POC accepted 3/30/09

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

Janeve Cook, ONRC

PRINTED: 03/18/2009
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
	535034	A. BUILDING _____ B. WING _____	03/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED 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 record review and staff interview, the facility failed to identify significant changes for two (#4, #24) of four sample residents who experienced significant changes in status. The findings were: According to the "Centers for Medicare and Medicaid Services, Revised Long Term Care Facility Resident Assessment Instrument User's Manual," revised August 2008, page 2.9....a significant change in resident status is a decline in 2 or more areas which include a significant decline or improvement in activities of daily living, the emergence of unplanned weight loss or gain, a change in continence, or a change in mental status. 1. Medical record review for resident #4 revealed a quarterly Minimum Data Set (MDS)	F 274	Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged or that any regulatory violations occurred. The following is to be considered our Credible Allegation of Compliance **F274:** The facility will ensure that significant changes in a resident's physical or mental condition are identified on the Resident Assessment Instrument. A. Resident #4 died on March 16, 2009. The medical record has been closed. A significant change MDS was completed for resident # 24 on 3-24-09 and the care plan will be reviewed by the Interdisciplinary Team. B. The MDS for residents will be audited to identify any other residents who may have experienced a significant change in condition.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Schultz — TITLE: Administrator — (X6) DATE: 3/25/2009

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

RECEIVED
Wyoming Dept. of Health
MAR 27 2009
Office of Healthcare Licensing and Surveys

Changes made per phone call to Donna Schultz, Admin and Janeve Cook on 3/30/09 @ 2:50pm

Licensing and Surveys

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F 274	Continued From page 1 assessment, dated 11/23/08, that showed the resident had significant weight loss; independent decision making skills; no indicators for depression and did not need assistance with walking, transfers and bed mobility. Review of the quarterly MDS assessment, dated 2/17/09, showed the resident continued to have significant weight loss; had moderate cognitive impairment; required assistance with walking, transfers and bed mobility; and developed indicators of depression (withdrawal from activities of interest and reduced social interaction). Interview on 3/3/09 at 4 PM with the MDS coordinator confirmed the quarterly MDS for resident #3, dated 2/17/09, was accurate and a significant change assessment should have been completed. 2. Medical record review for resident #24 revealed a quarterly MDS assessment, dated 11/11/08, that showed the resident needed extensive assistance with walking, had significant weight loss and was continent of bowel and bladder. Review of the quarterly MDS, dated 2/10/09, showed the resident continued to have significant weight loss; the resident did not walk; and s/he was occasionally incontinent of bowel and bladder. Interview on 3/5/09 at 10 AM with the MDS coordinator confirmed the 11/11/08 and 2/10/09 quarterly MDS assessments for the resident were accurate and a significant change assessment was not done.	F 274	The Director of Nursing will provide in-service to the Interdisciplinary Care Team on the identification of significant change and the correct coding of the MDS. C. An accuracy monitoring tool will be implemented to ensure significant changes have been identified before the MDS is transmitted. This tool will be completed weekly by the Risk Management Team. D. Results of the weekly monitoring will be reported to the Quality Assurance Committee on a monthly basis for continued compliance. Date of Correction 4-19-09	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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	F 280	**F280:** The facility will ensure that care plans are updated to reflect the current status of the resident.	

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F 280	Continued From page 2 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, family and staff interview, and medical record review, the facility failed to ensure the care plan was updated to reflect the current status for 2 (#39, #42) of 15 sample residents. The findings were: 1. Review of the 12/4/08 initial Minimum Data Set (MDS) assessment for resident #42 revealed s/he had problems with swallowing. Observation on 3/2/09 at 6:15 PM revealed the resident experienced a coughing/choking incident while eating the evening meal. Observation revealed the resident's face turned beet red, s/he pushed back from the table and threw his/her head backwards and held his/her hand to the chest. Observation revealed certified nurse aide (CNA) #5 assisting at another table went to the resident and asked if s/he was all right. The CNA did not assist the resident in any manner. Interview with	F 280	**A.** The care plan of resident #42 was updated on 3-24-09 to address coughing/choking spells. The care plan of resident #39 was updated on 3-24-09 to include seizure precautions and to address the meaning of teeth grinding behavior as a form of communication for this resident. **B.** The care plan of those residents with issues of coughing/choking and a history of seizures will be reviewed and updated with the appropriate interventions; the Interdisciplinary Team will review each resident to identify and care plan the meaning of physical behaviors which the resident uses to make their needs known. Charge Nurses will monitor resident behavior and staff performance at meal times.	

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F 280	Continued From page 3 the speech therapist on 3/4/09 at 11 AM revealed the recommended intervention for the resident's coughing/choking episodes was for staff to place an arm around the back of the resident's neck to provide support and to prevent the resident from throwing his/her head backwards. Observation revealed the CNA who went to check on him/her did not support the neck as instructed by the speech therapist. Review of the care plan revealed the resident's coughing/choking spells were not addressed. Interview with certified nurse aide #3 on 3/5/09 at 9 AM revealed she frequently assisted this resident with meals and she was unaware of the intervention to support the resident's neck and head. 2. According to the 11/12/08 quarterly, and the 2/11/09 annual MDS assessments, resident #39 had short and long term memory problems and moderately impaired cognitive skills for daily decision making. In addition, the assessments showed the resident was frequently incontinent of urine and was totally dependent on staff for transferring and toileting. The following concerns were noted with the care plan for this resident: a. Medical record review revealed a progress note dated 2/13/09 that documented the resident experienced a seizure lasting 10 minutes during lunch. Review of the resident's care plan showed seizure precautions were not included on the care plan. Interview with a family member on 3/4/09 at 9:10 AM revealed the resident had never experienced a seizure prior to 2/13/09. b. Observation on 3/3/09 between 1:45 PM and 2:15 PM revealed the resident was grinding his/her teeth. Observation on 3/3/09 at 2:15 PM revealed CNA #2 asked the resident if s/he needed to go to the bathroom. The resident indicated yes. Continued observation on 3/3/09 at	F 280	C. The Staff Development Coordinator will in-service the care giving staff on steps to take when someone is coughing/choking, and on reporting to the Care Planning Team those behaviors which are significant to the resident for communication so that these can be integrated into the plan of care for the resident. A Certified Nursing Assistant will be added to the weekly Risk Management team to review and update resident care plans as appropriate. The Social Service Designee will randomly quiz care givers about the meaning of behavioral communication techniques of residents to test care givers knowledge and accuracy of the care plan. Any new information gleaned will be added to the care plan. D. Results of monitoring of staff performance during meals, C.N.A	

