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

Printed: 01/30/2009
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
	535026	A. BUILDING _____ B. WING _____	C 12/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 82801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: Based on observation, review of facility policies and procedures, and staff interview, the facility failed to ensure adequate housekeeping and fire safety measures related to cleanliness in the laundry and in 9 of 10 resident bathrooms in the Special Care Unit. The findings were: Observation on 12/11/08 at 10:48 PM revealed the top of all four dryers in the laundry room were coated with a layer of lint that was approximately 1-inch thick. In addition, all three washing machines were covered with a thin layer of dust and lint. Interview with the laundry supervisor at the time of the observation revealed she was aware the accumulation of lint and dust in the laundry room represented a fire hazard and needed to be removed. In addition, the laundry supervisor also stated housekeeping, maintenance, and laundry staff shared the responsibility for cleaning the laundry room. Review of the facility's job description for housekeeping revealed the first essential duty was to "clean (dust, etc.) assigned areas daily according to facility procedure." Observation on 12/10/08 at 4:48 PM revealed all of the ceiling air vents in resident bathrooms in the Special Care Unit, with the exception of resident room #314, were covered with a layer of dirt and grime. Interview with the facility's maintenance manager at the time of the observation confirmed the vents were in need of cleaning.	F 253	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG F 253** The facility provides housekeeping and and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. A. The areas on top of the dryers and washing machines were cleaned of dust and lint. B. Ceiling vents in all bathrooms in the special care unit were cleaned of dirt and grime. 2. A. All rooms were checked and all ceiling vents were cleansed of dirt and grime. B. CLC Room Checklist has been implemented to ensure that all tasks, including cleaning ceiling vents are completed weekly. C. A Laundry Cleaning Checklist has been implemented to ensure that washers and dryers are cleaned of lint per schedule. 3. Residents currently residing in the facility are at potential risk 4. All Housekeeping and Maintenance Staff was in-serviced on 12/31/08 on the	1/7/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Conaway — TITLE: administrator — (X6) DATE: 02/06/07

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

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Wyoming Dept of Health

FORM CMS-2567(02-99) Previous Versions Obsolete ASUN11 If continuation sheet Page 1 of 14

Accepted w/ Changes Spoke w/ David Conaway Admin DOC = 2/4/09
Rachel Dean 2/9/09

FEB 06 2009

Office of Healthcare Licensing and Surveys

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F 281 SS=B	Continued From page 1 483.20(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 medical record review and staff interviews, the facility failed to ensure staff followed professional standards of practice related to documentation for medication administration for 2 (#70, #73) of 16 sample residents. The findings were: 1. Review of physician's orders for resident #73 showed the physician discontinued the previous orders for Vicodin on 11/6/08. Those orders were for Vicodin 5/325 milligrams (mg) four times a day and Vicodin 5/325 mg one tablet as needed (prn) for breakthrough pain. The physician then ordered two tablets of Vicodin 5/325 mg four times a day. Review of the November 2008 medication administration record (MAR) showed neither the order for one tablet of Vicodin 5/325 mg four times daily (scheduled) nor the prn dose were discontinued on 11/6/08. Instead, the number "1" was crossed out on the scheduled doses of Vicodin and the number "2" was written below it; the date of the change was not indicated. Although it was not clear when the order was changed or whether one or two tablets had been given, staff continued to sign out at that location on the MAR for the entire month. Furthermore, one nurse continued to sign out for the prn dose. Although review of the narcotic record showed the resident only received two tablets of Vicodin four times daily, the MAR and the signatures were incorrect. On 12/9/08 at 5 PM, the director of nursing (DON) confirmed staff should have discontinued the old Vicodin orders	F 281 F 281	implementation and use of these cleaning schedules. 4 Cleaning Schedules will be turned in to the Housekeeping Supervisor weekly and reviewed by QA&A committee monthly. **TAG 281** The services provided or arranged by the facility meet professional standards of quality. 1. A. Resident # 73: The order for Vicodin has been clarified on the MAR. B. Resident # 70: The order for Amitiza was corrected on the MAR. 2. Residents currently residing in the facility are at potential risk. 3. Licensed nurses on all units will audit MAR's and TAR's with the month-end change, correcting any and all errors as needed. 4. A. The licensed nurses on South Wing were in-serviced on the correct process of changing orders on the MAR. 5. Unit Coordinators will audit all telephone orders to ensure proper transcription of orders on the MAR and TAR. 6. The DON or designee will monitor the 24 Hour Report daily. All physician orders will	1/7/09

