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

PRINTED: 02/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	PP 01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN - registered nurse LPN - licensed practical nurse CNA - certified nursing assistant DON - director of nursing MDS - Minimum Data Set ADLs - activities of daily living Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164		

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

Administrator 3/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
Wyoming Department of Health
MAR 15 2011
Office of Healthcare Licensing and Surveys

3/21/11 PoC accepted per telephone call with DON, Brenda Gomez with changes. — PPrice

(R) 1446

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F 164	Continued From page 1 resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and review of the facility confidentiality policy, the facility failed to ensure health information was kept confidential for 1 of 11 sample residents (#43) and 1 supplemental resident (#34). The findings were: 1. Observation on 1/25/11 at 7 AM revealed CNA #13 was providing toileting assistance for resident #20 in the bathroom. During the observation, RN #9 joined the CNA and both discussed the assessed changes in the health condition of non-sample resident #34 as the CNA completed the toileting assistance for resident #20. 2. Observation on 1/25/11 at 7:15 AM revealed two CNAs were providing care for the two residents in a room. During the observation CNA #3 entered the residents' room and spoke loudly about the individualized care needs and medical diagnosis of sample resident #43. The information was heard through the partially closed door and throughout the hallway. This was verified by the surveyor in the hallway positioned two resident rooms away. 3. Review of the facility's policy and procedure	F 164	F164 The facility will ensure that health information is kept confidential for all residents. This will be accomplished by: A&B) Floor nurses (including day shift Medication Nurse, day shift Supervising Nurse, and Noc Nurse) will be alert to conversations of staff involving residents – including residents #34 and #43 – and ensure that health information is kept confidential. If confidentiality is breached, immediate in-servicing and corrective action will be taken. C) DON will review the need to keep each resident's health information confidential with the nursing staff and CNAs. The DON will encourage all staff to thoughtfully monitor their conversations and intervene if they hear inappropriate discussion of a resident's health information. D) A performance improvement tool will be implemented to ensure that resident's health information is kept confidential. This tool will be completed monthly and reported quarterly to the PI (Performance Improvement) Committee. The DON will be responsible for compliance.	3/14/11

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F 164	Continued From page 2 entitled "Confidentiality", last reviewed in 1997, showed "Reasons for admissions, diagnosis and treatment of patients and residents are absolutely confidential information. Disclosure of confidential information may be grounds for immediate termination of employment."	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the interdisciplinary team (IDT) failed to determine if self-administration of medications was a safe practice for 2 of 2 residents (#15, #41) who self medicated. The findings were: 1. On 1/25/11 RN #9 was observed administering medications to resident #41 at 9:06 AM. The resident was in the process of eating so the RN left guaifenesin (cough medicine) sitting on the table when she left the room. Review of the medical record failed to show a determination by the IDT that the resident was safe to self-administer medications. Interview with the DON on 1/27/11 at 4:58 PM revealed the resident did not want to self-administer medication when s/he was admitted to the facility so the evaluation was not completed at that time. The DON stated that instead of conducting an evaluation by the IDT when the resident's wishes changed, the facility was relying on the physician's statement	F 176	F176 The facility will ensure that the IDT determines if self-administration of medications is a safe practice for each resident who wishes to self administer his/her meds. This will be accomplished by: A) The IDT will develop a self-administration of medications assessment form. This form will be completed to determine whether residents #15 and #41 may safely self-administer medications. B) The DON will discuss self-administration of medications with residents who do not have a DX of dementia to determine if others are interested. The DON will also discuss this option with residents at admission. The IDT will proceed with the safety assessment for those residents who express interest. C) The DON provided education to the resident council on 2/8/11 explaining that for safety purposes nurses were required to observe residents taking their medications when given in public areas. The DON also explained that residents interested in self-administration in their	

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F 176	Continued From page 3 that the resident was competent to self-administer medications. 2. Observation on 1/26/11 at 8:45 AM revealed LPN #10 administered medications to resident #15. These medications included Clearlax (a bulk laxative) which the LPN poured into the resident's glass of orange juice. When the resident did not immediately drink the fluid, the LPN turned and walked back to the medication cart where she prepared medications for other residents. Resident #15 was out of the LPN's line of sight so she did not know whether the resident consumed the laxative. Review of the medical record failed to provide evidence of an evaluation by the IDT for self-administration of medications. Interview with the DON on 1/27/11 at 4:58 PM verified the evaluation was not done.	F 176	rooms would have a safety assessment completed. The DON will provide education to the nursing staff re the need for the IDT to assess safety prior to self-administration. Nurses are to inform the DON if a resident who has not yet been assessed expresses an interest in self-administration. The resident's MAR will indicate if self-administration of medications has been approved by the IDT. D) A performance improvement tool will be implemented to ensure that safety assessments are completed prior to self-administration of medications. This info will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance.	3/14/11
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to ensure that during 3 of 3 meals residents dined in an atmosphere that enhanced their dining experience. In addition, during 1 of 3 meals resident #23 was not treated in a manner that promoted dignity during the meal. The findings were: 1. Observations throughout the evening meal on 1/24/11, the noon meal on 1/26/11, and the	F 241	F241 The facility will ensure that residents dine in an atmosphere that enhances their dining experience. This will be accomplished by: A) The meal tray cart was moved to the far south side of the dining room away from resident #46. Resident #23 will be observed by his meal assistant, who will attempt to get this resident to blow his nose if it is runny. B) The meal cart was moved away from all residents. The Medication Nurse, CNAs assisting residents, and dietary staff serving	

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F 241	Continued From page 4 morning meal on 1/27/11 showed the meal tray cart was parked against the empty side of resident #46's dining table. A trash can, numerous plate covers, a bucket for discarded food, several empty trays, and numerous dirty dishes were stacked on top of the cart; staff were bussing tables and scraping food into the bucket while residents were eating. During an interview on 1/27/11 at 8:20 AM, CNA #3 stated the practice was instituted about a year ago; she acknowledged it did not create an appetizing or appealing dining atmosphere. At 8:32 AM resident #46 said s/he did not like the practice. The resident specifically stated,"I look the other way and try to ignore it." 2. Observation during breakfast on 1/27/11 showed resident #23 had a runny nose and mucus would collect at the tip. The resident was eating independently with CNA #7 sitting next to him/her and assisting when needed. Instead of attempting to get the resident to blow his/her nose, the CNA would blot it just before mucus dripped into the resident's food. Although this resident was not interviewable, a reasonable person would not want to eat with mucus collecting at the tip of his/her nose and threatening to drip into the food.	F 241	residents in the dining room will observe and intervene (dietary to inform nursing) if a resident has a runny nose and is unable to wipe or blow his or her nose independently. C) The DON will provide education to the nurses, CNAs, and dietary staff re providing residents with an enhanced dining experience, especially relating to the tray cart placement and runny noses. D) A performance improvement tool will be implemented to ensure that residents dine in an atmosphere that enhances their dining experience. This tool will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance.	3/14/11
F 258 SS=B	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on confidential resident interviews, the	F 258	F258 The facility will provide for the maintenance of comfortable sound levels. This will be accomplished by: A) As this information was obtained during confidential resident interviews, the specific residents affected will be included in "B." B) All residents could potentially be affected by noise levels in the corridors after the evening meal. The Noc shift Supervising	

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F 258	Continued From page 5 facility failed to ensure staff maintained acceptable sound levels during evening hours to promote an atmosphere conducive to sleep for 8 of 10 residents asked about noise levels in the facility. The findings were: During confidential interviews on 1/26/11, eight residents agreed staff were noisy after the evening meal. The residents stated staff would talk loudly in the corridors outside resident rooms. They described the noise as giggling or someone expressing anger at another staff member. One resident stated s/he felt "left out" of the conversation.	F 258	Nurse is on duty from 7:00p.m. to 7:00a.m. and will monitor noise levels during this time. If there are issues immediate in-servicing and corrective action will be taken. The DON will obtain input from random resident discussions re comfortable sound levels four times per month. C) The DON will provide education to the CNAs and Nurses regarding maintenance of comfortable sound levels. D) A performance improvement tool will be implemented to ensure that comfortable sound levels are maintained. This monitor will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	F272 The facility will ensure that a comprehensive assessment is conducted for each resident for bowel and/or bladder incontinence. This will be accomplished by: A) The RN Team Leader will complete a B&B assessment on resident #23. The RN Team Leader will analyze related bowel incontinence data to attempt to determine causative and contributing factors and address retraining potential for resident #24. B) The Nurse Team Leaders will review B&B assessments for their residents at the time of each resident's quarterly care conference and address any incomplete areas.	3/14/11