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F 280	Continued From page 4 2:25 PM revealed the resident's incontinence brief was saturated with urine and s/he had a bowel movement when assisted to the toilet. Interview with a family member on 3/4/09 at 9:10 AM revealed the teeth grinding usually indicated the resident needed to be toileted, or s/he was thirst or hungry. c. Interview with the MDS coordinator on 3/5/09 at 7:55 AM revealed she was aware the resident would grind his/her teeth. Further interview at that time confirmed that neither seizure precautions or the resident's behavior of teeth grinding were on the care plan. The MDS coordinator also confirmed that both of these areas should be on the care plan.	F 280	contribution to care planning conferences and weekly Risk Management sessions and Social Service quizzes will be reviewed by the Quality Assurance Committee monthly for the next three months. Date of correction: 4-19-09	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS 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, staff interview, and medical record review, the facility failed to ensure staff followed standards of practice in regard to infection control and physician's order clarification during one of two observations of medication pass. The findings were: 1. Observation on 3/4/09 at 7:20 AM revealed licensed practical nurse (LPN) #1 knocked over the medication cup spilling a Lasix tablet for resident #19 onto the top of the medication cart. The LPN picked the tablet up with a spoon, placed it back into the medication cup, and administered it to the resident. Interview with the LPN on 3/4/09 at 7:35 AM revealed she should have discarded the tablet because the top of the	F 281	**F281** The facility will ensure that services provided meet professional standards of quality. A. LPN #1 has received additional in-service on providing medication to resident #19 so that medications are free from contaminants; and to obtain clarification from the physician on the amount of Two Cal to administer to resident #22. A clarification order has been obtained for the amount of Two Cal to administer to the resident. B. The Director of Nursing and Staff Development Coordinator will observe medication administration on a periodic basis and intervene with immediate	

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F 281	Continued From page 5 medication cart was not considered a clean surface. According to "Nursing Interventions and Clinical Skills," 2007, fourth edition, by Elkin, Perry and Potter, pages 374 and 383, the nurse should, "avoid touching tablets and capsules"...and...not touch medications with fingers..." prior to and during administration of medications. In addition, according to "Medication Guide for the Long-Term Care Nurse, sixth edition, 2003, by Thomas R. Clark, RPh, page 67, there is potential for transmitting infection during medication pass due to accumulation of dust and contaminants on top of the medication cart. 2. Observation on 3/4/09 at 7:30 AM revealed LPN #1 poured Two Cal (dietary supplement) into a cup for resident #22 without measuring the amount. When asked by the surveyor to measure the amount it was 40 cc (cubic centimeters). Interview with the LPN at that time revealed there was no amount written by the physician so the nurses usually just gave 60 cc. Review of the physician's order revealed there was no amount written as the LPN stated, however, continued interview with the LPN revealed she should have clarified the amount with the physician. According to "Legal & Professional Issues" by Wolters, Kluwer, Lippincott, Williams & Wilkins, 2009, page 14, if a nurse was unsure of an order, she should clarify it with the physician prior to carrying it out.	F 281	correction if improper procedures are observed. All physicians' orders for Two Cal will be audited for specification of amount to administer, and correct orders obtained as needed. C. The Staff Development Coordinator will provide additional in-service to Licensed Nurses on the procedures of medication administration; and to the Registered Dietitian who makes recommendations to the physician on the amount of Two Cal that is therapeutic for the resident. Physician's orders will be audited weekly by the Risk Management team, clarification order will be requested if needed. D. Audits of Physicians' orders and random, periodic observations of medication administration will be done by the D.O.N, SDC and Pharmacy Consultant and reported to the Quality Assurance Committee monthly. Date of Correction: 4-19-09	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**F309** The facility will ensure that residents receive necessary care and services to attain or maintain the	

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview, and medical record review, the facility failed to ensure staff provided the necessary care and services for 3 (#39, #42, #55) of 13 sample residents. The findings were: 1. Review of the 10/22/08 annual MDS assessment for resident #55 revealed s/he had swallowing and chewing difficulties. Review of the 10/22/08 and 1/14/09 nutrition assessments revealed the resident required nectar consistency liquids in nosey cups. The following concerns were identified: a. Observation on 3/2/09 at 6:15 PM revealed the resident experienced coughing/choking after receiving each nosey cup of liquefied puree diet. CNA #5 who was feeding the resident added thickener after each episode. Interview with the speech therapist on 3/4/09 at 11 AM revealed the liquids should not be more than nectar thick. Observation revealed the CNA did not consult with a nurse regarding the increased amount of thickener. She also did not notify the nurse so an assessment could be performed. b. Observation on 3/3/09 during breakfast and lunch revealed the resident again had coughing/choking episodes while being fed the liquids from a nosey cup. Further observation revealed when given pudding in a spoon, the resident did not experience any coughing/choking episodes. c, During each observed meal, the resident sat with his/her head leaning slightly backwards. Interview with the speech therapist on 3/4/09 at	F 309	highest practicable physical, mental and psychosocial well-being. A. A series of care planning sessions will be held by 4/02/09 to review swallowing and chewing difficulties of resident # 55 to ascertain the accurate interpretation of resident behaviors so that appropriate interventions are implemented to include accurate food consistency, positioning, and food preferences. The diet card and nutritional assessment will be revised as needed. A series of care planning sessions will be held to strategize possible interventions for the optimal positioning for assisted dining of resident #39. and for Res # 42 for choking episodes. B. The care plan of those residents needing special positioning during meals will be reviewed and revised. The plan for positioning will be added to the resident's diet card so as to be readily available to care givers.	jc

