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F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy review and staff/resident interviews, the interdisciplinary team (IDT) failed to determine if self-administration of medications was a safe practice for 1 of one sample residents (#3) who self medicated. The findings were: 1. During initial tour observations on 6/13/11 resident #3 was observed in his/her room. Containers of Tums, Vicks and Nystatin were noted on the bedside table. 2. The resident indicated he/she takes these medications when he/she feels it is needed. 3. The medication nurse for the resident indicated on 6/13/11 the resident self-administers these medications. 4. Review of the facility policy titled "Administering Medications" indicated residents could only self-administer medications if the attending physician in conjunction with the Interdisciplinary Care Planning Team had determined the resident had the decision-making capacity to do so safely. 5. Review of the resident's medical record	F 176	**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 violation has occurred. The following is to be considered our Credible Allegation of compliance.** **F 176** X 1. Resident #3 has been evaluated for Self-Administration of Tums, Vicks, and Nystatin. Nystatin has been removed from the resident's room per physician's order. The self administration assessment has been completed and reviewed by the Interdisciplinary Team. 2. Resident rooms will be inspected for medications at the bedside. Self Administration assessments will be completed as needed. 3. Nursing staff will be inserviced on Self Administration policies and performing self administration assessments. Residents and families of residents will be educated about facility policies for medication at the bedside. Random monthly inspections will be done by the Social Service Designee in conjunction with the resident for medications kept at the bedside. If	X 07/22/11 X

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Donna Schultz | TITLE: X Administrator X | (X6) DATE: 7/01/2011

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

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F 176	Continued From page 1 showed no evidence of an evaluation of the resident's ability to self-administer these medications. 6. In an interview with the Director on Nursing on 6/14/11 at approximately 12:30 PM, she indicated the facility had a process for evaluating self administration of medications but was unable to provide documentation to show this resident had been evaluated by the IDT (including the attending physician) for self administration of these three medications.	F 176	unauthorized medications are found, the physician will be contacted and a self administration of medication assessment will be completed. 4. Results of monthly room inspections will be reviewed by the Quality Assurance Committee each month for continued compliance and will direct further corrective action as needed.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of five personnel files for newly hired staff and review of abuse/neglect policies and procedures, the facility failed to ensure five of five staff (staff A through E) reviewed had received orientation training on abuse and neglect. All five employees were assigned to and provided direct resident care. The findings were: 1. Review of the facility policies regarding abuse and neglect indicated the facility would provide in-service education regarding abuse/neglect upon initial orientation and annually. 2. In a staff interview with the social service staff	F 226	**F226** 1. The facility provides training on Abuse/neglect prevention upon initial orientation, before first assignment. Employees A, B and D received further training on Abuse/Neglect Prevention by the Social Service Designee on June 16, 2011. 2. Personnel files will be audited to ascertain that each staff member has received Abuse/Neglect Prevention training. 3. Department Managers with hiring responsibilities will be inserviced on training responsibilities for new	07/22-2011

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F 226	Continued From page 2 F on 6/15/11 at approximately 10 AM, she indicated the orientation of new employees was conducted monthly but had been cancelled in May 2011 due to the state survey. She indicated the form titled "Orientation Checklist" would be completed when the employee had finished the orientation. She indicated the staff had been given an abbreviated policy regarding abuse but confirmed the staff had not had the full training on abuse. 3. Review of the list of recent hires and the personnel files on staff members A through E showed no evidence (Orientation Checklist) of an orientation in-service on abuse/neglect for these staff members. a. Employee A had been hired 2/10/11, over four months prior to the survey but had no evidence of abuse/neglect training. b. Employee B had been hired 3/10/11, over three months prior to the survey but had no evidence of abuse/neglect training. c. Employee C had been hired 3/12/11. Her file showed orientation abuse training did not occur until 5/13/11 two months after her date of hire. d. Employee D had been hired 4/1/11. Her file showed orientation abuse training did not occur until 5/12/11, one and a half months after her date of hire. e. Employee E had been hired 4/22/11, three weeks before the survey, but had no evidence of abuse/neglect training.	F 226	employees before first assignment. Training documentation will be reviewed by the Administrator or designee before a new employee receives first assignment. Personnel files for new employees will be audited each month by the Business Office. Incomplete files will be given to the Administrator for follow-up. 4. Personnel file audits of training documentation will be reviewed by the Quality Assurance Committee each month for continued compliance and will direct corrective action as needed.	
F 253	483.15(h)(2) HOUSEKEEPING &	F 253	F 253	