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F 272	Continued From page 6 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to conduct comprehensive assessments for bowel and /or bladder incontinence for 2 of 11 (#23, #24) sample residents. The findings were: 1. Observation on 1/25/11 at 7:21 AM showed resident #23 was incontinent of bowel and bladder. Review of the 8/24/10 admission MDS assessment showed the resident should have had comprehensive assessments in these areas. However, review of the bowel and bladder assessment information showed that it was incomplete. On 1/26/11 at 4:55 PM, RN #4 confirmed she did not complete the assessments on admission. On 1/27/11 at 10 AM, the RN stated she forgot to re-assess the resident when s/he became more cooperative. 2. According to the 1/11/11 admission MDS assessment, resident #24 triggered for bowel incontinence and required a comprehensive assessment. Review of the assessment information showed data had been collected, but it had not been analyzed to determine causative and contributing factors. In addition, the section related to retraining potential had been left blank. On 1/28/11 at 7:55 AM, RN #4 confirmed the	F 272	C) The MDS coordinator will review B&B assessment expectations with the Nurse Team Leaders and provide education as needed or requested. D) A performance improvement tool will be implemented to ensure B&B assessments are completed. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC will be responsible for compliance. F274 The facility will assure that significant change assessments are completed as appropriate. This will be accomplished by: A) Resident #23 had a significant change assessment completed 1-31-11. B) A form will be developed for the bathing CNA to notify the RD (Registered Dietician) and nurse team leader of weight changes. The SCU Nurse Team Leader will check SCU weights weekly to identify changes. Nurse Team Leaders will listen to change of shift reports to identify possible areas of change. A form will be developed for the Supervising Nurse to identify areas of improvement or decline; this will be completed by the Supervising Nurse and	3/14/11

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F 272	Continued From page 7 bowel information was not a comprehensive assessment.	F 272	turned in to the Nurse Team Leaders' office.	
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 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 observation, review of medical records and internal tracking information, and family and staff interviews, the facility failed to complete a significant change assessment for 1 of 1 sample resident (#23) who required that assessment. The findings were: Observation on 1/26/11 at 10:12 AM showed resident #23 had escher (dead, black matter over a wound) covering the entire back of the heel. During the observation, RN #1 stated the area on the heel was a pressure ulcer that developed after the resident's admission to the facility. Review of the medical record showed the ulcer started as a blister and was first identified on 12/10/10. Further review of the record and	F 274	The DRC (Director of Resident Care) will randomly monitor that areas of significant change are being identified and acted upon. The DRC and Nurse Team Leaders will discuss changes and determine when a significant change assessment is appropriate. C) The DON will provide education to the nursing staff and CNAs re identifying and reporting possible improvement or decline in condition. D) A performance improvement tool will be implemented to ensure that significant change assessments are completed as appropriate. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC will be responsible for compliance.	3/14/11

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F 274	Continued From page 8 internal weight tracking information showed the resident lost nine pounds (6.47%) from November to December 2010. Interview with a family member on 1/25/11 at 8:28 PM revealed the resident was "much weaker." During an interview on 1/26/11 at 4:50 PM, RN #4 confirmed these declines should have resulted in a significant change assessment.	F 274		
F 280 SS=F	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure care plan interventions and goals were individualized, updated, and revised in accordance with the	F 280	F280 The facility will ensure that care plan interventions and goals are individualized, updated, and revised in accordance with the assessed needs of each resident. This will be accomplished by: A) The Nurse Team Leaders will revise the care plans for residents #1, 2, 10, 23. 24, 27, 29. 30. 36, 37, and 43 to meet this standard. Specifically, CP (care plan) for res. #1 will address cognitive loss and mood/behavior patterns. MSS will be involved with planning interventions. CP for res. #2 will be corrected re daily ambulation. CP for res. #10 will reflect specific toileting assistance techniques. CP for res. #30 will be updated re use of a walker. CP for res. #27 will be updated re ambulation. CP for res. #36 will be updated to provide comprehensive care re pressure ulcers, which is also addressed in Treatment Sheets. CP for res. # 37 will be updated re eye care. CP for res. #43 will be updated re recent surgery and positioning of the urinary catheter tubing and bag during transfers.	

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F 280	Continued From page 9 assessed needs for 11 of 11 sample residents (#1, #2, #10, #23, #24, #27, #29, #30, #36, #37, and #43). The findings were: 1. During an interview on 1/27/11 at 11:45 AM, LPN #6 revealed she was one of the nurses responsible for developing and updating the care plans and corresponding CNA flowsheets. She further stated that care was primarily provided according to the CNA flowsheets, because the care plans were "generic." Review of the generic care plans showed several different goals were listed for residents #1, #2, #10, #23, #24, ##27, #29, #30, #36, #37, and #43, but the correct one was not identified. 2. In addition to non-specific goals, the following concerns were noted with individual care plans: a. Review of the current care plan and January 2011 CNA flowsheet for resident #1 showed two identified problem areas, cognitive loss and mood/behavior patterns, had not been addressed. b. Review of the care plan for resident #2 showed one of the goals for this resident was daily ambulation. Review of the 11/14/10 significant change MDS assessment and care area assessments showed the resident did not have the ability to ambulate. During an interview on 1/24/11 at 2:45 PM, CNA #14 verified the resident's inability to ambulate. c. Review of the 8/3/10 care conference notes for resident #10 revealed the resident's voiding patterns had changed and specific toileting assistance techniques were necessary to help the resident empty his/her bladder. Review of the current care plan showed no revisions regarding this change. d. Observation on 1/26/11 at 10:12 AM	F 280	B) The Nurse Team Leaders will review each resident's care plan at the time of their quarterly care conference and make revisions as appropriate. C) The IDT will discuss and review care plan details quarterly. The Nurse Team Leaders will continue to encourage CNAs to alert them if they notice discrepancies. D) A performance improvement tool will be implemented to ensure care plans are individualized, updated, and revised in accordance with each resident's assessed needs. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC will be responsible for compliance.	3/14/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	53A002	A. BUILDING _____ B. WING _____	01/26/2011

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F 280	Continued From page 10 showed the resident required total assistance with oral care. The goal for the oral care plan was that the resident "will cont to (brush teeth...) with setup & cues..." Furthermore, the instructions for range of motion were not included in the plan. Refer to F318 for detailed information related to the restorative program. Interview with RN #4 on 1/27/11 at 6 PM confirmed the care plan was current, but it had not been updated to reflect the resident's current condition. e. Review of the current care plan and January 2011 CNA flowsheet for resident #30 showed an intervention for staff to remind the resident to use a walker. Further review showed this intervention was implemented on 12/16/09 and had not been revised according to the 12/9/10 annual MDS assessment. Review of that 12/9/10 assessment and an interview with CNA #14 on 1/24/11 at 2:45 PM revealed the resident no longer used a walker. Random observations on 1/24/11, 1/25/11, and 1/26/11 revealed the resident ambulated throughout the unit without a walker. f. Review of the current care plan goals for resident #27 showed the goals included the following: ambulate with his/her prosthesis twenty-five feet and fifty feet daily. However, review of the January 2011 CNA flowsheet revealed the mobility status for the resident was "no ambulation at this time." g. Observation on 1/25/11 at 9:25 AM showed resident #36 had pressure ulcers on the left heel, the top of the left great toe next to the nail, and the sacral/coccyx/buttock area. Review of the care plan showed it had not been updated to provide comprehensive care. Refer to F314 for detailed information. h. Review of the care plan for resident #37 showed the resident was receiving ophthalmic	F 280		

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F 280	Continued From page 11 medications and special eyecare. However, review of the January 2011 MAR and ADL/treatment flowsheet showed this resident's care did not include or special eyecare. I. Observation on 1/24/11 at 4:45 PM revealed resident #43 had an indwelling urinary catheter. Medical record review showed the resident returned on 1/18/11 from surgical placement of a suprapubic catheter and a colotomy. Observation on 1/25/11 at 7:32 AM showed the resident had an abdominal incision from hip bone to hip bone with the suprapubic catheter secured to the thigh. Observation on 1/27/11 at 9:07 AM revealed the catheter tubing was secured above the resident's abdominal incision. Refer to F441 for details related to incorrect positioning of the catheter bag during transfers. Review of the care plan showed it had not been updated to include the resident's recent surgery, the requirements for placement, and lack of information about positioning during transfers. Interview with RN #4 on 1/27/11 at 6 PM confirmed it was the plan currently in use.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff conformed to professional standards of practice related to medication administration (unlocked medication cart and resident #22). Furthermore, a medication order was not clarified for 1 of 11 residents (#11) observed during	F 281	F281 The facility will ensure that services meet professional standards of quality. This will be accomplished by: A) Nurses will lock medication carts and keep meds put away when out of the line of sight. Nurses giving res. #22 prn meds, including Ativan, will document according to the "6 rights" (right resident, med, dose, route, time, effectiveness).	