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F 309	Continued From page 7 11 AM revealed the resident should be positioned so his/her head was at a ninety degree angle from the ears to shoulders to prevent choking and aspiration. Observations on 3/2/09 and 3/3/09 revealed the resident's positioning was not at a ninety degree angle. d. Interview with CNA #3 on 3/5/09 at 9 AM revealed she frequently assisted the resident with meals. She further stated she was unaware the resident's head should be at a ninety degree angle from the ears to the shoulders. When asked by the surveyor how she handled the coughing/choking episodes while feeding this resident she stated she just "ignored" them because they happen all the time. e. Interview with the speech therapist on 3/4/09 at 11 AM revealed she thought the resident sometimes coughed/choked when s/he disliked a particular food and that the coughing/choking was partly behavioral. Review of the 10/22/08 annual and the 1/19/09 quarterly MDS assessments revealed the resident exhibited no behavioral symptoms. f. Interview on 3/5/09 at 9:15 AM with the social services director, who was also a CNA and assisted this resident with meals on occasion, revealed she thought some of the coughing/choking was due to foods the resident disliked. When asked how staff let dietary know which foods the resident did not like so they would not continue to serve them to him/her, she said "well people just kind of know." However, review of the 10/29/08 nutrition assessment revealed the resident's food preferences or dislikes were documented as unknown. During an interview with the dietary manager on 3/5/09 at 9:10 AM, she stated she was unaware of any food dislikes and preferences.	F 309	The thickening of food and fluid will be assigned to Cooks and Domestic Aides so that only those care givers who have been trained on the preparation of thickened food and beverages will have access to thickening agents. Charge Nurses will monitor the processes of positioning and resident assistance in the dining room. The Dietary manager will develop a written communication tool for the transference of information about resident's food preferences. C. The Staff Development Coordinator, with assistance of the Speech Therapist and Registered Dietitian, will in-service staff on the appropriate resident positioning, dealing with choking issues, thickened foods and liquids and recording resident food preferences. The Interdisciplinary Team will monitor activity in the dining room	

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F 309	Continued From page 8 2. Review of the 12/4/08 initial Minimum Data Set (MDS) assessment for resident #42 revealed s/he had problems with swallowing. Observation on 3/2/09 at 6:15 PM revealed the resident experienced a coughing/choking incident while eating the evening meal. Observation revealed the resident's face turned beet red, s/he pushed back from the table and threw his/her head backwards and held his/her hand to the chest. The following concerns were identified: a. Observation revealed certified nurse aide (CNA) #5 assisting at another table went to the resident and asked if s/he was all right. The CNA did not assist the resident in any manner. The coughing/choking incident lasted in excess of one minute.Interview with the speech therapist on 3/4/09 at 11 AM revealed the recommended intervention for the resident's coughing/choking episodes was for staff to place an arm around the back of the resident's neck to provide support and to prevent the resident from throwing his/her head backwards. Observation revealed CNA #5 who went to check on the resident did not support the neck as instructed by the speech therapist. b. During an interview with the speech therapist on 3/4/09 at 11 AM, she stated the resident was to be assisted with all meals. Observation on 3/2/09 during the evening meal where the resident experienced the coughing/choking incident revealed there was no staff member assisting the resident. 3. Review of the 12/17/07 admission/readmission physician's orders showed resident #39 had a diagnosis of dementia. According to the 11/12/08 quarterly, and the 2/11/09 annual MDS assessments, the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. In	F 309	for positioning, use of thickened products and the honoring of resident's food preferences 3 times per week at various meals for the next twelve weeks. **D.** The results of dining room monitoring will be reviewed by the Quality assurance committee to direct further in-services or monitoring as needed. Date of Correction: 4/19/09	

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F 309	Continued From page 9 addition, the assessments showed the resident did not ambulate and was totally dependent on staff for all activities of daily living. Observation in the dining room on 3/2/09 from 5:29 PM to 6:26 PM, and on 3/3/09 from 7:56 AM to 8:47 AM, showed the resident was seated in a wheelchair. The following concerns were noted with the resident's positioning: a. Observation during both meals revealed the resident leaned forward at the waist, with his/her head down, as staff assisted the resident. Repeated attempts by staff to reposition the resident to an upright position were unsuccessful. b. Interview with the speech therapist on 3/4/09 at 11 AM revealed she was aware the resident leaned forward in the wheelchair. The speech therapist further commented that based on the resident's positioning, it was difficult to assist the resident with meals. c. Interview with physical therapist (PT) #1 on 3/5/09 at 8:30 AM revealed the resident had used the wheelchair during meals for "several months" and she was aware the resident leaned forward while being assisted by staff. The PT further commented the resident's positioning in the wheelchair "sucks." d. Interview with a family member on 3/4/09 at 9:10 AM revealed a concern with the resident's positioning in the wheelchair. The family member commented the resident had recently tipped over while seated in the wheelchair. e. Review of the medical record showed a nursing note dated 1/31/09, timed at 9 AM, that documented the resident was in the wheelchair and leaning to the left. The note further documented that before the nurse could get to the resident, the resident "fell over to the left side on the floor."	F 309	**F312** The facility will ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene.	
F 312	483.25(a)(3) ACTIVITIES OF DAILY LIVING	F 312		

