POC accepted 12/22/08. Janeece Corder, LPN/C

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

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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
	535039	A. BUILDING _____ B. WING _____	11/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET 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 157 SS=G	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the physician and family were notified in a timely manner regarding a change in condition for one (#60) of	F 157	F157 NOTIFICATION OF CHANGES The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12 (a). 1) The facility is calling resident #60's family and physician weekly to update them on the status of the resident's wound. The Director of Nursing (DON) will audit to ensure that this is occurring. 2) The DON and/or the Unit Managers will audit charts of residents that have pressure sores to ensure that families, residents and physicians are notified appropriately and timely. 3) All nursing staff will be re-educated regarding the notification of residents, families and physicians regarding any changes mentioned in §483.10 (b) (11) including pressure sores. The DON will conduct this education on or before December 17, 2008. 4) The DON and/or Staff Development Coordinator (SDC) will conduct weekly	12/17/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia L. Rankin RN, CHSE NHA	Executive Director	12-5-08

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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POC accepted. Message left for Cynthia Rankin, R.N. on 12/22/08 @ 10:30 a.m.

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DEC 08 2008

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 890F11 Facility ID: WY0035 If continuation sheet Page 1 of 19

Janeece Corder, LPN/C

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Office of Healthcare Licensing and Surveys

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F 157	Continued From page 1 13 sample residents. The findings were: Review of the 6/5/08, the 8/6/08, the 8/20/08, and the 10/24/08 Braden skin assessment scale for resident #60 revealed s/he was a high risk for pressure sores. Review of the weekly skin assessments from 4/30/08 through 8/18/08 revealed the resident had no pressure sores. Review of the 5/30/08 nursing notes revealed there was a reddened area on the resident's right hip. Review of the nursing notes revealed that the reddened area (stage I) was open (stage II) on 6/23/08. The following concerns were identified: a. Review of the physician progress notes and the nursing notes revealed the physician was not notified of the pressure sore until 6/30/08 (31 days after the stage I was identified and 7 days after it became a stage II pressure sore). b. Review of the 7/9/08 nursing notes revealed the resident was started on antibiotics because the wound was infected. Further review of the nursing notes revealed the family was not notified the resident developed a pressure sore until 7/11/08 (42 days after the pressure sore was identified). By that time, the pressure sore had progressed to a stage II and was infected. c. Interview with the director of nursing (DON) on 11/6/08 at 8:45 AM, revealed she was unsure why the physician and family were not notified sooner.	F 157	audits of a sample of residents with pressure sores to ensure compliance. The audits will include resident #60. When non-compliance is noted there will be immediate education and corrective action to ensure ongoing compliance. 5) The results of the audits will be presented at the monthly Performance Improvement Meeting. Any trends or problems will be identified and acted upon. This will occur for a period of at least three months and until substantial compliance is met. F226 STAFF TREATMENT OF RESIDENTS The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1) An investigation of the bruises found on resident #28 was initiated on 115/08. Immediately following the completion of the investigation, education was given to nursing staff regarding the use of turn sheets and proper repositioning methods for obese residents. Therapy also provided this resident with a different wheelchair. Resident # 28 is being monitored for further bruising. 2) Nursing staff caring for resident # 28 were educated about the importance of reporting any bruises and following the facility policy regarding reporting bruising including, but not limited to reporting to the State Survey Agency any bruises of unknown etiology. Skin assessments will be checked weekly by the Unit Managers and/or Wound Nurse	12/17/08
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		

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F 226	Continued From page 2 by: Based on staff interview and medical record review, the facility failed to ensure an injury of unknown origin was investigated and reported for one (#28) of 13 sample residents. The findings were: Review of the 10/26/08 untimed nursing notes for resident #28 revealed the resident had several large bruises. There was a bruise located on the outer left leg which was purple, swollen, and approximately 4 inches by 5 inches in diameter. Another bruise was located on the same side of the leg that was approximately one and one half inches by one and one half inches, was swollen, and reddish in color. There was also a bruise on the right knee, the outer right thigh had three reddened areas, and there was a large purple area on the right hand and top of right thumb. Interview with the administrator, social services director, and the registered nurse (RN #1) who assessed the injury on 11/5/08 at 4:15 PM revealed there was no investigation completed on the cause of the bruises and the State Survey Agency was not notified of the unknown injury.	F 226	to ensure that there is a complete investigation of all bruises, and skin related incidents. 3) The DON will provide education to all nursing staff regarding the policy of investigating bruises of unknown origin to rule out possible mistreatment, neglect or abuse of residents. This education will occur on or before December 17, 2008. 4) The Executive Director will audit all investigations of occurrences at the daily incident management meeting to ensure that policy is being followed. When a problem is identified immediate education and/or corrective action will take place. 5) Results of the daily reviews will be reported at the monthly Performance Improvement Meeting, Any trends or problems will be identified and acted upon. This reporting will occur for at least three months and until substantial compliance has been achieved.	12/17/08
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272	F272 COMPREHENSIVE ASSESSMENTS The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity... using the RAI specified by the State. 1) A change of condition MDS was completed for resident #66 which included a comprehensive, accurate, standardized reproducible assessment of the resident's functional capacity. The Urinary Incontinence RAP summary was completed following the guidelines	12/17/08