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F 281	Continued From page 12 medication passes, neurological assessments were not completed properly for 1 of 1 sample residents (#23) for whom they were implemented, and physician orders were not followed for 1 of 12 sample residents (#24). The findings were: 1. Observation on 1/26/11 showed LPN #10 left the medication cart unlocked at 8:45 AM; she also left a medication sitting on top of the cart when she walked away to administer medications. The cart was parked in the large dining room with numerous residents and staff present and was out of the LPN's line of sight during this time period. The LPN locked the cart at 8:52 AM but left another medication on the top while she entered the smaller dining room. The cart was again out of her line of sight. According to Smith, S Duell, D and Martin S. "Clinical Nursing Skills Basic to Advanced Skills." New Jersey: Pearson Education, Inc.; 2008; 577, "Keep all medicines in locked carts or cabinets." According to Elkin M Perry, A and Potter P "Nursing Interventions & Clinical Skills" St. Louis, Missouri: Mosby; 2007; 375, "Medication carts must be kept locked when unattended..." 2. The back of the medication administration record (MAR) was reviewed while reconciling medications for resident #22. This side of the MAR was for documenting medications given on an as needed (prn) basis. The documentation was to include the name of the medication, dosage, time of administration, reason for administration, and the effectiveness of the medication. This resident had received some prn doses of Ativan, but the documentation was incomplete. RN #9 confirmed the lack of complete documentation on 1/26/11 at 1:32 PM. Interview with the DON on 1/26/11 at 3:30 PM	F 281	Res. #11's order for fish oil was clarified to identify the name of the med and specify the dose. Res. #24 weight order was changed to weekly and is being obtained by the bath CNA. Nurses will fill in any future neurological checks for res. #23 completely. B) At least four times per month DON will randomly observe medication passes to ensure carts are locked when out of the nurse's line of sight and meds are not left unattended on top of the cart. If infractions are identified, immediate in-servicing and corrective action will be taken with the nurse. DON will randomly check to ensure prn meds are documented according to the 6 rights, provident in-servicing if infractions are identified. The nurse noting physician orders will check that orders are clear re medication and dosage. DRC will check this when accompanying the physician on rounds. The nurse will seek clarification from the physician as necessary. When daily weights are ordered they will be obtained by the resident's assigned CNA and reported to the Supervising Nurse. If not completed, the Supervising	

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F 281	Continued From page 13 revealed the specified information should be documented each time a prn medication was administered. According to Elkin M Perry, A and Potter P "Nursing Interventions & Clinical Skills" St. Louis, Missouri: Mosby; 2007; documentation is one of the "6 Rights" of medication administration; it should be complete and include "...response to the medication." 3. Observation on 1/27/11 at 7:14 AM showed RN #1 administered 1000 milligrams of Omega 3 for resident #11. Reconciliation of the medication showed the physician ordered "...Fish oil..." 1 capsule on 7/21/09; however, the physician failed to identify the name of the oil or specify an amount. On 1/27/11 at 10 AM RN #4 stated the order should have been clarified related to the name of the medication and the amount to administer. On 1/28/11 at 8:17 AM the pharmacist confirmed the oil came in different amounts. According to Elkin M Perry, A and Potter P "Nursing Interventions & Clinical Skills" St. Louis, Missouri: Mosby; 2007; 367; physician orders are to include "...The name of the drug...The dose..." 4. Review of the orders for resident #24 showed the physician ordered daily weights. Detailed review of the medical record failed to produce the ordered information. On 1/27/11 at 11 AM RN #4 stated the resident lost approximately 80 pounds prior to admission, but his/her weight was now stable. However, she was unable to produce evidence daily weights had been obtained. According to the Wyoming State Board of Nursing Rules and Regulations Chapter 3 Standard of Nursing Practice, nurses are to carry out orders from physicians. 5. Medical record review showed resident #23 fell	F 281	Nurse will take corrective action with the CNA. DON will randomly audit neuro-checks for complete documentation and provide in-servicing with the nurse responsible if incomplete. C) DON will review professional standards of quality associated with this deficiency with nurses and CNAs. The DON will randomly audit four residents' charts per month, checking related documentation, to ensure professional standards of quality are met. D) A performance improvement tool will be implemented to ensure professional standards of quality are adhered to. This monitor will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance.	3/14/11

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F 281	Continued From page 14 on 11/24/10 and sustained a facial laceration and bruising at 4:10 AM. The resident was taken to the emergency room at 4:20 AM but sent back to the facility where s/he remained until 6:15 AM. On 1/26/11 at 3:30 PM the DON stated the instructions on the neurological (neuro) sheet should be followed. Review of the documentation showed neuro checks were not begun until 7 AM and were skipped twice during the every four hour checks. The time period from 4:30 through 6:30 AM was crossed off and "Res in ER" written in the space. Even though the injury occurred at 4:10 AM and the resident was sent back to the facility, staff failed to monitor him/her per the neuro instructions. Review of the "Neurological Exam Flow Sheet" showed neuro checks were to be completed "...with any head injury...at the time of injury...every 15min. for 1 hr...every 30 min. for the next 2 hrs...every four hours 6 times..."	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 medical record review, staff interview, and review of the bowel program, the facility failed to ensure the program was implemented for 5 of 9 sample residents (#2, #10, #24, #30, #37) whose bowel status was reviewed. In addition, pain monitoring for resident #2 was inadequate.	F 309	F309 The facility will ensure that the facility bowel program is implemented for each resident and that pain monitoring is adequate for each resident. This will be accomplished by: A) The noc shift nurse will prepare MOM (milk of magnesia) and Dulcolax suppository lists daily, according to facility protocol, when res. #2, 10, 24, 30, and 37 have had no BM recorded for 2 or more days. The day shift Medication Nurse will give and record the medication given, and the results, on the MAR.	

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F 309	Continued From page 15 The findings were: As related to the bowel program: 1. Review of the facility's 12/14/06 bowel program, entitled "Bowel and Bladder Elimination Pattern Assessment Key", showed the laxative, Milk of Magnesia, was ordered every twelve hours if needed. Additionally, a Dulcolax suppository was to be utilized "after positive rectal exam [feces in the colon that the resident cannot eliminate] &/or no BM [bowel movement] in 3 days." Failure to implement this program was identified as follows: a. Review of the CNA flowsheets showed resident #2 did not have a BM for three consecutive days from 1/9-1/11/11 and four consecutive days from 1/13-1/16/11. No interventions were listed. Review of the January 2011 medication administration records (MARs) showed no interventions were given for constipation. b. Review of the CNA flowsheets showed resident #10 did not have a BM for three consecutive days on 1/6-1/8/11. No interventions were listed. Review of the January 2011 MARs showed no interventions were implemented for constipation. c. Despite receiving Senokot S two tablets daily from January 1, 2011 through the 26th, the documentation on the CNA flowsheets for January 2011 indicated resident #24 did not have a bowel movement from 1/3 through 1/9/11 (seven days). The resident was given a Dulcolax suppository on 1/10/11 and had two large BMs. However, s/he then went from 1/11 through 1/18 (8 days) and from 1/20 through 1/25/11 (6 days) without bowel movements. RN #4 reviewed the CNA flowsheets on 1/27/11 at 6 PM and	F 309	Nurses giving Vicodin or other pain interventions to resident #2 will record the effectiveness on the MAR. B) The noc shift nurse will prepare MOM and Dulcolax suppository lists for all residents who have had no BM recorded for 2 or more days, unless the resident's individual bowel program indicates otherwise. Day Medication Nurses will provide and record the medication given and results on the MAR. Nurses giving pain medication to any resident will record the effectiveness on the MAR. C) The DON will review with CNAs and Nursing Staff the facility bowel program and the importance of documenting BMs, interventions, and results. The DON will review the "6 Rights" involving medicating residents with the Nursing Staff, including proper documentation of pain medications and effectiveness. D) A performance improvement tool will be implemented to ensure that the facility bowel program is followed and pain monitoring is adequate. This monitor will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance.	3/14/11

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F 309	Continued From page 16 confirmed the documentation. d. Review of the CNA flowsheets showed resident #30 did not have a BM for three consecutive days on 1/20-1/22/11. No interventions were listed. Review of the January 2011 MARs showed no interventions were given for constipation. e. Review of the CNA flowsheets showed resident #37 did not have a BM for four consecutive days on 12/3-12/6/10, five consecutive days on 12/8-12/15/10 and three consecutive days on 1/6-1/8/11. No interventions were listed. Review of the December 2010 and January 2011 MARs showed no interventions were given for constipation. 2. During an interview on 1/27/11 at 11:45 AM, LPN #5 stated the CNAs were responsible for recording the BMs and should have reported episodes of constipation to the nurse. The LPN stated staff should be following the bowel protocol. As related to pain: According to the medical record, resident #2 had pain due a pressure ulcer on his/her heel and a hip fracture that occurred in November 2010. Further review showed the physician ordered one or two Vicodin tablets four times daily when needed. Review of the November 2010 through January 2011 pain flow records revealed incomplete documentation regarding the effectiveness of the pain medications and non-pharmacological interventions. Review of the pain flow records also showed no systematic approach or rationale for administering one or two Vicodin tablets. During interviews on 1/26/11 at 9:10 AM with LPN #5 and on 1/28/11 at 8:16 AM	F 309		