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F 281	Continued From page 2 and made a different area for the new one. According to the 4th edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, nurses are responsible for verifying that the MAR is "accurate and up-to-date" and they are to "verify inaccurate documentation before giving medications." 2. According to the December 2008 recapitulation of physician's orders, resident #70 was to receive enough Amitiza 24 mcg capsules to equal 8 mg twice daily. Review of the December 2008 MAR showed the medication order was entered as written. To accomplish this, the facility would have to give the resident 666.6 capsules per day. Although this was an apparent error, no one had clarified the order. On 12/10/08 at 5:17 PM, the DON, the staff development coordinator, and the restorative nurse, all registered nurses, confirmed the order was an error and should have been clarified. Review of the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, revealed "If a written order is illegible or is questionable for any reason, the physician must be notified for clarification."	F 281	be reviewed to ensure they have been followed. Problems and trends will be reviewed by the QA&A committee for 3 months or until resolved.	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This Requirement is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to follow the plans of care for 2 (#73, #82) of 16 sample residents. The findings were:	F 282	**TAG F 282** The services provided or arranged by the facility are provided by qualified persons in accordance with each residents written plan of care. 1. A. Resident # 73: was assessed. The skin is intact with no redness, irritation or signs of breakdown. B. Resident # 82: was assessed. The skin is intact with no redness, irritation or signs of breakdown.	1/7/09

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F 282	Continued From page 3 1. According to the care plan, staff were to check resident #73 for urinary incontinence every two hours and change him/her if necessary. Observation on 12/9/08 showed the resident was not checked or changed from 7:40 AM until 11 AM, a time period of 3 hours and 20 minutes. Interview with certified nurses aide (CNA) #5 confirmed she had changed the resident just before 8 AM that day. That was the last time the resident was checked or changed as s/he was off the unit until 10:50 AM. Interview with CNA #3 on 12/11/08 at 9 AM revealed she thought the incontinence care plan was to check and change the resident upon arising and after meals. On 12/11/08 at 10:48 AM, registered nurse (RN) #2, who was responsible for developing the incontinence care plan, confirmed it was current and the resident was supposed to be toileted every two hours. 2. Observation of resident #82 on 12/9/08 from 8:10 AM through 11:30 AM (3 hours and 20 minutes) revealed the resident had not been toileted. Review of the resident's care plan revealed s/he was to be toileted every two hours and as needed. Interview with CNA #4 on 12/9/08 at 1:45 PM revealed she believed the resident's care plan called for toileting before or after meals, upon getting up in the morning, and at bedtime.	F 282	2. Residents currently residing in the facility are at potential risk. 3. A. The care plans of all residents with toileting or changing schedules have been audited to identify those whose schedules should be individualized and adapted. The care plans and schedules have been updated with the appropriate interventions. B. Toileting Schedules for all residents on a Toileting Program are posted on the front of the MAR and the Restorative Books on each Unit. 4. Nursing staff was in-serviced on 12/31/08 on care plans and toileting schedules and their appropriate implementation. 5. For the next 90 days the Restorative Nurse will conduct a random weekly audit of one resident on each wing on a Toileting Program to ensure that staff is adhering to those posted programs. Patterns and trends identified in the audits will be reviewed by the QA&A Committee monthly or until resolved.	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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 review	F 312	**TAG F 312** The facility ensures that a resident who is unable to carry out the activities of daily living receives the necessary services to maintain good nutrition, grooming, personal	1/7/09