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F 253 SS=D	Continued From page 3 MAINTENANCE SERVICES 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 and interview, the facility failed to ensure the carpet in the physical therapy room was maintained in good repair for 5 of 5 days of the survey (6/13-17/11). 1. Observation was made of the Physical Therapy area during the initial tour conducted of the facility at 3:30 PM on 6/13/11. The carpeting in the mat room and exercise room was heavily stained with multiple large black spots and appeared to be soiled in general. 2. During an interview on 6/15/11 at 9:15AM, physical therapist J stated the carpet had large black grease spots for two weeks that she had worked. 3. During an interview on 6/15/11 at 9:30 AM, the maintenance supervisor stated housekeeping had cleaned the carpet, however, the large black spots remained.	F 253	F253 continued 1. The carpet in the therapy room will be replaced. Carpet was ordered on June 16, 2011 and is scheduled for delivery on July 14, 2011. 2. Carpet through-out the facility will be inspected for intractable stains. Corrective action will be taken as needed. 3. All carpet will be inspected each month by the Housekeeping Supervisor for general cleanliness and stain removal. The Housekeeping Supervisor and maintenance Supervisor will be instructed on reporting intractable stains to the Administrator. Carpet will be replaced as needed. 4. Results of monthly carpet inspections will be reviewed by the Quality Assurance Committee each month for continued compliance and will direct further corrective action as needed.	7/22/2011
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance;	F 363	**F 363** 1. Resident #14 continues to receive a dysphasia diet which includes pureed meat and pureed bread. Bread is being pureed separately from other food items to assure a complete serving of bread per menu specifications.	07/22/2011

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F 363	Continued From page 4 and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of the menu, review of the facility policy, and staff interview, the facility failed to ensure the menu was followed during 3 of 3 meal observations for nine residents on puree and dysphasia diets. The findings were: 1. A current menu signed by the dietician on 5/10/2011 was received from the dietary aide H on 6/13/11 at 4:00 PM. a. The breakfast menu for 6/14/11 stated to serve pureed sausage for both a puree and dysphgia diet. b. The lunch menu for 6/14/11 stated to serve a whole wheat roll pureed for both a puree and dysphasia diet. Additionally the menu stated to serve baked ground chicken for dysphasia diet and puree baked chicken for the puree diet 2. Observation of the lunch tray line service on 6/14/11 from 12:10 PM to 12:40 PM revealed that the pureed wheat roll was not included on puree or dysphasia resident trays. 3. During an interview on 6/14/2011 at 12:10 PM, cook G stated that baked beans, chicken, and pears were pureed for the meal and four residents were on dysphasia and five residents on puree diets. The cook reported using only 3 slices of bread for the 5 servings instead of bread. The menu for five residents on the dysphasia diet required ground baked chicken.	F 363	2. The facility has determined that all residents on pureed and dysphasia diets are affected by accurately following the menu per amount of bread and texture of food, thus bread items being pureed separately will assure accurate portion for each resident. 3. Dietary staff will receive further inservice education on adherence to the menu, specifically portion control and texture of food to be served. The Dietary manager will observe meal service three times per week for adherence to correct texture and following the menu. Deviations from standard will be corrected immediately. 4. The findings of weekly meal service audits will be reviewed each month by the Quality Assurance Committee for continued compliance and will direct corrective action as needed.	