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F 272	Continued From page 3 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a comprehensive assessment was completed in a variety of areas for two (#66, #71) of 18 sample residents. The findings were: 1. Review of the 9/6/08 Resident Assessment Protocol (RAP) summary for resident #66 revealed s/he triggered for comprehensive review of urinary incontinence. Review of the 9/6/08 RAP assessment revealed there were no causation or contributing factors in regard to why the resident was incontinent. Review revealed the assessment included only the diagnosis of Alzheimer's Disease with some periods of confusion. 2. Review of the 8/4/08 RAP summary for	F 272	1) in the RAI manual, Resident #71 no longer resides in the facility. 2) The DON or designee will audit all admission, change of condition and annual MDS's with Assessment Reference Dates beginning 12/1/08 to ensure that the RAP summaries meet the guideline as outlined in the RAI manual. 3) The MDS coordinator will receive education regarding the proper completion of RAP summaries as outlined in the RAI manual. The DON will conduct this education on or before December 17, 2008. 4) While conducting audits of RAP summaries, the DON or designee will identify any problems and immediately address any education and/or corrective action necessary. 5) The results of the audits will be presented at the monthly Performance Improvement Meeting for a period of at least three months and until substantial compliance is achieved. Any problems or trends will be identified and acted upon.	

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F 272	Continued From page 4 resident #71 revealed s/he triggered for comprehensive review of psychotropic drug use. Review of the 8/4/08 RAP assessment revealed no causative or contributing factors had been identified in regard to why the resident was on psychotropic medications (other than the diagnosis). 3. Interview with the Minimum Data Set coordinator on 11/6/08 at 10:55 AM verified the RAP summaries for the aforementioned residents were not comprehensive.	F 272	F281 COMPREHENSIVE CARE PLANS The services provided or arranged by the facility will meet professional standards of quality. 1) A clarification order has been obtained for resident #21 to discontinue Valtrex 1000 milligrams (mg) three times per day. There was a clarification order obtained for resident #28 to administer Namenda 5 mg twice daily. 2) The DON and/or Unit Managers will audit a sample of different residents weekly to ensure that current medication and treatment orders are correct and match the medication administration record (MAR). Physician progress notes will be reviewed as well to ensure that there are no "hidden" orders contained within. These weekly audits will include the medication orders for resident's #'s 21 and 28, 3) Licensed nurses will be re-educated regarding writing telephone orders and clarifying medication orders according to the Nursing Practice Act July 2005 and Administrative Rules and Regulations November 2003 for the Wyoming Board of Nursing. The DON will conduct this re-education on or before December 17, 2008, 4) The DON and/or Unit Managers will conduct weekly audits of medication orders as stated above. Any problems noted will result in immediate education and/or corrective action. 5) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of at least three months and until substantial	12/17/08
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 medical record review and staff interview, the facility failed to ensure staff maintained professional standards related to medication administration and medication orders for 2 (#21, #28) of 18 sample residents. The findings were: 1. Review of physician orders for resident #21 showed on 9/24/08 the physician wrote an order for Valtrex 1000 milligrams (mg) three times per day. Review of the medication administration record (MAR) showed the Valtrex was discontinued starting with the 6 PM dose on 10/7/08. However, further review of the physician orders showed no order to discontinue the medication. During an interview on 11/5/08 at 11:50 AM, the director of nursing (DON) stated the physician wrote a progress note stating the Valtrex was to be given for 7 days. However, the	F 281		