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F 312 SS=E	Continued From page 10 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, staff interview and medical record review, the facility failed to ensure staff provided adequate personal hygiene for four (#21, #37, #39, #54) of six residents during random observations of personal care and for two (#4, #56) of six residents during random observations of oral care. The findings were: 1. Observation on 3/2/09 at 7:50 PM revealed certified nurse aide (CNA) #1 assisted resident #21, who was incontinent of both urine and feces, to the toilet. Interview with the CNA at that time revealed the resident was usually incontinent of bowel and bladder. Continued observation revealed the CNA provided perineal care but did not cleanse the penis or scrotal area which was in contact with the wet brief. Interview with the infection control coordinator on 3/5/09 at 9:20 AM revealed CNAs were taught and expected to cleanse all areas of the body that were in contact with a wet or soiled incontinence brief. Review of the procedure for male perineal care, revised 2/05, revealed the following instructions for male residents: "....wash the perineal area including the penis, scrotum, and inner thighs..." 2. Observation on 3/3/09 at 1:58 PM revealed resident #54 was incontinent of urine and feces. Continued observation revealed CNA #2 used the	F 312	A. Certified Nursing Assistants # 1 and #4 has been re-in-serviced using demonstration and return demonstration of correct procedures for perineal care, use of peri-wipes, glove use, hand washing and oral care. C.N.A. #2 is no longer employed at the facility. Residents # 21, 37, 39, and 54 are receiving perineal care which includes all skin which may have come in contact with urine, using multiple wipes so that non-soiled skin does not become soiled; residents were assessed and found to be free of infection. Resident #4 has died. Resident #56 is receiving oral care upon rising and at bed time. The Charge Nurse will observe perineal and oral care for proper procedures. B. The Staff Development Coordinator, or designee will in-service nursing staff on proper incontinent care and technique, to	

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F 312	Continued From page 11 same area of the wipe seven times to clean feces from the rectum and buttocks. A second wipe was used in the same area three times then the CNA folded it to a clean area and used that area four times. The third wipe was used five times without folding to a clean spot. All three wipes were soiled with feces which the CNA used over and over. In addition, the CNA used a wipe four times to cleanse the anterior perineal area with gloves that had feces on them. During an interview with the CNA on 3/3/09 at 2:50 PM she stated she was unaware she should not use the same soiled area of the wipe more than once. 3. Observation on 3/3/09 at 2:25 PM revealed resident #39 was assisted on the toilet by CNA #2 using the EZ lift. Observation revealed the resident's incontinence brief was saturated with urine. While on the toilet the resident had a bowel movement. The following concerns were identified: a. Observation revealed CNA #2 provided perineal care but did not cleanse the penis or scrotal area which was in contact with the wet brief. Interview with the infection control coordinator on 3/5/09 at 9:20 AM revealed CNAs were taught and expected to cleanse all areas of the body that were in contact with a wet or soiled incontinence brief. Review of the procedure for male perineal care, revised 2/05, revealed the following instructions for male residents: "....wash the perineal area including the penis, scrotum, and inner thighs..." b. While providing perineal care, CNA #2 used the same area of the wipe fives times, another wipe in the same spot eight times, another wipe in the same area twelve times and a fourth wipe in the same spot three times. All four wipes were soiled with feces. In addition, the CNA	F 312	include a return demonstration on technique and supplies to be used. Staff will receive additional in-service on providing oral care to residents at a minimum of twice daily: upon rising and at bed time. **C.** Random weekly observations of staff performing perineal care and oral care will be completed by the Director of Nursing (or designee) to assure that staff is following the proper procedure. Immediate retraining will be done if correct procedures are not used. **D.** A log of random observations will be maintained to assure all C.N.A.s demonstrate proficiency at least annually. The log will be reviewed quarterly by the Quality Assurance Committee for continued compliance. Date of Correction: 4-19-09	

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F 312	Continued From page 12 did not cleanse the penis or scrotal area which was in contact with the urine saturated incontinence brief. During an interview with the CNA on 3/3/09 at 2:50 PM she stated she was unaware she should not use the same soiled area of the wipe more than once. 4. Observation on 3/2/09 at 7 PM, revealed resident #37 had urinated and defecated in the toilet. Observation of the perineal care by CNA #4 revealed she used the same area of the wipe four times to cleanse the anterior perineal and rectal areas. During an interview with the CNA on 3/2/09 at 7:20 PM, she said she should have folded the wipe to a clean area when she performed perineal cleansing. She also stated she forgot to change her gloves. 5. Interview with the infection control coordinator on 3/5/09 at 9:20 AM revealed CNAs were taught and expected to use the same area of a wipe only once if soiled. Review of the perineal care procedure revised 7/04 revealed the following instructions: "If the resident has had.....stool present, clean the rectal area first and then change gloves before completing the rest of the steps....Change area of cloth with each wipe....If gloves become contaminated with feces, etc., gloves should be changed before continuing" 6. Review of the 2/9/09 quarterly MDS assessment for resident #56 revealed s/he required extensive assistance with personal hygiene. Observation on 3/2/09 at 6:52 PM revealed the resident was assisted to bed. Interview with CNA #1 at the time revealed the resident was in bed for the night. Observation revealed the resident received no oral care.	F 312		