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F 312	Continued From page 4 of policies and procedures, the facility failed to ensure staff provided incontinence care for 1 (#8) of 4 incontinent residents observed during the provision of perineal (incontinence) care. The findings were: Observation on 12/9/08 at 8:45 AM showed certified nurse aide (CNA) #7 assisted non-sample resident #8 into the bathroom. The resident had been incontinent of urine, and the CNA removed the wet, disposable brief before assisting the resident to the toilet. After the resident used the toilet, the CNA put a new brief on him/her, but did not provide perineal care. When questioned, the CNA removed the old brief from the trash can and confirmed it was wet. Interview with the staff development coordinator (SDC) on 12/10/08 at 5:25 PM revealed staff were expected to provide perineal care every time a resident's brief was changed, whether or not the resident had been incontinent. The SDC further stated this was what she taught all staff. Review of the facility's 2007 policy and procedure related to perineal care verified perineal care should be performed "after urination."	F 312	hygiene and oral hygiene. 1. Resident #8: was assessed. The skin is intact with no redness, irritation or signs of breakdown. The resident is receiving appropriate peri-care. 2. Residents currently residing in the facility are at potential risk. 3. The Staff Development Coordinator conducted an in-service for nursing staff on 12/31/08 regarding proper peri care techniques. 4. The Staff Development Coordinator will conduct periodic random audits of staff performing peri-care and report results to QA&A monthly.	
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:	F 315	**TAG F 315** The facility must ensure that a resident who enters the facility without a 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	1/7/09

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F 315	Continued From page 5 Based on observation, record review and staff interview, the facility failed to provide appropriate treatment and care to restore as much normal bladder function as possible for 2 (#82 and #84) of 16 sample residents. As a result of this failure, one resident had a urinary catheter that was not clinically or medically necessary, and one resident did not receive toileting assistance as needed. The findings were: Review of the 9/15/08 and 11/20/08 Minimum Data Set (MDS) assessments, 11/7/08 nurses' notes, and 11/14/08 social services' progress notes for resident #84 revealed s/he was transferred to the hospital on 10/31/08 without a urinary catheter, but returned to the facility on 11/7/08 with a urinary catheter. Observation on all days of the survey from 12/8 to 12/11/08 revealed the resident had a urinary catheter. Review of the November 2008 physician's orders and progress notes revealed no valid medical justification for continued use of the catheter and no attempts to remove it. Interview with RN #2 on 12/10/08 at 2:45 PM, revealed the resident's clinical condition did not warrant having a urinary catheter and the catheter should have been discontinued after the resident returned from the hospital. RN #2 said the resident's urinary catheter had not been discontinued because "it was overlooked" and staff had not reported it to the physician. 2. Review of the 1/18/08 annual Minimum Data Set (MDS) and 9/27/08 quarterly MDS assessments revealed resident #82 was coded for occasional incontinence. Review of the resident's care plan for urinary incontinence revealed s/he was to be toileted every two hours and as needed. Observation of resident on 12/9/08 from 8:10 AM through 11:30 PM (3 hours and 20 minutes) revealed s/he was not toileted	F 315	treatment and services to restore as much normal bladder function as possible. 1. A. Resident #84: The foley catheter has been removed. B. Resident # 82: was assessed. The skin is intact with no redness, irritation or signs of breakdown. 2. Residents currently residing in the facility are at potential risk. 3. A. The Restorative Nurse has conducted an audit of all other resident's with indwelling catheters to ensure that appropriate orders and diagnoses are in place. B. The care plans of all residents with toileting or changing schedules have been audited to identify those whose schedules should be individualized and adapted. The care plans and schedules have been updated with the appropriate interventions. C. Toileting Schedules for all residents on a Toileting Program are posted on the front of the MAR and the Restorative Books on each Unit. 4. Nursing staff was inserviced on 12/31/08 on care plans and toileting schedules and their appropriate implementation. 5. For the next 90 days, the	