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Thus the 5 residents on the dysphsia diet were not served the whole wheat roll pureed according to the menu and no bread portion.

4. The lunch menu for 6/16/11stated to serve a dinner roll pureed for both a puree and dysphasia diet. Additionally the menu stated to serve baked ground ham for dysphasia diet and puree baked ham for the puree diet.

5. Observation of the ham puree preparation at 11:00 AM, cook G added 6 slices of ham, 2 slices of bread and 8 scoops of orange glaze for 5 puree servings. Six slices of bread was needed to follow the menu for the bread portion.

6. Observation of the lunch tray line service on 6/16/11 at 11:45 AM, the pureed wheat roll was not included on puree or dysphasia resident trays. The cook for the noon meal pureed baked beans, pears, steamed cabbage, and baked ham. The five residents on the dysphasia diet were not served the whole wheat roll according to the menu. The five servings of pureed ham included two slices of bread not five slices.

7. The facility policy, Pureed Diet - Level 1 NDD (National Dysphasia Diet) received on 6/16/11 showed bread pureed for the puree diet.

8. During a phone interview on 6/16/11 at 4:20 PM, the dietician stated if the bread is included in the meal in other food items, puree portions are one to one portion of bread item and should be combined to equal one to one.

9. Review of the medical record for sample

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F 363	Continued From page 6 resident #9 revealed the resident was identified as being at risk for aspiration due to difficulty swallowing and had a physician's order for a "Dysphagia" diet. a. Review of the menu for breakfast on 6/14/11 indicated residents on a Dysphagia diet were to receive pureed sausage. b. Observation of breakfast on 6/14/11 showed resident #9 was served ground sausage not the ordered pureed. c. The menus for 6/14/11 and 6/15/11 also required pureed rolls/bread which the resident was not served.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed - to ensure food preparation surfaces and dishware were sanitized for 2 of 2 days observed - to ensure dry and refrigerated food were stored to prevent contamination for 2 of 2 days	F 371	**F371** 1. Dishwasher wash temperatures are checked twice daily with heat sensitive test strips. Test strips show wash water is 150 degrees or higher. The lid has been affixed to the sanitizer test strip container. Two logs have been established: one for the 3 compartment sink, a second for the cleaning cloth solution New cutting boards are being used. The hand washing sinks have been cleaned Cereal bags have been closed An additional freezer was purchased for the storage of non-food items. The freezer has been cleaned. 2. To protect all residents, dishwasher wash temperatures will be tested twice daily, sanitizing solution will be tested with test strips, hand washing sinks will be used solely for hand washing, food packages will be properly closed and non-food items will be stored separately from food items.	**07/22/2011**

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F 371	Continued From page 7 observed, - to ensure 2 of 2 hand washing sinks were only used for hand washing 1. Dish Machine Sanitation a. Observation was made during a kitchen tour on 6/14/11 at 12:50 PM. The dish machine wash cycle temperature was 146 degrees Fahrenheit (F). b. The dish machine daily temperature log for June 2011 documented wash temperature and rinse temperature for the morning and afternoon. The wash temperature log had 5 days (6/3/11, 6/4/11, 6/11/11, 6/12/11, and 6/13/11) documented as below the expected 150 F. c. During an interview on 6/15/2011 at 9:45 AM, the dietary manager stated the dish machine temperature gauge was not accurate for about one month. The dishes are sanitized with hot water. Maintenance checked the temperature once a week with the maintenance thermometer. Dietary did not have a thermometer to check the dish machine water temperature. The maintenance supervisor reported a call was made last week to the service company and did not talk to maintenance at the service company. d. The surveyor requested a work order for the repair and date the service company was called. On 6/15 at 9:55 AM, the maintenance supervisor stated the service company was called again and the dish machine thermocouple probe was not working. A copy of a work order was not provided by the end of survey.	F 371	3. Dietary staff will be re-inserviced on proper sanitation techniques, documentation on logs, food storage and specific use of sinks. Dietary and non-dietary staff will be inserviced on refrigerator/freezer storage of food and non-food items. The Dietary manager or designee will observe three times each week the completed documentation of dishwasher temperature logs and sanitizer test strip logs. The Dietary manager or designee will inspect three times each week hand washing sinks, food storage, freezer storage and cutting board condition. Deviations from standard will be corrected immediately. 4. Results of observations and inspections of sinks, storage, freezers and cutting boards will be reviewed by the Quality Assurance Committee each month and will direct further corrective action as needed	