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F 281	Continued From page 5 DON stated physician progress notes are not orders, and nursing staff should have asked for a clarification order. According to the "Nursing Practice Act July 2005 and Administrative Rules and Regulations November 2003" for the Wyoming State Board of Nursing, nurses shall practice under the direction of a licensed physician. In addition, according to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, 2004, "If a written order is...questionable for any reason, the physician must be notified for clarification." 2. Review of a telephone order written and noted on 10/10/08 for resident #28 revealed an increase in Namenda (a medication to treat Alzheimer's disease) to 40 mg a day. However, review of the medication administration record (MAR) for October 2008 revealed the resident received 10 mg of Namenda twice a day (total of 20 mg) throughout the month. Interview with the director of nurses (DON) on 11/6/08 at 4 PM revealed the order for Namenda should have been clarified. Interview on 11/6/08 at 8:20 AM with the pharmacist revealed he had faxed the physician on 10/15/08 in which he voiced his concern about the increased dose and the resident's creatine levels, but had not heard back from the physician. Both the DON and the pharmacist confirmed the most recent dose order for the Namenda was 40 mg a day, but the resident was receiving 10 mg two times a day. Review of the Wyoming Nurse Practice Act of July 2005, pages 3-6 revealed nurses function under the direction of physicians.	F 281	5) compliance is achieved. Any problems or trends will be identified and acted upon.	
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	F 282		

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F 282	Continued From page 6 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure care plans were followed for 3 (#27, #28 and #60) of 13 open sample residents. The findings were: 1. Review of the 8/5/08, the 8/6/08, the 8/20/08, and the 10/24/08 Braden skin assessment scale for resident #60 revealed s/he was a high risk for pressure sores. Review of the 5/30/08 nursing notes revealed there was a reddened area over a bony prominence on the resident's right hip. Review of the nursing notes revealed the reddened area (stage I) was open (stage II) on 6/23/08. Review of the 10/30/08 pressure ulcer status record revealed the wound measured 0.7 centimeters (cm) by 0.2 cm. Review of the 10/30/08 care plan revealed the resident should have his/her position changed every hour when up in the chair. However, observation on 11/4/08 from 8 AM until 9:50 AM (1 hour 50 minutes) revealed the resident was seated at the breakfast table in the wheelchair and was not repositioned during that time. Interview with the certified nurse aide (CNA #2) on 11/6/08 at 9:30 AM revealed she was unaware the resident had any special treatment or required repositioning every one hour. 2. Refer to F315 regarding the failure to implement the toileting care plan for resident #28. 3. Refer to F315 for details regarding the failure to implement the toileting care plan for Resident	F 282	F282 COMPREHENSIVE CARE PLANS The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. 1) The CNA care guide for resident #60 will be updated to include frequency of the resident's repositioning. The CNA care guide for resident #28 will be updated to include his/her toileting schedule. The CNA care guide for resident #27 will be updated to include his/her toileting schedule. 2) CNA care guides for all residents will be updated and utilized by nurses and CNA's. The care guides will include interventions that are specific to resident needs and can be updated as often as necessary. 3) The DON will re-educate nursing staff regarding where to locate care plan and CNA care guide interventions and how to follow them. This education will occur on or before December 17, 2008. 4) The Wound Nurse or designee will audit CNA care guides for residents with pressure sores weekly to assure the accuracy of interventions. Nursing Administration will audit by observation, CNA compliance with care planned interventions weekly. 5) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of at least three months and until substantial compliance is achieved. Any problems or trends will be identified and acted upon.	12/17/08

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F 282	Continued From page 7 #27.	F 282	F314 PRESSURE SORES Based on the comprehensive assessment of a resident, the facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1) The alternating air pressure mattress and frequency of repositioning for Resident # 60 was placed on the resident's care guide used by the CNAs and nurses. The wound nurse will notify family and physician weekly regarding the status of # 60's current pressure sore. Resident #27 has intervention on the care plan for EZ boots. This intervention will be communicated to nursing staff by placing it on the care guide. The DON and/or wound nurse will check this resident's weekly skin assessment to ensure that it has been completed as assigned. 2) A weekly audit of the skin assessments of a random sample of residents will be conducted by the Staff Development Coordinator and/or Wound nurse to ensure that the skin assessments are completed as assigned. The sample of residents will be assessed by the SDC and/or Wound nurse to ensure that the skin assessments have been completed accurately. These weekly skin	12/17/08
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to implement pressure ulcer prevention practices were followed for two (#27, #60) of three sample residents who had pressure sores. As a result of this failure, both residents experienced avoidable declines in their skin condition. The findings were: 1. Review of the 5/30/08 annual, the 8/18/08 significant change, and the 10/30/08 quarterly Minimum Data Set assessment for resident #60 revealed s/he required extensive staff assistance with transfer and mobility. Review of the 6/5/08, the 8/6/08, the 8/20/08, and the 10/24/08 Braden skin assessment scale revealed s/he was a high risk for pressure sores. Review of the 10/30/08 pressure ulcer status record revealed the resident had a 0.7 centimeter (cm) by 0.2 cm by 1.8 cm pressure sore on the right buttocks. Observation on 11/4/08 at 9:50 AM revealed there was a wound VAC in place. a. Refer to F282 for details regarding the facility's failure to implement this residents's care	F 314		