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F 309	Continued From page 17 with RN #4, both stated the incomplete and inconsistent documentation in the pain flow records made it difficult to implement an effective pain management program for the resident.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure staff provided appropriate incontinence (perineal) care for 2 residents (#23, #44) observed during 7 observations of that care. The findings were: According to the 9th edition of "Nursing Assistant A Nursing Process Approach" by Hegner, Acello, and Caldwell, "Always wipe from clean to dirty with a single wipe, then turn or discard the cloth." Failure to follow this standard of practice was identified in the following instances: a. Observation on 1/25/11 at 7:21 AM revealed CNA #17 was providing fecal incontinence care for resident #23. During the observation, the CNA used multiple back to front strokes to cleanse the resident. Interview on 1/26/11 at 4:50 PM with RN #4 revealed the observed care was not consistent with acceptable standard of practice because using the same wipe and cleansing with back to front strokes puts the resident at risk for infections. b. Observation on 1/25/11 at 6 AM showed	F 312	F312 The facility will ensure that the appropriate incontinence care is provided for each resident. This will be accomplished by: A) The DRC, or an appropriately trained designee, will observe perineal care for proper infection control technique on res. #23 and 44. B) The DRC or designee will randomly observe perineal care at least four times per month. If proper infection control technique is not followed, immediate in-servicing and corrective action will be taken. C) The DRC or designee will provide education to the Nursing Staff and CNAs re appropriate perineal care. D) A performance improvement tool will be implemented to ensure that appropriate incontinence care is provided. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC will be responsible for compliance.	3/14/11

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F 312	Continued From page 18 CNA #16 assisted resident #44 with perineal care after the resident urinated in the bathroom. The CNA donned gloves and cleansed the resident's perineal area using the same section of the wipe to perform three repetitive front to back strokes. The wipe did not have a clean surface area after the first two strokes, but the CNA continued to use it.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, medical record review, and review of policies and procedures, the facility failed to ensure 3 of 5 sample residents (#1, #36, #43) with pressure ulcers received the necessary services and treatment to promote healing and/or prevent worsening of the ulcers. This failure resulted in avoidable harm to resident #36. The findings were: 1. Medical record review showed resident #36 was admitted on 12/16/10 with pressure ulcers on the left heel, the top of the left great toe next to the nail, and the sacral/coccyx/buttock area. Review of documentation dated 12/26/10 showed	F 314	F314 The facility will ensure that residents with pressure ulcers receive the necessary services and treatment to promote healing and/or prevent worsening of the ulcers. This will be accomplished by: A) Res. #36: PUSH Tool completed 2/15/11 shows wound at gluteal groove and one on the left buttock are healing. (The third 0.5cm by 0.5cm wound documented on 1/25/11 has healed. ~~This was also on the left buttock, not right.~~) Nurses will use separate applicators to apply ointment to separate wounds and clean the scissors before and after cutting dressings. A bed cradle was added to this res. bed. RN Team Leader changed care plan to remind res. to lift bottom up and inch forward, no sliding across bed/chair. PUSH tool was completed 2/15/11 and will be completed weekly according to facility policy. Dressings will be promptly replaced for res. #1. The skin assessment will be completed weekly by the bath CNA who	

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F 314	Continued From page 19 two open ulcers on the buttock area; the wound in the "...gluteal groove..." measured 0.6 centimeters (cm) by 0.6 cm and the one on the left buttock measured 0.5 cm by 0.4 cm. Review of the skin care plan showed the resident had a gel cushion in the recliner and staff were to float the resident's heels at all times. Staff were also to complete a daily skin inspection and notify the nurse immediately of redness or breakdown. During observation of dressing changes on 1/25/11 at 9:25 AM, RN #4, LPN #5, the physician, and the resident were discussing the resident's pressure ulcers. Of particular concern were the open areas on the resident's buttock that the physician and nurses stated were caused by friction (or shearing) from sliding or scooting back in the recliner. Observation of the buttocks showed bright red skin surrounding open areas covered with small amounts of serous drainage. This observation also showed the resident's heels were floated, but the covers were tucked in tightly at the foot of the bed. The following concerns were identified: a. Three open areas were present on the resident's buttocks instead of the initial two. According to the facility's documentation, the wounds had increased in size; the ulcers measured 1 cm by 0.7 cm in the midline, 0.5 cm by 0.5 cm on the left buttock, and 0.5 by 0.6 on the right buttock. Review of the "Pressure Ulcer Scale for Healing" (PUSH) tool dated 1/25/11 showed the wounds were deteriorating. During an interview on 1/27/11 at 6 PM, RN #4 confirmed the wounds on the buttocks were worse. b. Observation of the treatment showed LPN #5 used the same applicator to apply ointment to all three wounds on the buttocks. Refer to F441 for details related to infection control. c. Observation of the dressing to the heel	F 314	will promptly report skin problems or changes to the Supervising Nurse. Res. #43 unstageable pressure ulcer on the buttocks has resolved and is open to air. Appropriate dressings will be used if needed in the future. B) WCC (Wound Care Certified) RN will complete PUSH tool and pictures weekly for all decubs stage2 and greater. WCC RN will randomly audit Wound Care Documentation Monitor Weekly to ensure appropriate documentation is completed and appropriate dressing is in place. If documentation problems are found the WCC will in-service the appropriate supervising/treatment nurse. PT will provide education to nurses on infection control techniques for wound care. DRC will randomly observe nurses completing dressing changes four times per month and if correct protocol in not followed will provide immediate in-servicing. Nurse Team Leaders will check care plans of residents with wounds to ensure that appropriate measures are in place to promote healing. DON will educate CNAs to notify the Supervising Nurse immediately if a dressing needs to be replaced. The bath aide will complete skin assessments weekly. The WCC RN will randomly check that this is done; if not,	

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

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F 314	Continued From page 20 showed RN #4 did not clean the scissors before or after cutting the dressing. Refer to F441 for information regarding infection control. d. Although the resident had a pressure ulcer on the end of the great toe, the covers over his/her feet had not been loosened. Nor was a bed cradle utilized to eliminate pressure and/or friction on the toe. During an interview on 1/26/11 at 1:52 PM, the resident stated the covers were often too tight and s/he used his/her feet to loosen them. On 1/27/11 at 6 PM RN #4 stated she had not thought to use a bed cradle or instruct staff to loosen the covers, and she was unaware the resident loosened the covers with his/her feet. e. Review of the care plan for mobility showed staff were to, "Have Res [resident] slide forward to front of chair..." At 9:54 AM that morning, observation of the resident transferring from the bed to the recliner showed the resident independently scooted forward twice before s/he was able to stand; staff made no attempt to remind the resident not to scoot/slide forward or assist him/her to stand without sliding to the edge of the bed. During the 6 PM interview on 1/27/11, RN #4 confirmed there were no instructions on the care plan related to reminding the resident not to slide or scoot. f. Review of the facility's policies and procedures related to wound care showed the PUSH tool was to be completed weekly "on bath day when take picture." Review of the provided information showed the PUSH tool was not completed from 1/3/11 to 1/25/11 and pictures were not taken weekly. On 1/27/11 at 6 PM RN #4 confirmed the policies and procedures were not followed. 2. Review of the January 2011 treatment record	F 314	immediate in-servicing and corrective action will be taken. C) The DON will educate the nursing staff and CNAs on the importance of promoting wound healing by implementing and following appropriate care plan interventions, replacing soiled dressings promptly, practicing sound infection control techniques when doing dressing changes, documenting assessments as per facility protocol and checking orders prior to wound care. D) A performance improvement tool will be implemented to ensure that residents with pressure ulcers receive the necessary services. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC will be responsible for compliance.	3/14/11