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2. Food preparation surface sanitation

a. Observations were made in the kitchen on 6/13/2011 at 3:45 PM to 4:00 PM and on 6/14/2011at 9:00 AM.

b. During the observations in the kitchen, the sanitizer test strips located on the shelf above the 3 compartment sink did not have a cover on the container.

c.On 6/14/2011 at 9:00 AM, dietary aide and cook reported the disinfectant solution from the three compartment sink was used to sanitize kitchen cloths.

d.The last recorded results of testing on the three compartment sink water temperature log and sanitizer test strip log was on April 30, 2011, six weeks prior to the survey.

e. During an interview on 6/15/2011 at 9:45 AM, the dietary manager stated the sanitizing solution is expected to measure 200 part per million on the test strips and there was not another log for test strip results.

f. According to the facility Kitchen Cloths policy (undated) received on 6/16/2011, cloths that are used for cleaning purposes should be stored in sanitizing solution between uses.

g. During observations in the kitchen, three white cutting boards were reddish brown and the surfaces were rough with numerous cuts.

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h. During an interview on 6/15/2011 at 9:45 AM, the dietary manager confirmed new cutting boards are needed when they have excessive cuts and are discolored. The cutting boards had not been replaced for three years.

3. Handwashing Sink

a. Observations were made in the kitchen on 6/13/11 at 3:45 PM to 4:00 PM and on 6/14/11at 9:00 AM. The hand washing sink located in the dish room had a red bucket sitting in the sink. The sink was dirty with a ring of black grime in the sink bowl. The kitchen hand washing sink located by the janitor closet was dirty with black grime in the sink bowl.

b. According to Food Code 2009, U.S. Food and Drug Administration, operation and maintenance chapter 5-205.11, "A handwashing sink may not be used for purposes other than handwashing."

c. During an interview on 6/15/2011 at 9:45 AM, the dietary manager comfirmed that a hand washing sink is only used for handwashing.

4. Food Storage

a. Observations were made in the kitchen on 6/13/11 at 3:45 PM to 4:00 PM and on 6/14/11at 9:00 AM.

b. Three bags of cereal were open in the dry storage area.

c. During an interview in the kitchen on 6/15/11 at

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F 371	Continued From page 10 9:45 AM, the dietary manager stated the cereal bags are stored properly by rolling the end and taping the bag. The three cereal bags were remained open in the storage room. d. Observation was made of the refrigerator located in the nutrition and ice room located near the nurse's station on 6/13/11 during the intial tour. The freezer portion of the refrigerator contained food for resident use and ice packs. The freezer was observed to be dirty with loose food particles and ice build up. e. During an interview on 6/15/11 at 9:45 AM, the dietary manager stated the nurses use the freezer in the ice room. The refrigerator freezer in the ice room still had 12 ice packs for residents one marked with a resident name. The freezer was still dirty and contained two buckets of ice cream.	F 371		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION 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 record review, and interview, the facility failed to ensure the maintenance of one of one hydrocollator (a heating unit for patient therapy packs) located in the therapy department. 1. During an interview on 6/15/2011 at 1:20 PM, the new therapy program manager stated the previous program manger was notified of the high	F 456	F456 1.The temperature of the hydrocollator was adjusted on 6/15/11 by the Maintenance Supervisor. The new Therapy manager was immediately trained on actions to take when hydrocollator temperature are outside acceptable range. 2. There are no other hydrocollator units in the facility. 3. Therapists who use the hydrocollator will be inserviced by the Maintenance Supervisor or Designee on the proper logging of temperatures and actions to	07/22/11