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F 314	Continued From page 8 plan and the CNA's lack of awareness of the care required, related to this resident's pressure ulcer. b. Refer to F157 for details regarding the failure of this facility to notify the physician of this resident's pressure ulcer at the earliest stage in order to minimize the risk that this ulcer would deteriorate. c. Review of the pressure ulcer status report revealed that by 7/31/08, the wound had deteriorated to a stage IV and required surgical debridement and placement of a wound VAC. Review of the hospital discharge summary documented the resident was hospitalized for treatment of the wound from 7/30/08 through 8/6/08. During an interview with the director of nursing on 11/06/08 at 8:45 AM, she stated she was unsure why the physician had not bee notified sooner. 2. Record review for resident # 27 revealed a nurse's note dated 8/29/08 which stated the resident returned from the hospital after having hip surgery. The nursing service initial data collection tool dated 8/29/08 revealed the resident had a surgical incision on the left hip area and and had a stage II pressure ulcer on the right buttock. A pressure ulcer status record was initiated on 8/31/08 which identified a stage II pressure ulcer on the right buttock. There were no other pressure ulcer areas identified at that time. a. The care plan last updated on 9/18/08 which identified the resident had the potential for skin breakdown and called for weekly skin assessments. No specific measures to prevent pressure ulcers from developing on the heels were identified. b. Interview on 11/5/08 at 2 PM with the DON revealed weekly skin assessments for this resident could not be found.	F 314	assessment audits will include residents #60 and #27. 3) The DON will conduct re-education for nursing staff regarding following the facility wound care policy (including risk assessment, prevention and appropriate treatment) and immediate notification of family and physician. This re-education will be held on or before December 17, 2008. 4) While conducting the weekly audits any problems will be identified and immediate re-education and/or corrective action will take place. 5) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of three months and until substantial compliance is achieved.	

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F 314	Continued From page 9 c. A nurse's note dated 9/15/08 revealed the resident had developed a large blister on the left heel. The resident's treatment sheet for September 2008 revealed treatment for the blister on the left heel was initiated on 9/15/08. However, the resident's care plan did not include specific care for the resident's heel until 10/21/08. d. Interview on 11/5/08 at 2 PM with the DON revealed the pressure ulcer status record that was initiated on 8/31/08 would have all areas of pressure ulcers on the resident on this record, but she could not identify which specific documentation was for the pressure ulcer on the right buttock and which was for the left heel. e. A nurse's note dated 10/14/08 revealed the resident's left heel was necrotic. A physician's progress note date 10/23/08 revealed the left heel was unstageable and required surgical debridement. The DON confirmed this was done and a wound vac was placed on the wound. f. Observation on 11/5/08 at 1:45 PM of the dressing change to the resident's left heel revealed a stage IV pressure ulcer. Interview with licensed practical nurse #3 at that time confirmed the pressure ulcer was a stage IV. The 9th edition of "Nursing Assistant, A Nursing Process Approach", by Hegner, Acello, and Caldwell, copyright 2004, page 649 revealed, "...following hip surgery, the patient will be at high risk for pressure ulcer development, particularly on the heels."	F 314		
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	F 315		