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F 314	Continued From page 21 showed resident #1 required daily dressing changes and treatments for two open pressure sores and protective dressings for two closed pressure ulcers. Observation on 1/26/11 at 11:45 AM revealed CNA #18 removed the fecally contaminated protective dressing from the resident's right hip, thoroughly cleansed and dressed him/her, then wheeled the resident to the dining room. Continuous observation revealed the CNA did not replace the soiled protective dressing, nor did she report this to the charge nurse. During an interview on 1/26/11 at 12:35 PM, the CNA stated the usual practice was to report the need for a replacement dressing at a later time, and the nurse would take care of it when convenient. Interview with RN #4 on 1/26/11 at 4:45 PM revealed the CNA did not tell the nurse about the removed dressing until 2 PM, 2 hours and 15 minutes later. The RN stated the resident needed to have the protective dressing when sitting to prevent further deterioration in the skin. She also stated the dressing should have been re-applied promptly. During a review of the pressure ulcer monitoring records with the RN, it was noted the weekly skin assessments for December 2010 and January 2011 were incomplete. In interview at that time the RN verified staff had not consistently completed the weekly skin assessments for this resident. 3. Observation of a pressure ulcer on resident #43 on 1/27/11 at 9:30 AM with RN #2 revealed a Mepitel Border dressing had been applied. The RN stated the dressing was not what the physician ordered. She further stated the resident had previously reacted to the adhesive around the edges. Review of the physician's order dated 1/8/11 showed the resident was to have a Mepilex Foam dressing to the unstageable pressure ulcer	F 314		

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

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F 314	Continued From page 22 on the buttocks; the documentation indicated the rationale for the specific dressing was that the resident "...reacts to adhesives tapes etc."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to appropriately manipulate the indwelling urinary catheter for 1 of 1 sample resident (#43) with a catheter. The findings were: Observation of staff providing care for resident #43 on 1/25/11 at 7:32 AM showed the resident had an indwelling urinary catheter. During the observation, RN #4 attached the catheter drainage bag to the mechanical lift while transferring the resident from the bed to the wheelchair. Continuous observation revealed the attached catheter bag was positioned at the level of the resident's head during the transfer, and urine drained back towards his/her bladder. Interview on 1/28/11 at 11:45 AM with the DON revealed this was not an acceptable standard of	F 315	F315 The facility will ensure that indwelling urinary catheters are appropriately manipulated. This will be accomplished by: A) The DRC or trained designee will observe the staff as they provide cares for res. #43 to ensure the urinary catheter bag is kept below the level of the bladder at all times. B) At least four times per month the DRC or designee will observe staff as they provide cares for other residents with indwelling urinary catheters to ensure the catheter bags are kept below bladder level at all times. If infractions are identified, immediate in-servicing and corrective action will be taken. C) The DON will review the facility's "Care and Maintenance of Foley Catheter" policy and procedure with the Nursing Staff and CNAs, stressing the importance of keeping the catheter bag below bladder level. D) A performance improvement tool will be implemented to ensure indwelling urinary catheters are appropriately manipulated. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC will be responsible for compliance.	3/14/11

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F 315	Continued From page 23 practice for catheter care. Review of the care plan showed the position of the catheter bag during transfers was not addressed. According to the facility's policy and procedure, "Care and Maintenance of Foley Catheters", last reviewed 2/09, staff are to keep the collection bag "...below the level of the bladder..."	F 315		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide services to prevent decline in range of motion (ROM) for 6 of 8 sample residents (#2, #23, #29, #36, #37, #43) with range of motion limitations. The findings were: 1. Review of the 8/24/10 admission and 11/23/10 quarterly MDS assessments showed resident #23 had no limitations in range of motion (ROM). During an interview on 1/25/11 at 8:28 PM, a family member stated the resident's neck was becoming stiff and s/he was seen by physical therapy (PT) with the result that the resident was to perform exercises for his/her neck three to five times per week. Review of the PT evaluation dated 12/29/10 showed the resident was to be involved in the restorative program for active and	F 318	F318 The facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further de crease in range of motion. This will be accomplished by: A) PT will complete physical therapy evaluations and restorative exercise flow sheets for residents #23, 29, 36, and 43. Specific exercises, number of reps, and frequency per week will be addressed. Individual and group exercise will also be addressed as appropriate. PT will supervise the program for residents #2 and 37 to ensure that it is being followed per PT directives. A supervisory physical therapist has been designated to oversee the Restorative Exercise Program and ensure that it is being followed. B) The Supervisory PT will address restorative aides questions and concerns, review flow sheets for completeness (at least monthly), and update the flow sheets and adjust the program as needed. If	

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F 318	Continued From page 24 active assistive ROM exercises. On 1/26/11 at 11:25 AM physical therapist #6 stated the resident was working with PT and was not in the restorative program. At 11:55 AM that same morning, physical therapist #8 stated the resident was involved in the restorative program and not PT for ambulation and the neck exercises. Detailed review of the medical record and restorative program information showed no instructions related to the exercise program. Interview with RN #4 on 1/27/11 at 10 AM revealed she was unable to find a restorative exercise program for the resident. The RN stated she talked with physical therapist #6 who reported talking with a restorative CNA on 1/18/11 and 1/24/11; however, the therapist stated she never developed a written program. Therefore, the exercises had not been provided by restorative personnel. 2. According to the medical record, resident #43 was readmitted to the facility on 1/18/11 after undergoing surgery. The nursing documentation showed the resident was much weaker, and observation showed the resident was transferred with a full body mechanical lift. Review of nursing notes dated 1/19/11 showed the physician was notified of the resident's weakness and ambulation was discontinued as the resident was unable to bear his/her own weight. However, the documentation indicated the physician continued the restorative program with "...minimal exercises (no Nu Step)..." Review of the restorative documentation showed the resident last participated in the program on 1/10/11. Interview with RN #4 on 1/27/11 at 10:30 AM confirmed the program had not been implemented since the resident's return from surgery.	F 318	problems are identified the Supervisory PT will provide in-servicing and corrective action with the Restorative CNA. C) PT staff will educate Restorative Staff re exercise flow sheet instructions, including providing instructions for special exercise techniques. D) PT will implement a tool to ensure that residents with limited range of motion receive appropriate treatment and services. This will be reported quarterly to the PI Committee. The Supervising PT will be responsible for compliance.	3/14/11

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F 318	Continued From page 25 3. Review of the 10/27/10 admission MDS assessment showed resident #29 had impaired ROM in both the upper and lower extremities. Observation on 1/26/11 at 1:50 PM showed the resident was ambulating with PT while wearing a brace on the left leg and hand. Review of the restorative program showed the resident participated, but a written program that included the number of repetitions for each exercise and the frequency of the program had not been developed. Further review showed the resident frequently participated in group exercises but there was no documentation indicating which exercises were performed. On 1/27/11 at 1:20 PM CNA #11 stated the physical therapist wanted the resident to do restorative exercises at least three times per week, but she confirmed there was no written program to follow. During an interview on 1/27/11 at 2:55 PM, RN #4 confirmed the facility did not have a written restorative program for the resident. The RN also acknowledged she had no way of knowing if the group exercises included those specified for the resident. On 1/28/11 at 9:58 AM physical therapist #8 confirmed there should be a written program for staff to follow. 4. Review of restorative flow sheets showed resident #2 received ROM four times in November 2010, three times in December 2010 and four times from 1/5/11 to 1/23/11. Interview with physical therapist #6 on 1/26/11 at 9:20 AM revealed the resident should have been receiving ROM at least three times every week since November 2010 per the physical therapy recommendation. She stated she was responsible for therapy assessments, making recommendations, and being available for assistance if the restorative staff needed; but she	F 318		

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

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F 318	Continued From page 26 was not responsible for overseeing the facility's ROM program. 5. Review of the PT evaluation dated 12/14/10 showed resident #37 had upper and lower extremity range of motion with functional limitations. Further review showed the therapist recommendation included the following: CNA to do basic ROM program, ROM up to four times a week, and ambulation up to daily. However, review of restorative flow sheets showed the resident received ROM eleven times from 12/20/10 to 1/26/11 (approximately one to two times a week). 6. Review of the 12/29/10 admission MDS assessment showed resident #36 had impaired ROM in the lower extremities. Review of a PT note dated 12/16/10 showed an exercise program "...will be provided for the exercise CNAs to do with [resident's name] 3 to 4 days per week." Review of the resident's restorative information showed a specific program was lacking. Interview with RN #4 on 1/27/11 at 6 PM confirmed a written program was not in place. 7. Interview on 1/26/11 at 9:45 AM with CNA #11, one of the five staff responsible for providing ROM for the residents, revealed the facility's restorative program was recently reorganized. There was no assigned staff person responsible for overseeing the program or system for ensuring the residents received the services as they should. Interview with the DON on 1/26/11 at 3:40 PM verified the information provided by the CNA. The DON further stated that she was unable to determine whether the lack of documentation was the problem or whether the residents did not receive the ROM.	F 318		