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F 315	Continued From page 6 during that time period. Interview with CNA #4 on 12/10/08 at 1:45 PM confirmed the resident had been incontinent of urine which was noted by the CNA when providing personal care after the observation period had ended.	F 315	Restorative Nurse will conduct a random weekly audit of one resident on each wing on a Toileting Program to ensure that staff is adhering to those posted programs. Patterns and trends identified in the audits will be reviewed by the QA&A Committee monthly or until resolved.	
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION 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 ensure a safe environment for residents in the facility 's activities room. The findings were: Observation on 12/09/08 at 4:48 PM and then again on 12/11/08 at 2:30 PM revealed an electric range in the activities room. The range top consisted of four electrical elements for cooking. All four elements had individual control knobs. Interview with the DON on 12/11/08 at 2:30 PM revealed the range was used by residents for Activities of Daily Living (ADL) purposes. The DON also stated the electric current to the range was controlled by an easily reached, but unsecured, wall switch directly behind the range. The DON confirmed the wall switch should be secured in order to prevent the range from being turned on by residents when no staff were present. Observation on 12/09/08 at 4:48 PM and again on 12/11/08 at 2:30 PM revealed approximately	F 323	**F TAG 323** The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. 1. Residents currently residing in the facility are at potential risk. 2. A. The switch that controls the electric current to the range in the ADL Room has been replaced with a lock out switch. The key to this switch is secured in a desk in the ADL Room accessible to staff only. B. The Treatment Cart in the ADL Room is now secured by a padlock. Only the Restorative Nurse and Restorative Aides have access to the key. 3. Restorative Nurse will monitor for compliance for the next 90 days. 4. Any issues will be reported to the	1/7/09

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F 323	Continued From page 7 15 transparent drawers along one wall in the activities room. The drawers contained ADL materials and supplies. None of the drawers could be locked. Two of the drawers contained ten pairs of sharp and snub nosed scissors. Interview with the DON on 12/11/08 at 2:30 PM revealed the scissors should be secured in order to prevent residents from accessing the scissors when the area was unsupervised.	F 323	Quality Assurance Committee.	
F 371 SS=E	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 review of the 2005 Food Safety Code, the facility failed to ensure food was safe from contamination. The findings were: 1. Intermittent observation from 12/8/08 at 4:11 PM through 12/11/08 at 11:48 AM revealed ten No. 10 of food in the dry food storage area room. The cans were dented along the top and/or bottom seams. The involved items included. a.) Two cans of cut green beans. b.) One can of sliced carrots. C.) One can of sliced pears. d.) One can of sliced pineapples. The seam of one of the cans of green beans appeared to be leaking and a rusty stain was visible on the can.	F 371	**TAG F 371** 1/7/09 The facility will store, prepare, distribute and serve food under sanitary conditions. 1. A. All dented cans have been removed from the storage area and placed on the "dented can shelf" to be picked up by food service supplier. B. Spoiled cucumbers were immediately removed from the walk-in refrigerator and discarded. C. The door hinge and fire suppression pipes in the area of the convection oven and the ceiling vent in the dry storage room were cleaned. 2. Residents currently residing in the facility are at potential risk. 3. Maintenance and Cleaning Schedules for the kitchen have been changed to include the convection oven, fire suppression pipes, walk-in refrigerator and ceiling vents.	

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F 371	Continued From page 8 Interview with the kitchen manager on 12/11/08 at 11:48 AM revealed dents at the ridge lines of cans represented a possible source of contamination of the can's contents, and the cans should be returned to the distributor. The manager stated the facility had no written policy to this effect. According to Food Code 2005, U.S. Public Health Service 3-202.15, Package Integrity, "Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants." 2. Observation on 12/8/08 at 4:11 PM through 12/10/08 at 4:49 PM revealed a box in the walk-in refrigerator contained 10 cucumbers. Each cucumber was noted to have some degree of mold on it. Interview with the kitchen manager on 12/11/08 at 11:48 AM revealed the dirt and mold represented a possible source of food contamination during food storage and preparation. 3. Intermittent observation from 12/08/08 at 4:11 PM through 12/11/08 at 11:48 AM revealed the door hinge underneath the convection/conduction oven in the kitchen was coated in a layer of lint and grime. Also, the fire suppression system pipes over the same oven were encrusted with lint and grime. In addition, the ceiling air vent in the dry food storage room was coated in dust and lint.	F 371	4. Dietary Manager conducted an in-service for dietary staff by on 12/31/08 regarding proper maintenance of these areas and completion of the cleaning schedules and audits. 5. The Dietary Manager will audit all cleaning schedules and conduct inspections of all areas weekly. Noted problems will be addressed immediately. Patterns and trends will be reviewed with the IDT for further recommendations and reviewed at the QA&A Committee meeting monthly for 90 days or until resolved.	
F 386 SS=E	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal	F 386	**TAG F 386** The facility will ensure that the physician will review the resident's total program of care, including medication and treatments, at each visit required by paragraph "c" of this section; write, sign, and	2/4/09