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F 315	Continued From page 10 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 and medical record review, the facility failed to ensure 2 (#27 and #28) of 11 sample incontinent residents received appropriate services to restore as much bladder function as possible. The findings were: 1. Review of the significant change Minimum Data Set (MDS) assessment dated 9/9/08 for resident #27 revealed the resident was completely incontinent of urine. A bowel and bladder assessment completed on 6/5/08 for the resident revealed the resident was a candidate for toileting, timed or scheduled voiding. The resident's incontinence care plan last updated on 9/10/08 revealed a plan to promote toileting awareness, but did not include timed or scheduled voiding. Observation on 11/4/08 at 8:25 AM revealed the resident was in the dining room eating breakfast. When the resident was finished with breakfast, s/he was taken to the activity room without being prompted to use the bathroom. The resident remained in the activity room until 11:20 AM, when the resident was taken to the shower room for a shower. At that time, the resident's incontinent pad was noted to be soaked with urine. 2. The quarterly MDS assessment dated 10/20/08 for resident #28 revealed the resident was frequently incontinent of urine. Review of the	F 315	F315 URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility will 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. 1) Residents #27 and # 28 have care plan interventions for urinary incontinence with a toileting schedule. The Staff Development Coordinator and/or Unit Manager will observe care for residents #27 and #28 to ensure that CNAs and nurses are offering to toilet them according to their planned schedules. 2) A review of care plans for incontinent residents was completed to ensure that residents have appropriate care plan interventions to promote possible resident continence. 3) The DON will re-educate the nursing staff regarding providing appropriate treatment and services for residents to restore as much urinary continence as possible. This re-education will take place on or before December 17, 2008. 4) Weekly observation audits of a random sample of residents will be completed by the Staff Development Coordinator and/or Unit Managers to ensure compliance with toileting schedules. If any problems are noted immediate re-education and/or corrective action will	12/17/08

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F 315	Continued From page 11 incontinence care plan last updated on 10/24/08 for resident #28 revealed the resident was to be prompted to use the toilet upon arising, and before and after meals. Observation on 11/4/08 at 8:30 AM revealed the resident was in the dining room eating breakfast. When the resident finished breakfast, the resident was taken to the activity room without being prompted to use the bathroom. The resident stayed in the activity room until 11:45 AM, at which time s/he was taken to the shower room for a shower. At that time, the resident's incontinent pad was soaked with urine.	F 315	occur. These weekly audits will include residents #27 and #28. 5) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of three months and until substantial compliance is achieved. Any problems or trends will be acted upon.	
F 323 SS=D	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, staff and visitors by not replacing a broken plastic cover over a fire extinguisher housing. The findings were: Observation at various times throughout the survey from 11/3/08 at 4 PM to 11/6/08 at 9:48 AM revealed opposite the "North Forty" nurse's station was a fire extinguisher encasement mounted waist high in the wall. Inside the encasement was an ABC type fire extinguisher. The plastic cover of the encasement projected	F 323	F323 ACCIDENTS AND SUPERVISION The facility will 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. 1) The plastic cover of the fire extinguisher encasement on the "North Forty" hall has been replaced and no longer presents a safety hazard. 2) A member of the safety committee will check all fire extinguisher encasements monthly to ensure that they are intact and do not present any safety hazard. 3) An audit will be conducted about the condition of the fire extinguisher encasements to ensure there are no safety hazards. If any problems are noted, the maintenance director will be notified immediately and the covering will be replaced. 4) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of three months and until substantial compliance is achieved. Any problems or trends will be acted upon.	12/17/08

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F 323	Continued From page 12 4-inches into the hallway and was broken away near the bottom. Sharp edges were exposed to residents, staff, and visitors. Interview with the maintenance manager on 11/6/08 at 9:48 AM revealed he was aware the cover was damaged and represented a safety hazard. He also stated he was "in the process" of ordering a new cover.	F 323	F329 UNNECESSARY DRUGS Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and family and staff interviews, the facility failed to	F 329	1) The physician and consulting neurologist have reevaluated resident #21 and have concurred that the medication be increased due to persistent grinding of teeth as a manifestation of agitation. This behavior has been added to the resident's daily behavior monitoring sheet. 11/29/08 the physician for resident # 68 has ordered no further medication reduction attempts be made due to previous failed attempts. The use of Xanax as needed for resident #28 has been clarified for anxiety as evidenced by continual crying. The behavior of continual crying is being tracked on the behavior monitoring sheet. The effectiveness of the medication is being tracked on the back of the medication administration record. 2) An audit conducted by Nursing Administration of residents receiving Zyprexa, Risperdal, Seroquil, and	12/17/08