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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 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to consistently implement a method of obtaining assistance when needed in the secure care unit (SCU). Five residents resided in the SCU at the time of the survey. The findings were: Observation on 1/24/11 at 2:30 PM and at 4:45 PM showed CNA #14 was the only staff member on duty in the SCU. Further observation showed the CNA had no obvious way of obtaining assistance. Interview with the DON on 1/24/11 at 4:45 PM revealed the scheduled staffing for the SCU consisted of one CNA for one to six residents. During the interview, the DON stated that due to the potential safety issues associated with one staff person working alone in the SCU, the facility used portable communication devices. The DON stated the device enabled the CNA to promptly communicate the need for assistance. The DON also stated the CNA on duty in the SCU and the charge nurse on duty in other areas of the facility were required to carry the device at all times. However, she stated she was aware staff did not consistently do this. Observation on 1/25/11 at 6 AM revealed neither the CNA on duty	F 323	F323 The facility will ensure that a method of obtaining assistance in the SCU when needed is implemented. This will be accomplished by: A&B) The facility will obtain a communication device (TracFones) with which the SCU CNA may obtain assistance as needed for the care of the residents in that area. At least four times per month the DON will randomly check that the devices are being carried; if not immediate in-servicing and corrective actions will be taken. C) The DON will educate the nursing staff of the need for the Day Shift Supervising Nurse, SCU CNA, and Noc Nurse to carry these devices on their person when on duty. D) A performance improvement tool will be implemented to ensure that assistance can be obtained to the SCU. This monitor will be completed monthly and reported quarterly at the PI Committee. The DON will be responsible for compliance.	3/14/11

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F 323	Continued From page 28 In the SCU, nor the charge nurse on duty in the other areas of the facility, carried the communication device.	F 323		
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to ensure staff provided appropriate intervention during one meal observation for 1 of 2 sample residents (#23) with significant weight loss. The findings were: According to the 8/24/10 admission MDS assessment, resident #23 was 6 feet 1 inches tall and weighed 149 pounds. Review of the monthly weights showed the resident started losing a significant amount of weight in November 2010 and weighed 123 pounds in January 2011. According to the care plan, the resident responded better to directions and commands. Observation on 1/27/11 at 7:50 AM showed the resident was eating breakfast very slowly. CNA #7 sat next to the resident and would, at times, offer bites of food. The resident continued to eat	F 325	F325 The facility will ensure that staff provide appropriate interventions when assisting residents at meal time. This will be accomplished by: A) The Day Shift Medication Nurse will observe CNAs as they assist res. #23 with meals. The nurse will observe that the CNA verbally encourages the resident to eat and swallow, and offers him/her more or different food if s/he has not eaten well. B) At least four times per month the Medication Nurse will randomly observe that CNAs are verbally encouraging other residents who require assistance with eating. If the nurse notes that this this not being done, in-servicing and corrective action will be taken. C) The DON will provide education to the nursing staff and CNAs re appropriate intervention when assisting residents at meal time. D) A performance improvement tool will be implemented to ensure that residents are adequately assisted at meal time. This will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance.	3/14/11

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F 325	Continued From page 29 with intermittent assistance until 8:15 AM. At that time, the resident picked up a portion of the scrambled eggs and began to roll the eggs between his/her fingers while continuing to make chewing motions with his/her mouth. The CNA offered the resident a bite of eggs but the resident refused. At 8:17 AM the CNA tried to take the resident's plate, but the resident refused and kept rolling the piece of egg in his/her fingers while making chewing motions. The CNA spoke to another staff member and said, "[resident's name] is playing with [his/her] food." Between 8:17 and 8:25 AM, staff tried three separate times, and finally succeeded in taking the resident's plate. No one instructed the resident to eat or swallow, nor offered him/her more food.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	F329 The facility will ensure that each resident's drug regimen will be free from unnecessary drugs, this will be accomplished by: A). The AHCC Pharmacist will conduct a MRR on Rsdt. #10. The MRR will cover: a). Excessive dose b). Excessive duration c). Appropriate monitoring by nursing and physician's notes. d). Adequate indication for use e). Adverse consequences f). Need for gradual dose reduction unless clinically contraindicated. Any irregularities will be reported to the attending physician and DON. Any irregularities will be acted	

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

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OMB NO. 0938-0391

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	53A002	A. BUILDING _____ B. WING _____	01/28/2011

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F 329	Continued From page 30 drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimen for 1 of 12 sample residents (#10) was free from unnecessary drugs. The findings were: Medical record review showed resident #10 had been receiving one milligram (mg) of Haldol every night since 10/19/09 for dementia with associated behavioral symptoms. Further review showed the resident had also been receiving one mg of Xanax every night since 8/21/08 for anxiety, and 50 mg of Zoloft daily since 1/6/09 for depression. According to the 2008 to 2010 antipsychotic medication quarterly evaluations, an unsuccessful gradual dose reduction was attempted for the Haldol in June 2009, but reductions of the other medications had not been attempted. During an interview on 1/28/11 at 8:16 AM, RN #4 stated a gradual dose reduction had not been attempted during the past year because the physician did not want the medication changed. Review of the medical record with RN #19 on 1/28/11 at 8 AM failed to reveal a physician's rationale and statement delineating the risks versus the benefits of continued use of the medications at their current dosages.	F 329	upon and recorded on the MRR form in the resdt #10 medical record. B). AHCC Pharmacist will conduct a MRR on all new admissions and monthly thereafter. AHCC and DRC will conduct a MRR monthly on all AHCC Rsdts using QA indicators as a guideline to detect any irregularities. All irregularities will be acted upon and recorded on the MRR form in each rsdts medical record. C). AHCC Pharmacist and DRC will review the F329 regulations and present this information to the Physicians at medical staff meeting. D). Results of the MRR according to the QA indicators will be reported the Performance Improvement Committee Quarterly. The DRC will be responsible for compliance.	3/14/11
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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FORM APPROVED
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 31 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of standards of practice for sanitary food preparation, the facility failed to ensure dietary staff stored, served and prepared food in a sanitary manner during 3 of 3 observations of the dietary department. The findings were: 1. Observation on 1/24/11 at 1:40 PM revealed an opened case of Ensure nutritional supplement labeled with an expiration date of 1/1/11. At that time, the certified dietary manager (CDM) stated she did not know how many of the expired cans had been used because she had not noticed the expiration date. An opened bottle of seasoning salt with the expiration date of 2007 was also observed on the condiment shelf later that day at 1:50 PM. 2. The following concerns were identified while observing cook #21 prepare the evening meal on 1/25/11 from 2:15 PM until 3 PM: a. The cook wore the same gloves for multiple tasks including the following: He touched counter tops, opened and closed milk cartons, added liquids and stirred foods, moved pans and put foods in the warmer. He had direct glove to food contact when, wearing the same gloves, he	F 371	F371 It is the policy of this facility to procure, store, prepare, and serve food in a sanitary manner. A) The Certified Dietary Manager (CDM), on 1/24/11, reviewed the expiration dates of the items in the dietary department. All outdated items found, including the Ensure with the expiration date of 1/1/11 and the seasoning salt with the expired date, have been discarded. The CDM instructed and reviewed the proper use of gloves and hand washing techniques with employee #20 and #21 on 1/26/11. The maintenance and dietary staff completed the cleaning of the range hood and filters on 1/25/11, removing the collected dust particles. B) The CDM will conduct random observation of product storage including reviewing of the expiration dates. Monitoring will also be conducted and recorded by assigned staff on the staff's daily checklists to assure no outdated items are found. The CDM will conduct random observation on the preparation of meals, addressing any observed concerns as they are seen to assure sanitary food production. Monitoring will also be recorded twice daily by the cook in	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 32 used his fingers to remove a beef based substance from a large spoon to the pan of cream beef cooking on the stove. He then changed gloves, but did not wash his hands between changes. With the clean pair of gloves he periodically placed his hands on his anterior thighs, moved closed containers of food from the warmer, and combined the two pans of food cooking on the stove. b. Observation of the kitchen on 1/26/10 at 3 PM revealed dust particles on the range hood and filters directly above the stove. At that time, the certified dietary manager (CDM) said the maintenance department was responsible for cleaning the range hood and filters every week. Review of the cleaning logs with the CDM revealed the filters had not been cleaned according to the weekly cleaning schedule from November 2010 to January 2011. Interview with maintenance staff person #22 on 1/25/10 at 3:30 PM revealed he had no explanation for why the weekly cleaning had not been done. 3. Observation of employee #20 as she served food from the steam table on 1/26/11 from 12:30 PM to 1:50 PM revealed she wore the same gloves for many tasks. She repeatedly handled serving utensils, touched carts, and touched counter tops. In addition, her contaminated gloves had direct contact with bread and parsley when she placed these items on individual plates. According to chapter 3 of the 2009 FDA Food Code, measures to prevent food contamination include the following: b. 3-304.16...."If used, single-use gloves shall be used for only one task ..." According to Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: Food	F 371	charge to assure the proper use of gloves and hand washing are maintained. The CDM will randomly monitor the cleanliness of the kitchen including the range hood and filters to assure they remain dust free. A work order will be completed if additional cleaning above the weekly level is needed. C) To maintain the currently compliant operation under the direction of the CDM with input from the Registered Dietitian (RD), all dietary staff will receive in-service training regarding state and federal requirements on proper glove use and hand washing techniques as well proper product storage guidelines and dates by 3/14/11. The maintenance supervisor will conduct an in-service on the timing and proper removal of the range filters. The dietary staff will be in-serviced on the actual cleaning of the range hood and filters, including the documentation on the dishwasher checklist log by 3/14/11. D) The CDM will enforce and monitor weekly the proper compliance through the Food Borne Illness Prevention-Daily Checklist which includes the documentation of proper glove use and hand washing, the Daily Employee Checklist which monitors for out of date items, and the Dishwashers Checklist which includes the documentation of the	