Accepted per phone call w/ Dave Conway VHA on 2/9/09 @ 11:00 AM

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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 386	Continued From page 9 polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This Requirement is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to ensure each resident's physician signed and dated verbal orders or progress notes as required by the regulation for 5 (#20, #70, #74, #84, #86) of 16 sample residents. The findings were: 1. Medical record review showed resident #20 was admitted on 10/7/08. Review of physician progress notes and nursing documentation showed the physician saw the resident on 10/28/08. However, the typed note did not indicate the date it was transcribed, was not authenticated, and the physician's signature was not dated or timed. No other progress note had been entered in the record as of 12/10/08. The director of health information management (HIM) was interviewed on 12/10/08 at 1:40 PM. The interview did not reveal that there was any additional documentation to review. 2. Review of the medical record for resident #74 revealed the last documented physician's progress note was dated 7/14/08. Interview with the director of HIM on 12/10/08 at 11 AM established that the physician did not dictate progress notes, but hand wrote his own. In addition, the resident had five unsigned verbal orders entered in the medical record since 8/6/08. One order referred to an 8/6/08 faxed order for the resident. However, the faxed order on 8/6/08 for resident #74 was also unsigned. The unsigned orders included an order on 8/7/08 to increase	F 386	date progress notes at each visit; and sign and date all orders with exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician approved facility policy after an assessment for contra-indications. 1. Resident # 20: The physician's note from 11/20/08 has been transcribed, signed by the physician and placed in chart. 2. Resident #74: The physician's orders and faxes have been signed and placed in the resident's record. 3. Resident # 70: The resident's progress notes have been signed by the physician and placed in the resident's record. 4. Resident #86: The resident's progress notes have been signed by the physician and placed in the resident's record. 5. Resident #84: The resident's progress notes have been signed by the physician and placed in the resident's record. 6. Residents currently residing in the facility are at potential risk. 7. The Health Information Manager will review all residents to ensure physician visits are timely Records	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535026	A. BUILDING _____ B. WING _____	C 12/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 82801

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F 386	Continued From page 10 the dosage of Seroquel (an antipsychotic medication) to 50 milligrams (mg) at bedtime, an order on 8/28/08 to start Zoloft 50 mg each morning for depression, an order on 10/29/08 to increase the dose of Zoloft to 75 mg each morning, and an order on 11/6/08 for Septra DS to be given twice a day for seven days as a result of an unsigned 11/4/08 order for a urine culture & sensitivity. Interview with the director of health information management (HIM) on 12/10/08 at 2:40 PM confirmed the physician had not signed the five verbal orders for resident #74. According to the director of nursing (DON) on 12/11/08 at 12:25 PM, the facility did not have a policy on timeliness of physician orders. 3. Review of the medical record showed resident #70 was admitted on 12/21/07. Review of physician progress notes from 1/24/08 through 10/25/08 showed they were not signed by the physician. On 12/10/08 at 1:40 PM the director of HIM confirmed the notes lacked the physician's signature. 4. Review of the medical record for resident #86 revealed the 2008 physician's progress notes, dated 3/20, 4/30, 5/23, 7/31, 8/28, 9/19 and 10/28, were not signed by the physician. 5. Review of the medical record for resident #84 revealed the most current physician's progress notes dated 8/29, 9/18 and 10/28/08 were not signed by the physician. 6. Interview with the DON on 12/11/08 at 12:45 PM revealed staff did not place the transcribed progress notes in the medical record in a timely manner and the progress notes were not available for the physician to sign during visits to	F 386	and documented appropriately. 8. The Health Information Manager will develop a tickler system for physician visits and will notify the DON of any physician who has not completed a visit and provided documentation of the visit in a timely manner. Health Information Manager will monitor physician visits to ensure the facility if receiving appropriate documentation. Noted problems will be reviewed with the QA&A Committee, to include the Medical Director. 9. The Health Information Manager will sign and indicate the date each dictated progress note is transcribed. 10. Accredited physicians will be notified by mail of the requirement that they include the date when they sign the transcribed notes. 11. The Facility Administrator and the the Medical Director will contact any physicians not fulfilling the dating requirement for the transcribed notes. Any issues will be reported to QA&A for review and follow up.	

