality of care and quality of life for the residents and provided for a fully active quality assurance committee. The findings included: 1. Interview with the Administrator who was currently the QA Coordinator on 8/13/10 at 8:00 AM revealed that the QA committee had quarterly meetings. The meeting were held with the hospitals QA meetings. However the MD (Medical Director) did not always attend. There was no evidence the MD had input or was actively involved in QA issues. The Administrator reported, "QA is in transition and not effective at this point". She was not aware if Quality	F 520		

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F 520	Continued From page 85 Indicators were being looked at or addressed for potential areas of investigations in the QA process. 2. Review of the attendance list for those meetings revealed the MD (Medical Director)/ physician had not been in attendance at those meetings for the last year nor were the meetings held at least quarterly. The review showed the following: 6/28/10 MD (Medical Director) was not in attendance, (Review of these minutes gave no indication of discussion for the long term care.) 3/3/10 MD was not in attendance, 5/20/09 MD was in attendance, (This was the last documented attendance by the MD.) 1/28/09 MD was not in attendance, The facility failed to maintain a quality assessment and assurance committee for the long term care which included a physician (MD) designated by the facility; which meets least quarterly. 3. The QAA committee failed to address previously cited deficiencies from the 5/14/09 survey. The facility was identified with repeat deficiencies cited in the following areas: F441(The Infection Control Program) was cited on the previous survey as well as the current survey. (Cross refer to F441) F281 (Standards of practice) was cited on the previous survey as well as the current survey. (Cross refer to F281)	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 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. Acceptable standard levels will be identified to meet the goals of the plans and will be reported to the committee at each meeting.	10/1/10

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F 520	Continued From page 86 F323 (resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents), was cited on the previous survey as well as the current survey. (Cross refer to F323) The QA committee is responsible for developing plans of action to correct quality deficiencies and for monitoring the effect of these corrections. There was no evidence of follow up with these repeated quality deficiencies. 4. The number of current issues identified during the survey included: a. Cross Reference F309: The facility's QA program did not address issues with the bowel management program or resident identified as skin risk to ensure resident needs were being met. b. Cross reference F311: The facility's QA program did not address resident level of care and need for cueing and assistance with ADLs. c. Cross reference F312: The facility's QA program did not address resident level of care and need for increased assistance with residents dependent on staff for care. d. Cross reference F353: The facility's QA program did not address staffing issues. e. Cross reference F363: The facility's QA program did not address dietary issues. f. Cross reference F225: The facility's QA program did not address issues with abuse .	F 520	This requirement 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 87 g. Cross reference F253: The facility's QA program did not address housekeeping and maintenance issues.	F 520		