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F 312	Continued From page 13 7. Review of the 2/17/09 quarterly MDS assessment and corresponding care plan for resident #4 revealed s/he required assistance with activities of daily living including oral care. Observation on 3/2/09 from 6:45 PM to 7:30 PM revealed CNA #5 assisted the resident with toileting, perineal cleansing and facial cleansing, then transferred the resident to bed without providing assistance with oral care.	F 312		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and family interview, the facility failed to ensure that staff provided toileting in a timely manner to promote dryness for one (#39) of seven sample residents who were incontinent of urine. In addition, the facility failed to provide catheter care in a manner to minimize the risk for urinary tract infection during two random observations of one (#37) non-sample resident who utlized a urinary catheter. The findings were: 1. According to the 11/12/08 quarterly and 2/11/09 annual Minimum Data Set assessments, resident #39 had short and long term memory	F 315	**F315** The facility will ensure that toileting will be provided to promote dryness and to provide catheter care in a manner to minimize risk for urinary track infection. A. The care plan for resident #39 has been reviewed with nursing staff for toileting of this resident upon rising, before and after meals and before retiring. This resident is free from urinary tract infection and the skin is in good condition. The Charge Nurse will monitor adherence to the care plan. For resident # 37, a new catheter bag/catheter tubing containment system has been purchased and installed to hold the catheter bag/catheter tubing off the floor.	

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F 315	Continued From page 14 loss, was frequently incontinent of urine, and was totally dependent on staff for transfers and toilet use. Review of the care plan dated 9/2/08, updated on 2/17/09, revealed the resident should be informed of the toileting program and solicit cooperation upon rising, before meals, and activities, at bedtime and at night and after drinking coffee. The following problems were noted with the timely toileting of this resident: a. Periodic observation on 3/3/09 between 7 AM and 8:47 AM revealed the resident was in the dining room for breakfast. At 8:50 AM the resident was taken from the dining room to the library where s/he remained until being transferred to a recliner at 10:39 AM. The resident remained in the library until 12:10 PM and at that time was transferred back to his/her wheelchair and taken to the dining room. The resident remained in the dining room until the observation ceased at 1 PM. b. Further observation on 3/3/09 from 1:45 PM to 2:15 PM revealed the resident was in his/her room seated in a wheelchair, grinding his/her teeth. At 2:15 PM, CNA #2 asked the resident if s/he needed to go to the bathroom. The resident indicated yes. Interview with the CNA at 2:15 PM revealed she was waiting for another CNA to assist with transferring the resident to the toilet. Further interview with CNA #2 at that time revealed the resident was not toileted that morning after breakfast or before lunch (a time span of at least 7 hours and 15 minutes). c. Continued observation on 3/3/09 at 2:25 PM revealed the resident's incontinence brief was saturated with urine and s/he had a bowel movement when assisted to the toilet. d. Interview with a family member on 3/4/09 at 9:10 AM revealed that when the resident grinded his/her teeth, it was an indication that the	F 315	The Charge Nurse will monitor for correct positioning of catheter bag/tubing. B. The Charge Nurse will monitor the toileting of incontinent residents and the placement of catheter bags and tubing off the floor. The Director of Nursing or designee will randomly monitor toileting frequency of incontinent residents and catheter bags/tubing. If expected protocols are not being followed, immediate corrective action will be taken. C. The Staff Development Coordinator will provide education to the nursing staff on the appropriate toileting of incontinent residents to include upon rising, before and after meals and at bed time to promote as much dryness as possible; and provide education on the correct handling and placement of catheter bags and catheter tubing.	

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F 315	Continued From page 15 resident may need to be toileted, or s/he was hungry or thirsty. 2. The following concerns were noted with proper catheter care: a. Observation on 3/2/09 at 7:45 PM revealed CNAs #4 and #6 used a mechanical lift to transfer resident #37 from the wheelchair to the bed. Further observation revealed the resident's urinary drainage bag was dragged across the floor during the transfer and remained on the floor while the CNAs removed the lift, undressed and dressed the resident and positioned the resident in bed. b. Observation on 3/3/09 at 1:10 PM revealed a student nurse pushed resident #37 in his/her wheelchair from the dining room to the resident's room with the urinary drainage bag dragging on the floor. During an interview on 3/3/09 at 1:20 PM, the student nurse said staff were expected to provide a protective cloth support bag for the urinary drainage bag and keep it off the floor at all times.	F 315	**D.** The results of periodic observations of toileting frequency and catheter bag/tubing placement will be reported monthly to the Quality Assurance Committee for continued compliance. Date of Correction 4-19-09	
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure one (#54) of six sample residents with a limited range	F 318	**F318** The facility will ensure that a resident with limited range of motion receives appropriate services to increase range of motion and/or prevent further decrease in range of motion. **A.** Resident #54 will be evaluated by the Physical Therapist for a regimen of active and/or passive range of motion exercises.	