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F 329	Continued From page 13 ensure the drug regimen was free of unnecessary medications for 3 (#21, #28, #68) of 16 sample residents. The findings were: 1. Review of physician's orders showed that since re-admission on 5/7/08, resident #21 was ordered Zyprexa [antipsychotic] 2.5 mg. twice daily. The following concerns were identified: a. On 9/23/08 the physician increased the evening dose to 5 mg (for a total of 7.5 mg per day). However, review of physician's progress notes and nursing notes for the month of September 2008 showed no rationale for the increase in the Zyprexa. Review of the behavior monitoring sheet for September 2008 showed the resident did not exhibit any behaviors [striking out]. Review of the antipsychotic medication quarterly evaluation form dated 9/3/08 showed the resident had not exhibited any behaviors and was stable on the current dose [5 mg per day]. b. During an interview on 11/5/08 at 11:50 AM, the director of nursing (DON) stated nursing staff had not seen an increase in behaviors. She stated the Zyprexa was increased because the "family requested" an increase from the physician. c. During an interview on 11/5/08 at 8:15 PM, a family member stated he/she asked the physician to increase the Zyprexa because the resident was "chattering [his/her] teeth." Further review of the behavior monitoring sheets showed the behavior the resident exhibited to warrant the Zyprexa was "striking out," not chattering teeth. d. During an interview on 11/6/08 at 9:25 AM, the physician stated although the resident had some bruxism [grinding teeth], he wasn't aware that was the issue. He thought the dose was increased because of an increase in behaviors. 2. Review of the physician's orders for resident	F 329	Xanax was completed to ensure that behaviors indicate the necessary continued use of the medications. 3) Re-education of the Psychoactive Medication Committee will be conducted by the new consulting pharmacist by 12/17/08. 4) A quarterly review of all residents receiving psychoactive medications will be completed by the Psychoactive Medication Committee with recommendations presented to the physician of record for action or a risk/benefit statement for continued use of the monitored medication. 5) Results of the audits will be presented at the monthly Performance Improvement meeting for a period of three months and until substantial compliance is achieved. Any problems or trends will be acted upon.	

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F 329	Continued From page 14 #68 revealed s/he was prescribed Risperdal (antipsychotic) on 3/26/07 and Seroquel (antipsychotic) on 7/18/07. Review of the entire medical record revealed there was no gradual dose reduction attempted on either medication. In addition, review of the physician's progress notes revealed there was no evidence a gradual dose reduction attempt was contraindicated. Interview with the social services director and the DON on 11/6/08 at 8:45 AM revealed they were unable to provide any information as to why a gradual dose reduction was not attempted for over one year. 3. Review of physician's orders for resident #28 revealed an order on 5/7/08 for Xanax 0.25 mg (an antianxiety medication) three times a day as needed. The following concerns were noted: a. The physician's did not write any rationale for the medication. b. A physician progress note on 5/3/08 stated the resident was much more at ease, which was repeated in a 6/13/08 physician's progress note, but there was no mention of the need for Xanax. c. A pharmacy review note dated 5/27/08 confirmed the Xanax order, but, again, there was no rationale listed for the medication. d. The behavior monitoring sheets for September and October 2008 indicated the Xanax was for paranoid behaviors and continuous crying. The medication administration records (MAR) for September and October 2008 revealed the resident was given Xanax 19 times in those two months, but only twice was it documented as being given for crying. The other 17 times there was no reason noted for why the Xanax was given.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be	F 428		

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F 428	Continued From page 15 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the pharmacist reported potential irregularities in the drug regimen to the physician for 2 (#21, #68) of 16 sample residents. The findings were: 1. Review of physician's orders showed that since re-admission on 5/7/08, resident #21 was ordered Zyprexa [antipsychotic] 2.5 milligrams (mg) twice per day. On 9/23/08 the physician increased the evening dose to 5 mg (for a total of 7.5 mg per day). However, review of physician's progress notes and nursing notes for the month of September 2008 showed no rationale for the increase in the Zyprexa. Review of the behavior monitoring sheet for September 2008 showed the resident did not exhibit any behaviors [striking out]. Review of the antipsychotic medication quarterly evaluation form dated 9/3/08 showed the resident had not exhibited any behaviors and was stable on the current dose [5 mg per day]. During an interview on 11/5/08 at 11:50 AM, the director of nursing (DON) stated nursing staff had not seen an increase in behaviors. She stated the Zyprexa was increased because the family requested an increase from the physician. The	F 428	F428 DRUG REGIMEN REVIEW The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist. The pharmacist will report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. 1) The facility is actively persuing a new pharmacy contract with Emmisary Pharmacy. This contract is expected to be finalized before 12/21/08. 2) Upon acceptance of the pharmacy contract, the new consulting pharmacist will complete a facility audit of all resident medications. The results of this audit will be presented to physicians for follow up. 3) Licensed staff will be re-educated on the consulting pharmacists reports and their responsibility related to following up with physicians in a timely manner. The DON will conduct this education on or before December 17, 2008. 4) The pharmacist's recommendations with physician responses will be given to the DON by the licensed nurses monthly for review. 5) The results of the pharmacist's recommendations and physicians' responses will be presented quarterly at the Performance Improvement Meeting by the consulting pharmacist. Any problems or trends will be acted upon.	12/17/08