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F 371	Continued From page 33 Employees shall clean their hands and exposed portions of their arms ... Immediately before engaging in FOOD preparations including working with exposed FOOD , clean Equipment and UTENSILS, and unwrapped SINGLE SERVICE and SINGLE-USE ARTICLES and;;; (E) After handling soiled EQUIPMENT of UTENSILS ...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands.	F 371	hood and filter cleaning. These results will be reported to the PI Committee on a quarterly basis.	3/14/11
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure monthly medication regimen reviews (MRRs) were appropriately completed for 3 of 12 sample residents (#10, #24, #36). The findings were: 1. Medical record review showed resident #10 had been receiving one milligram (mg) of Haldol every night since 10/19/09 for dementia with associated behavioral symptoms. Further review showed the resident had also been receiving one mg of Xanax every night since 8/21/08 for	F 428	F 428 The facility will ensure a drug regimen is conducted monthly and on admission. This will be accomplished by: A). The Pharmacist will place his admission review on rsdt. #24 and #36 in the medical record. The Pharmacist will complete a drug review on Rsdt. #10 and report any irregularities to the attending Physician and DON. Any irregularities will be acted upon. B). AHCC Pharmacist will conduct a MRR on each new admission and monthly thereafter. All residents in AHCC will have a monthly MRR conducted, using QA indicators as a guideline to detect any irregularities. Evidence of these reviews will be in the medical record on the Chronological Drug Regimen Review (CDRR). Irregularities will be reported to the attending physician and DON and acted upon. All corrective actions will be	

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F 428	Continued From page 34 anxiety, and 50 mg of Zoloft daily since 1/6/09 for depression. Review of the 2010 - 2011 pharmacy monthly MRRs showed the pharmacist failed to identify and report the medications as irregularities. This failure was later confirmed during interview with the pharmacist on 1/28/11 at 1:40 PM. 2. Medical record review showed resident #36 was admitted on 12/16/10 and received drugs that included narcotics, antidepressants, antarthritics, and cardiac medications. Review of the pharmacist's MRR for December 2010 showed the statement, "Not entered into system." Interview with the pharmacist on 1/28/11 at 12:55 PM provided no evidence he had evaluated the medications to determine possible side effects, interactions, or adverse consequences. 3. According to the medical record, resident #24 was admitted on 12/29/10 and was on eleven medications daily. Review of the MRR for December 2010 showed all the pharmacist wrote was "Need Diagnoses for Celexa; simvastatin; pantoprozole." There was no evidence the pharmacist evaluated the resident's medications to determine possible interactions and/or adverse consequences with the combined medications. On 1/28/11 at 12:55 PM the pharmacist stated he had a computerized list of the resident's medications, but confirmed the lack of evidence that he had evaluated them.	F 428	recorded on the CDRR QA form in the residents medical record. C). AHCC Pharmacist and DRC will review the F428 regulations and report to the Physicians at the medical staff meeting. D). Results of the MRR monitoring will be reported Quarterly to the Performance Improvement Committee. The DRC will be responsible for compliance.	3/14/11
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441	F441 The facility will establish and maintain an infection control program as evidenced by:	

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F 441	Continued From page 35 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control surveillance records, the facility failed to maintain accurate and timely infection control surveillance records for 2 of 6	F 441	A) The infection control nurse (ICN) will maintain accurate, complete and timely infection control surveillance records. All incomplete records will be completed with pathogen and the complete resolution information. The facility failed to ensure that the staff followed appropriate infection control practices for hand hygiene, medication administration and personal care involving the following residents: #22, #1, #47, #15, and #33. Refer to B&C to ensure that these inappropriate infection control practices do not reoccur. Infection control surveillance will be randomly conducted to assure proper procedures are followed. Improper care techniques for dressing changes on residents # 43 and #36 were conducted. These resident's wounds have continued to improve with no adverse outcomes. The infection control nurse will observe dressing changes on #43 and #36 and correct any inappropriate techniques. Glucometer equipment does have a procedure to clean and disinfect the case and unit in-between resident use and can be used for more than one resident. The ICN will do surveillance when the nurse is using the glucometer on resident #24 making sure proper infection control practices are followed.	

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F 441	Continued From page 36 sample months. The facility further failed to ensure staff followed appropriate infection control practices for hand hygiene, medication administration, and personal care. The findings were: As related to an incomplete surveillance program: Review of the facility's surveillance records with the infection control nurse revealed areas where information regarding known pathogens was omitted and resolution information was incomplete. The nurse confirmed the lack of information at the time of the review. As related to lack of hand hygiene and medication administration: 1. Before preparing medication for resident #22 on 1/24/11, RN #9 completed hand hygiene. She then rubbed her neck and the side of her face and stated she was not feeling well. She reported she was not nauseated but had not eaten all day due to not feeling well. She further stated her daughter vomited during the night, and she produced an emesis bag for herself from her pocket. Without using a hand sanitizer again, the RN prepared and administered the resident's medication at 5:34 PM. 2. On 1/24/11 RN #9 was observed preparing medication for resident #1. The RN dropped the cap from the ibuprofen bottle onto the floor, picked it up, and, without cleaning it, replaced it on the bottle. Without cleansing her hands, the RN continued to prepare the medications and, at 5:05 PM, administered them to the resident. 3. At 8:15 AM on 1/25/11 RN #9 spilled	F 441	Hand sanitizer containers were checked throughout the facility and all out dated containers were destroyed. Proper hand hygiene and glove use will be observed during infection control surveillance on residents #20 and #2 and corrective action will be taken when necessary. Facility motto "Floor is Bad" will be enforced and any oxygen tubing being taken off the floor for continued resident use must be disinfected thoroughly before being placed back on the resident. B) Infection control policy, procedures and practices on hand washing, proper glove use, disinfection of glucometer machine between residents, medication administration, feeding residents, dressing changes, proper cleaning and disinfecting personal care items that have been contaminated before resident use, will be reviewed with the AHCC staff. Infection control surveillance will be conducted and corrective action taken on any inappropriate infection control practices. Purchasing will monitor for outdated products before delivering to the AHCC. Physical therapy will make a video on proper techniques for dressing changes using the correct infection control practices.	

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F 441	Continued From page 37 medications for resident #47 onto the top of the medication cart. The RN was observed to use her bare hands to scoop the medications into a spoon and put them back into the container. The cart had not been cleaned and the RN did not use a hand sanitizer prior to touching the medications. 4. While preparing medications for resident #15 on 1/26/11, LPN #10 was observed to drop a medication onto the top of the medication cart. After donning gloves, the LPN scooped the medicine up with a spoon and administered it to the resident at 8:45 AM; the top of the cart had not been cleaned. 5. On 1/25/11 at 8:13 AM nutrition support assistant #15 was observed while assisting resident #33 with breakfast. The assistant would run her hands through her hair then pick up the various glasses of fluids and hold them while the resident drank. She then played with her hair again before using the same hand to manipulate the silverware and feed the resident. 6. Observation on 1/27/11 at 3 PM showed two separate containers of hand sanitizer had expired, one on October 2009 and one on March 2010. On 1/28/11 observation at 8:15 AM revealed another container of hand sanitizer in the special care unit had expired in March 2010. Interview with the DON on 1/28/11 at 10:20 AM revealed the facility did not have a system for monitoring the sanitizers. As related to improper care techniques: 1. Observation of staff changing the dressing on resident #43's surgical site on 1/25/11 from 7:26 AM to 7:55 AM revealed the following breech in	F 441	C) Infection control Nurse will educate all AHCC staff through videos, in-services, policies and procedures and surveillance with corrective action on the proper infection control practices. D) Infection control surveillance will be conducted weekly and complied monthly and reported to the PI committee. A rapid improvement project will be implemented if surveillance falls below 90%. The ICN will be responsible for compliance.	3/14/11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 38 infection control: RN #4 removed the old dressing and applied the new dressing and calcium alginate treatment while wearing the same pair of gloves. RN #1 removed, used, and replaced the scissors in her pocket during the procedure while wearing the same pair of gloves. Neither of the two nurses changed their gloves when they repositioned the urinary drainage bag, and CNA #17 repositioned it without wearing gloves. 2. During a dressing change for resident #36 on 1/26/11 at 9:26 AM, LPN #5 was observed to use the same applicator to apply Xenaderm ointment to three separate open wounds on the resident's buttocks and coccyx. During the same observation, RN #4 used a pair of scissors to cut a dressing to fit the pressure ulcer on the resident's heel. However, she failed to clean the scissors either before or after using them 3. On 1/26/11 at 4:15 PM LPN #10 was observed while performing a blood sugar test for resident #24. The LPN placed the glucometer and the equipment case on the resident's bed before obtaining blood to complete the test. The LPN returned the glucometer to the case without cleaning it and then replaced the case in the medication room for future use. Although the manufacturer's instructions specified cleaning the glucometer daily with soap and water, the "APIC position paper: Safe injection, infusion, and medication vial practices in health care" American Journal of Infection Control, Association for Professionals in Infection Control and Epidemiology (APIC), April 2010, provides the following information related to blood glucose monitoring devices: "Assign a glucometer to each individual patient if possible. Clean and disinfect glucometers if they must be shared between	F 441		