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F 318	Continued From page 16 of motion received appropriate services to increase range of motion. The findings were: Review of the medical record face sheet showed resident #54 was readmitted to the facility on 2/3/06. Review of the February 2009 physician orders showed the the resident had diagnoses that included senile dementia. According to the 3/6/08 quarterly, 11/5/08 annual, and 2/2/09 quarterly Minimum Data Set assessments, the resident had one leg (including the hip or knee) with limited range of motion and partial loss of voluntary movement. The following concerns were identified: a. Review of the resident's open medical record showed no evidence the resident had been assessed, or was receiving services, to address the limited range of motion and partial loss of voluntary movement to the leg. b. Interview with the director of nursing (DON) on 3/5/09 at 8:26 AM revealed the resident had received restorative range of motion services in the past, but was discontinued from the program. The DON said she did not know why the range of motion was discontinued, but she would review the resident's purged medical records. c. Review of documentation faxed to the state survey agency on 3/10/09 showed the resident was discontinued from the restorative nursing program in May 2005 due to the resident's refusal to participate. Review of additional documentation faxed to the state survey agency on 3/11/09 showed the resident received physical and occupational therapy services in December 2006 following a hospitalization. A physical therapy summary of progress/discharge note dated 12/20/06 documented the resident did not like to be moved and would refuse treatment if uncomfortable. The note further documented the	F 318	**B.** The MDS assessment of each resident will be reviewed to ascertain which residents may have been assessed with limited range of motion. Those identified will be evaluated for inclusion in activities to enhance range of motion which may include daily exercise class, restorative program or specialized rehabilitative services. **C.** The Interdisciplinary Care Planning Team will review each resident quarterly for possible referral to the therapy department for further evaluation of the need for a range of motion regimen. **D.** A tracking log will be developed to ensure at risk residents are periodically evaluated. The log will be updated weekly, reviewed by the Risk Management Team weekly and reported to the Quality Assurance Committee quarterly for continued compliance. Date of Correction: 4-19-09	

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F 318	Continued From page 17 resident allowed gentle passive range of motion as well as active assisted range of motion to all extremities. Interview with the DON on 3/11/09 at 2:45 PM confirmed there was no evidence the resident had been re-evaluated to address the limited range of motion and partial loss of movement since December 2006.	F 318	**F356**	
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	The facility will ensure that nurse staffing posting is completed daily and accurately. **A.** The Charge Nurse on each shift will record on the white board at the nurse's station the current date, the total number of staff and hours worked by category and the census. **B.** The nurse staffing scheduler will observe the accuracy of the information posted and correct the information posted as needed. **C.** The Director of Nursing, or designee, will in-service the Charge Nurses on the process of posting staffing information. **D.** A monitoring tool will be implemented to ensure staffing posting is complete and correct.	

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F 356	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to complete the nurse staffing posting at the beginning of each shift during four of four survey days. The findings were: Upon entrance into the facility on 3/2/09 at 2:25 PM, observation revealed the nurse staffing posted was dated 3/1/09 and had all three shifts posted at the same time. Observations on 3/3/09, 3/4/09, and 3/5/09 revealed the exact same date and numbers were posted. During an interview with the administrator on 3/5/09 at 9:40 AM, she revealed the scheduler usually posted the nurse staffing for all three shifts at the beginning of the day. In addition, she stated the posting should have been updated everyday.	F 356	The monitor will be completed weekly for the next twelve weeks and reported monthly to the Quality Assurance Committee for continued compliance. Date of Correction 4-19-09 **F371** The facility will ensure that staff follow proper procedures for manual dishwashing. A. Cook #1 has been re-inserviced on the correct procedures for washing utensils in the three compartment sink of washing in the first sink, rinsing in the second and sanitizing in the third sink. B. All Dietary staff will use the proper procedures for washing utensils in the three compartment sink. C. Signage above the sink will be installed to serve as a reminder of the correct procedure.	
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed during one of two observations to ensure staff followed proper procedures for manual dishwashing. The findings were:	F 371		

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F 371	Continued From page 19 Observation of the three compartment sink on 3/2/09 at 2:25 PM showed the first and third sink were filled with water; however, the second sink was empty. Further observation revealed cook #1 used the three compartment sink to wash measuring cups and knives. The cook washed the utensils in the first sink, then without rinsing, immediately placed the utensils in the third sink. Interview with the cook at that time revealed the first sink had detergent in the water and the third sink a sanitizing agent. The following concerns were noted with this procedure: a. Interview with the registered dietitian (RD) on 3/4/09 at 8:45 AM revealed the proper method for manual dishwashing was to wash in the first sink, rinse in the second, then sanitize in the third sink. The RD further commented that dietary staff had been trained on this procedure. b. Interview with cook #1 on 3/5/09 at 11:45 AM revealed she was trained on the proper use of the three compartment sink, but "forgot" to fill the second sink with the rinse water. c. Review of the facility's policy and procedure "Cleaning Dishes Manual Dishwashing" dated 2005, showed the procedure was to wash in the first sink, rinse in the second, and sanitize in the third sink.	F 371	All dietary staff will be in-serviced on the correct procedure. The Dietary Manager will observe periodically the dietary staff as they wash kitchen utensils. Deviations from proper procedures will be corrected immediately. **D.** The Dietary Manager will report quarterly to the Quality Assurance committee, using sanitation checklist, the results of staff adherence to correct procedures for continued compliance. Date of correction: 4-19-09	
F 406 SS=E	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in	F 406	**F406** The facility will ensure that when specialized rehabilitative services are required in a resident's comprehensive plan of care the services are obtained and provided.	