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F 428	Continued From page 16 following concerns were identified regarding the required drug regimen review: a. Review of the pharmacist's drug regimen review for the month of October 2008 showed the pharmacist noted the Zyprexa dose had been increased. However, the pharmacist did not identify the lack of evidence supporting a dosage increase of the Zyprexa as a potential irregularity. b. During an interview on 11/6/08 at 8:15 AM, the pharmacist stated he didn't know why the Zyprexa dose was increased. He stated since he's not that close to the residents, he leaves it up to nursing to decide if the medications are appropriate. The pharmacist further stated he was not involved in the quarterly reviews of the psychotropic medications. 2. Review of the physician's orders for resident #68 revealed s/he was prescribed Risperdal (antipsychotic) on 3/26/07 and Seroquel (antipsychotic) on 7/18/07. Review of the entire medical record revealed there was no gradual dose reduction attempted on either medication. In addition, review of the physician's progress notes revealed there was no evidence a dose reduction attempt was contraindicated. Interview with the social services director and the director of nursing on 11/6/08 at 8:45 AM revealed they were unable to provide any information on why a gradual dose reduction was not attempted. Review of the pharmacy review from 6/17/07 through 10/8/08 revealed the pharmacist did not identify the Risperdal and lack of a gradual dose reduction attempt as a possible irregularity. Further review of the pharmacy report revealed the pharmacist had not identified the Seroquel as a possible irregularity since 9/11/07 (over one year ago). During an interview with the pharmacist on 11/6/08 at 8:20 AM, he stated he usually left decisions about gradual dose reductions and	F 428		

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F 428	Continued From page 17 changes up to the nursing staff because he did not know the residents very well.	F 428		
F 465 SS=E	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe and clean environment for facility staff by not cleaning four ceiling air vents. The findings were: Ceiling air vents were not cleaned in the following areas: 1. Observation on 11/5/08 at 9:11 AM revealed the ceiling air vent in the medication room directly behind the main nurse' s station was encased in a thick layer of dirt and dust. The medication cart was located directly beneath the air vent. Interview with licensed practical nurse (LPN) #4 at that time revealed the vent was significantly dirty and had probably not been cleaned in quite a awhile. 2. Observation on 11/4/08 at 3:20 PM revealed the ceiling air vent in the oxygen store room was coated in dust. 3. Observation on 11/5/08 at 4:25 PM revealed the ceiling air vent over the ice machine in the clean utility room was coated with dirt and dust. 4. Observation on 11/4/08 at 8:34 AM revealed	F 465	F465 OTHER ENVIRONMENTAL CONDITIONS The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1) Ceiling air vents in the Central Station Medication room, oxygen store room, over the ice machine in the clean utility room and in the clean laundry room have been cleaned. 2) All ceiling vents are on a monthly schedule to be cleaned. 3) The Environmental Services Director will check the cleanliness of all vents on a weekly basis. This audit will be completed weekly and will include all the ceiling air vents in the facility. Any problem noted will result in immediate re-education and/or corrective action. 4) The Environmental Services Director will re-educate the housekeeping staff regarding how to clean the ceiling air vents and this task will be added to their cleaning schedule. This education will take place on or before December 17, 2008. 5) The results of these audits will be presented at the monthly Performance Improvement Meeting for a period of three months and until substantial compliance is achieved. Any problems or trends will be acted upon.	12/17/08

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F 465	Continued From page 18 the ceiling air vent in the clean laundry room was covered in dirt and lint. The vent was directly over a washing machine. Interview with the housekeeping manager on 11/6/06 at 8:48 AM confirmed the above identified ceiling air vents were dirty and needed to be cleaned.	F 465		