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F 386	Continued From page 11 the facility.	F 386		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW 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, staff interview, and interview with the consulting pharmacist, the facility failed to ensure irregularities were reported as required for 1 (#52) of 16 sample residents. The findings were: Review of physician's orders and the medication administration records revealed resident #52 had received Zyprexa (an antipsychotic medication) 7.5 milligrams daily since 5/29/07. Review of the pharmacist's monthly medication regimen reviews from 6/13/07 through 12/8/08 showed the pharmacist had not documented the extended use of the medication at the same dose as an irregularity. The DON reviewed the medical record on 12/11/08 at 8:30 AM and confirmed the absence of documentation. On 12/11/08 at 9:10 AM the consulting pharmacist stated he was aware the lengthy use of the particular medication at the same dose was considered an irregularity. However, he confirmed he did not report it.	F 428	**TAG F 428** 1/7/09 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. 1. The Registered Pharmacist has completed an audit of all residents on psycho-active medications, preparing a checklist which has been shared with the consulting pharmacist. 2. Residents currently residing in the facility are at potential risk. 3. The Director of Nursing and the Registered Pharmacist will meet monthly and review this list. 4. The Consulting Pharmacist will continually monitor residents' medication regimen for irregularities. 5. The Director of Nursing will report the findings to QA &A Committee monthly.	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION	F 444		

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F 444	Continued From page 12 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 random observations, staff interview, and review of policies and procedures, the facility failed to ensure staff performed hand hygiene procedures as indicated by accepted professional standards. Specifically, before providing further personal care, one direct care staff person failed to complete hand hygiene after changing an incontinence brief for non-sample resident #8. The findings were: Observation on 12/9/08 at 8:45 AM showed CNA #7 assisted non-sample resident #8 into the bathroom. The resident had been incontinent of urine, and the CNA removed the old incontinence brief before assisting him/her to the toilet. After the resident used the toilet, the CNA put a new brief on the resident, but she did not change her gloves and perform hand hygiene. Wearing the same contaminated gloves, the CNA then put toothpaste on the resident's toothbrush and the resident used it to brush his/her teeth. The CNA also washed the resident's face and hands and brushed and smoothed his/her hair into place before removing the gloves and washing her hands. On 12/10/08 at 5:25 PM the staff development coordinator stated all staff were taught to change their gloves after completing perineal care, and her expectation was that they would do so. Review of the facility's 2007 policy and procedure, "Using Gloves," revealed disposable gloves must be replaced as soon as practical "when contaminated." Further review	F 444	**TAG F 444** The facility requires staff to wash their hands after each direct contact for which hand washing is indicated by accepted professional practice. 1. Resident #8 was assessed. The skin was intact with no redness, irritation or breakdown. The resident displays no signs or symptoms of infection. 2. Residents currently residing in the facility are at potential risk. 3. The Staff Development Coordinator conducted an in-service for all staff on 12/31/08 regarding proper hand washing technique, peri care and glove use. 4. The Staff Development Coordinator conduct periodic random audits of staff performing hand-washing and peri-care and report results to QA&A monthly.	1/7/09

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F 444	Continued From page 13 showed hand hygiene should be done "after removing gloves. Gloves do not replace hand hygiene."	F 444		