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F 406	Continued From page 20 accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and medical record review, the facility failed to ensure specialized rehabilitation services were provided according to the prescribed plan for 4 (#13, #21, #47, #57) of 8 sample residents who required physical therapy. The findings were: 1. Review of the admission face sheet for resident #21 revealed s/he had diagnoses including closed dislocated hip, and was admitted on 1/23/09 for rehabilitation. Review of the 2/5/09 initial Minimum Data Set (MDS) assessment revealed the resident had partial loss of function in both arms and partial loss of function in the right leg. Review of the 1/30/09 Resident Assessment Protocol (RAP) worksheet and the 2/23/09 physical therapy (PT) evaluation revealed the resident's goal was to return home. Review of the 1/24/09 physician's orders revealed physical therapy was to see the resident five times per week for twelve weeks for therapeutic exercise, bed mobility, transfers, gait, balance, and endurance. Review of the rehabilitation progress notes revealed the resident was re-evaluated for services on 2/23/09 and was scheduled for PT services fives times per week for four weeks, then three times per week for four weeks. The following concerns were identified: a. Review of the therapy visit billing log provided by the facility revealed the resident received no physical therapy from 2/14/09 to date (3/5/09). b. Interview with physical therapist #2 on	F 406	**A.** Residents # 21 and #13 are receiving specialized rehabilitative services. Resident # 57 has met all therapy goals and therapy has been discontinued. Resident # 47 is receiving nursing restorative services. **B.** Residents on the Specialized Rehabilitative caseload will be reviewed weekly by the Risk management team for completion of therapy as ordered. A full-time on-site Therapy Program Manager has been hired and will begin working on March 30, 2009. The Program Manager will oversee the completion of Specialized Rehabilitative services as required by the comprehensive care plan. The Program Manager will be responsible for staffing and making arrangements for alternate staff in the event of therapist illness.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 21 3/4/09 at 4:42 PM revealed he did not know anything about this resident and would have to review the medical record to determine the needs. The therapist also stated he only worked part time so could not keep up with all that was going on with the residents receiving physical therapy. c. Interview with physical therapist #1 on 3/5/09 at 8:30 AM revealed she also worked part time. She stated she was unsure why the resident received no services since 2/14/09. 2. Review of the February 2009 summary of physician orders for resident #47 revealed s/he had diagnoses including spinal stenosis and osteoporosis and was re-admitted for rehabilitation on 8/27/08. Review of the 10/22/08 annual and the 1/9/09 quarterly MDS assessments revealed the resident had partial loss of function in one leg. The following concerns were identified: a. Review of the PT evaluation performed on 12/10/08 revealed the resident was to receive PT for bed mobility, transfers, and gait training with a front wheeled walker five times per week for twelve weeks. Review of the rehabilitation progress notes revealed there was no evidence the resident received therapy from the time the evaluation was completed on 12/10/08 until 2/10/09. Review of the 2/10/09 rehabilitation progress notes revealed the notes did not identify how many times or when the resident received PT services. Review of the 2/20/09 entry revealed no therapy was provided from 2/16/09 through 2/19/09 due to the unavailability of a therapist. The next rehabilitation progress note was dated 2/25/09 and again did not identify when or how often services were provided. b. Review of the therapy visit billing log	F 406	C. The Program Manager will attend daily the management meetings to report on the completion of therapy and documentation thereof. The Risk Management team will audit the medical record weekly for the completion of therapy and therapy documentation for those with orders for Specialized Rehabilitative services. D. Results of daily reporting by the Program Manager and audits by the Risk Management team will be reported monthly to the Quality Assurance committee for continued compliance. Date of Correction 4-19-09	

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	535034	A. BUILDING _____ B. WING _____	03/05/2009

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F 406	Continued From page 22 revealed there were no visits entered since 9/4/08. Interview with the resident on 3/2/09 at 2:55 PM revealed s/he thought therapy had not been provided for about one week. Interview with PT #1 on 3/5/09 at 8:30 AM revealed she was unaware why no visits were entered into the log. c. Interview with PT #2 on 3/4/09 at 4:42 PM revealed he did not know anything about this resident and would have to review the medical record to determine the needs. The therapist also stated he only worked part time so could not keep up with all that was going on with the residents receiving therapy. d. Interview with PT #1 on 3/5/09 at 8:30 AM revealed she worked part time and did not know how often the resident should receive physical therapy but did know the resident would be discharged from physical therapy and started on restorative services on 3/9/09. 3. Review of the 2/23/09 physician's orders for resident #13 revealed an order for physical therapy three times a week for eight weeks. Review of the physical therapy evaluation and rehabilitation progress notes, dated 2/23/09, revealed the resident needed physical therapy to improve his/her ability to function more independently with toileting, bed mobility and walking. Review of the 2009 therapy visit billing log revealed the resident did not receive physical therapy after the initial evaluation on 2/23/09, until 3/4/09. During an interview on 3/4/09 at 10:10 AM, licensed practical nurse (LPN) #1 said the resident had not received physical therapy as ordered due to lack of therapy staff. Interview on 3/4/09 at 4:42 PM with physical therapist #2 confirmed the resident did not receive therapy between 2/23/09 and 3/4/09.	F 406		

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F 406	Continued From page 23 4. Review of the 12/11/08 physician's orders for resident #57 revealed an order for physical therapy five times a week for twelve weeks. Review of the physical therapy evaluation and rehabilitation progress notes, dated 12/11/08, revealed the resident needed physical therapy to decrease hip pain and function more independently. Review of the 2008-2009 therapy visit billing log revealed the resident did not receive physical therapy, as ordered, at least once in January 2009 and three times in February 2009. Additional review of the therapy visit billing log confirmed the resident did not receive physical therapy from 2/28-3/4/09. Interview with physical therapist #1 on 3/5/09 at 8:30 AM revealed she worked part time and was was unsure why the resident received no services since 2/14/09.	F 406		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure staff followed acceptable handwashing practices during random observations of personal care for five (#21, #37, #39, #54, #55) residents. The findings were: 1. Observation on 3/2/09 at 7:50 PM revealed resident #21 was incontinent of both urine and	F 444	**F444** The facility will ensure that staff wash their hands after direct resident contact for which hand washing is indicated by accepted professional practice.	