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F 441	Continued From page 39 multiple patients. According to the Centers for Medicare and Medicaid Services Survey & Certification letter Ref: S&C: 10-28-NH deficient practice in infection control exists when facilities used "a blood glucose meter (or other point-of-care device) for more than one resident without cleaning and disinfecting it after use." Further review showed "If the manufacturer does not specify steps for cleaning and disinfection between uses of a point-of-care device, then the device generally should not be used for more than one resident." 4. Observation on 1/25/11 at 6:55 AM showed a mat placed on the floor beside the bed for resident #20. CNA #13 entered the room, donned gloves, and picked up the mat. She handled the top and bottom of the mat, and placed it against the wall. The CNA then changed the resident's disposable brief and performed incontinence care, handling the wipes with the same gloves that were in contact with the dirty floor mat. 5. Observation on 1/25/11 at 6:14 AM showed CNA #14 picked up resident #2's oxygen cannula from the floor and laid it aside. After the completion of care, the CNA placed the cannula on the resident without cleaning it.	F 441		
F 514 SS=E	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	F 514	F514 The facility will ensure that clinical records are complete and accurate for each resident. This will be accomplished by: A) Refer to F280 POC regarding incomplete care plans for resident: 1 regarding cognitive loss and mood behavior problems 2 regarding daily ambulation 10 regarding specific toileting assistance techniques 27 regarding ambulation 30 regarding us of walker 36 regarding comprehensive care, regarding pressure ulcers 37 regarding eye care 43 regarding recent surgery and positioning of urinary catheter tubing and lay down transfers Resident 23,24 and 29 will also have care plans reviewed and revised as needed. Refer to F281 POC regarding incomplete assessments for resident: 23 related to neurological checks. Refer to F309 POC regarding lack of pain monitoring for resident 2 related to effectiveness of pain interventions	

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	53A002	A. BUILDING _____ B. WING _____	01/28/2011

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F 514	Continued From page 40 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 medical record review and staff interview, the facility failed to ensure records were complete and accurate for 11 of 11 sample residents (#1, #2, #10, #23, #24, #27, #29, #30, 36, #37, #43). The findings were: Medical record review revealed, and staff interviews confirmed, the following records were incomplete and/or inaccurate: Refer to F280 for details related to incomplete care plans for residents #1, #2, #10, #23, #24, #27, #29, #30, #36, #37, and #43. Refer to F281 related to incomplete assessments for resident #23. Refer to F309 for information related to lack of pain monitoring for resident #2. Refer to F314 for details related to incomplete documentation of pressure ulcers for residents #1 and #36. Refer to F318 for information related to lack of restorative documentation for residents #10, #23, #20, #36, #37, and #43.	F 514	Refer to F314 POC regarding incomplete documentation of pressure ulcers for resident: 1 related to weekly skin assessment 36 related to PUSH Tool and pictures Refer to F318 POC regarding lack of restorative documentation for resident: 2 and 37 related to monitoring that appropriate number of sessions are completed 23, 29 and 36 related to written exercise programs 43 related to updated restorative program B and C) The above POCs will also address other residents potentially affected and measures to ensure the deficient practices do not recur. The DON will audit 4 charts monthly for complete documentation in these areas.	5/14/11 PP
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	D) A performance improvement tool will be implemented to ensure clinical records are complete and accurate. This tool will be completed monthly and reported quarterly to the PI Committee. 3/14/11	3/14/11

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F 620	Continued From page 41 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the Performance Improvement (PI) program, review of minutes from the PI meetings, and staff interview, the facility failed to ensure the PI committee met quarterly. The facility also failed to identify quality of care issues and develop and implement action plans to resolve those concerns. The findings were: Review of the PI meeting minutes showed the committee did not have the scheduled quarterly meeting in October 2010. Interview with the administrator on 1/28/11 at 8:55 AM confirmed the quarterly meeting was cancelled. Review of the PI program showed the facility was tracking several indicators, but no action plans were	F 620	F520 (A, B, C) Refer to the POC for the following deficiencies. Specifics for D: F309 related to the lack of implementation of the bowel program and lack of appropriate pain monitoring D) A performance improvement tool will be implemented to ensure that the facility bowel program is followed and pain monitoring is adequate. This monitor will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance. F312 related to inappropriate incontinence care D) A performance improvement tool will be implemented to ensure that appropriate incontinence care is provided. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC will be responsible for compliance. F314 related to pressure ulcers D) A performance improvement tool will be implemented to ensure that residents with pressure ulcers receive the necessary services. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC will be responsible for compliance.	

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F 520	Continued From page 42 identified. During the aforementioned interview, the administrator stated the facility had not instituted any "rapid improvement projects" during the past year. These projects were defined as the action plans developed, initiated, and monitored when concerns were identified. Failure to identify quality of care deficiencies prior to the survey were identified as follows: a. Refer to F309 for details related to lack of implementation of the bowel program and lack of appropriate pain monitoring. b. Refer to F312 for information related to inappropriate incontinence care. c. Refer to F314 for details related to pressure ulcers. d. Refer to F315 for detailed information related to inappropriate indwelling urinary catheter care. e. Refer to F318 for information related to the restorative program. f. Refer to F323 for details related to safety concerns in the secure unit. A deficiency citation under this category was written during each of the last four surveys. g. Refer to F325 for information related to nutrition concerns. h. Refer to F329 for information related to lack of appropriate evaluations of medications. Other deficiencies of significant concern included two in quality of life (refer to F241 and F258), one in dietary services (refer to F371, also cited during three of the last four surveys), and infection control (refer to F441).	F 520	F315 related to inappropriate indwelling urinary catheter care D) A performance improvement tool will be implemented to ensure indwelling urinary catheters are appropriately manipulated. This monitor will be completed monthly and reported quarterly to the PI Committee. The DRC will be responsible for compliance. F318 related to the restorative program D) PT will implement a tool to ensure that residents with limited range of motion receive appropriate treatment and services. This will be reported quarterly to the PI Committee. The Supervising PT will be responsible for compliance. F323 related to safety concerns in the Special Care Unit D) A performance improvement tool will be implemented to ensure that assistance can be obtained to the SCU. This monitor will be completed monthly and reported quarterly at the PI Committee. The DON will be responsible for compliance. F325 related to nutrition concerns D) A performance improvement tool will be implemented to ensure that residents are adequately assisted at meal time. This will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance.	

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F 520		F 520	F329 related to lack of appropriate evaluations of medications D) Results of the MRR according to the QA indicators will be reported to Performance Improvement Committee Quarterly. The DRC will be responsible for compliance. F241 related to quality of life D) A performance improvement tool will be implemented to ensure that residents dine in an atmosphere that enhances their dining experience. This tool will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance. F258 related to quality of life D) A performance improvement tool will be implemented to ensure that comfortable sound levels are maintained. This monitor will be completed monthly and reported quarterly to the PI Committee. The DON will be responsible for compliance.	

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F 520		F 520	F371 related to dietary services D) The CDM will enforce and monitor weekly the proper compliance through the Food Borne Illness Prevention-Daily Checklist which includes the documentation of proper glove use and hand washing, the Daily Employee Checklist which monitors for out of date items, and the Dishwashers Checklist which includes the documentation of the hood and filter cleaning. These results will be reported to the PI Committee on a quarterly basis. F441 related to infection control D) Infection control surveillance will be conducted weekly and complied monthly and reported to the PI Committee. A rapid improvement project will be implemented if surveillance falls below 90%. The ICN will be responsible for compliance.	3/14/11