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F 444	Continued From page 24 feces. The following handwashing concerns were identified: a. Observation revealed after providing perineal care, CNA #1 opened the bathroom door, the closet door, rummaged through the closet to find a clean incontinence brief which she placed on the resident, pulled the resident's sweat pants up, assisted him/her to the wheelchair, then transferred the resident to bed. Observation revealed the CNA performed all of these tasks with the same soiled gloves used to clean the resident's buttocks and rectal area of feces. b. Observation on 3/2/09 at 7:50 PM revealed CNA #1 rubbed lotion on the resident's feet. With the same gloves on, the CNA then washed the resident's face and removed his/her dentures. c. Interview with CNA #1 on 3/4/09 at 3:35 PM revealed she should have removed her gloves and washed her hands after providing perineal care, She also stated she should have removed her gloves after applying lotion to the resident's feet and before assisting the resident with washing his/her face and removing the dentures. 2. Observation on 3/2/09 at 7 PM, revealed resident #37 urinated and defecated in the toilet. After performing perineal care, CNA #4 undressed, dressed and transferred the resident without washing her hands and using the same pair of gloves that she used to provide the perineal care. During an interview with the CNA on 3/2/09 at 7:20 PM, she said she forgot to wash her hands and change the gloves. 3. Observation of personal care for resident #39 on 3/3/09 at 2:25 PM revealed the resident's incontinence brief was saturated with urine. While on the toilet the resident had a bowel movement.	F 444	A. C.N.A.s # 1, 4 and 6 received additional training on hand washing after resident contact and the protocols for glove use. C.N.A. # 2 is no longer employed at the facility. Wheelchairs and lifts are cleaned weekly. Environmental surfaces are cleaned daily. B. The Staff Development Coordinator, or designee, will observe staff hand washing and glove use. If improper technique is identified, immediate in-servicing and corrective action will be taken. C. The Staff Development Coordinator, or designee will provide in-service education to staff on hand washing and glove use. Random, weekly observations of hand washing and glove use will be done by the SDC, or designee, and recorded on the skills checklist. D. The completion of skills checklist will be reported to the Quality Assurance Committee	

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F 444	Continued From page 25 After performing perineal care, the CNA touched the lift, the resident's clean clothes, the door, and wheelchair without removing the soiled gloves used during perineal care. She also removed the lift sling, folded it, smoothed it, then placed it in the lift pouch for use by another CNA and resident. Finally, the CNA placed her gloved hand on the side of the resident's face and head/hair with the soiled gloves used to clean feces to hold his/her head up straight while she fastened the seat belt on the wheelchair. After these tasks were completed, the CNA removed her soiled gloves and left the room without washing her hands. 4. Observation on 3/3/09 at 1:58 PM revealed resident #54 was incontinent of urine and feces. Continued observation on 3/3/09 at 1:58 PM revealed after providing perineal care, CNA #2 placed a clean incontinence brief on the resident, straightened him/her in bed, and clipped the call light button on the bed with the same soiled gloves used for perineal care. During an interview with the CNA on 3/3/09 at 2:50 PM she acknowledged gloves should be changed when soiled. 5. Observation on 3/2/09 at 7:55 PM revealed CNA #6 wore the same pair of gloves when she used a mechanical lift to transfer resident #55 to bed, removed the urine and fecal soiled incontinent brief, provided incontinent care and washed the resident's face. In addition, the CNA completed all the tasks prior to removing her gloves and washing her hands. During an interview, the CNA said she forgot to remove her gloves and wash her hands after she provided incontinent care.	F 444	monthly for continued compliance of hand washing and glove use. Date of Correction: 4-19-09	

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F 444	Continued From page 26 6. Interview with the infection control coordinator on 3/5/09 at 9:20 AM revealed CNAs were taught and expected to remove gloves when soiled and to wash their hands before putting another pair on. Review of the handwashing competency revised 2/07 revealed the following instructions on when to wash hands: "After handling contaminated items (linens/garbage/briefs, etc.)....After any contact with body fluids..."	F 444	**F456** The facility will ensure that essential mechanical, electrical and patient care equipment is maintained in safe operating condition. **A.** The wheelchair armrest of residents #13 and 26 have been replaced, resident #34 died and the wheelchair has been removed for refurbishment. New foot rest cushions for #54 have been ordered and will be installed upon arrival. **B.** All wheelchairs will be inspected. Any worn or frayed upholstery will be replaced by the Maintenance Department. **C.** Wheelchairs will be inspected weekly when they are washed. Request for repairs or replacement parts will be recorded on the maintenance log.	
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain wheelchairs in a safe and comfortable condition for 3 (#13, #26, #54) of 13 sample residents and 1 (#34) non sample resident whose primary locomotion was their wheelchair. The findings were: 1. Observation on 3/2/09 at 2:55 PM revealed the wheelchair for resident #13 had torn and frayed areas on the right arm. Further observation at that time revealed the torn area exposed pieces of the cushion and created a rough surface. 2. Observation on 3/4/09 at 4:15 PM revealed resident #26 sat in a wheelchair that had a 2 inch piece of cushion protruding through the torn cushion on the right arm. Further observation at that time revealed the resident repositioned his/her right arm repeatedly to avoid contact with the torn cushion.	F 456		

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F 456	Continued From page 27 3. Observation during a tour of the facility on 3/2/09 at 2:45 PM revealed the fabric back of the wheelchair used by resident #34 had torn areas. In addition, observation revealed there was a torn sheepskin pad on the left arm of the wheelchair. 4. Observation of the wheelchair for resident #54 on 3/3/09 at 1:58 PM revealed there was a 2 inch by 2.5 inch piece of wheelchair fabric which was missing from the back of the foot rest cushion, creating a jagged edge next to the resident's leg. 5. Interview with the assistant maintenance supervisor on 3/12/09 at 8:20 AM revealed the maintenance department was unaware the above noted wheelchairs were in need of repair.	F 456	The Central Supply Clerk will inspect wheelchairs monthly. D. Maintenance logs and monthly Central Supply inspections will be reported to the Quality Assurance Committee for continued compliance. Date of Correction: 4-19-09	