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F 456	Continued From page 11 hydrocollator temperatures. The temperature range is 160 to 165 F. No one knew how to adjust the temperature. A manufacturer manual was not available. Temperature readings are taken every day except weekends. 2. The temperature log for March 2011, April 2011, and June 2011 showed temperatures above the acceptable range for use of 160 to 165 F. The hydrocollator cleaning log for 2011did not identify a date cleaned for January, February, May or June. 3. During an interview on 6/15/20111 at 3:35 PM, the hydrocollator was not cleaned in May 2011 and not done yet for June 2011.	F 456	take when temperatures are outside expected range. The Maintenance Supervisor or Designee will review the hydrocollator temperature log each week and make adjustments to the control unit as needed. 4. The temperature log of the hydrocollator will be reviewed each month by the Safety/Quality Assurance Committee for continued compliance and will direct corrective action as needed.	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 interview, the facility failed to ensure kitchen ceiling tiles were sanitary for 4 of 5 days of the survey (6/13 to 16/2011). Observation was made of the kitchen during the initial tour on 6/13/11at 3:45 PM. The five ceiling tiles next to the kitchen hood and above the food preparation area were brown with grease stains covering each tile. During an interview on 6/14/11 at 11:20 AM,	F 465	**F465** 1. Five ceiling tiles adjacent to the kitchen hood were replaced on June 17, 2011. 2. All ceiling tiles in the kitchen and through-out the facility have been inspected. 3. The staff of the Maintenance and Housekeeping Department will be inserviced on the expected standard of the cosmetic appearance of ceiling tiles. The Housekeeping Supervisor or Designee will inspect all ceiling tiles each month. Ceiling tiles will be replaced as indicated. 4. The results of the monthly ceiling audit will be reviewed each month by the	07/22/2011

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F 465	Continued From page 12 cook # stated the ceiling tiles were brown from overspray during the cleaning of the kitchen hood. During an interview on 6/15/11 at 9:30 AM, the maintenance supervisor stated that the ceiling tiles in the kitchen needed replacing and would make a list of needed repairs. Observation was made in the kitchen on 6/16/11 at 11:00 AM, the ceiling tiles looked the same as the initial tour and had not been replaced	F 465	Quality Assurance Committee for continued compliance and will direct corrective action as needed.	
F 494 SS=C	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.	F 494	**F494** 1. Employee A was removed from the Nursing schedule on June 17, 2011. 2. The tenure of all Nursing Assistants has been calculated and so noted on the Nursing schedule to ascertain the 120 day parameter. 3. The Director of Nursing or Designee will track the tenure and progress of newly hired Nursing Assistants each month. The Director of Nursing will report each month to the Administrator on the certification status of each Nursing Assistant. The Nursing schedule will be adjusted as needed. 4. Monthly reports of Nursing Assistant status will be reviewed by the Quality Assurance Committee for continued compliance and will direct corrective action as needed.	07/22/2011

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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to ensure one of four employees (staff A) working in the facility as a nurse aide for more than 4 months had evidence of completion of a training and competency evaluation program, or a competency evaluation program approved by the state of Wyoming. Findings included:

1. Review of the personnel file for Employee A showed she had been hired on 2/10/11, over four months prior to the survey but had no evidence of training and competency evaluation program or a competency evaluation program.

2. Review of the current June 2011 staffing schedule for CNAs showed Employee A had worked from February 2011 through June 13 (survey entrance). This period is over the four months (120 days) specified in the regulations. The June schedule showed Employee A had worked on the night shift directly providing personal care to residents on June 13 and 14. She was also on the schedule to work through the end of June 2011.

3. Administrative staff confirmed this employee had taken the aide training but was still waiting to take the test for the competency evaluation.

F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514	F514	07/22/2011

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F 514	Continued From page 14 resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure clinical records were complete and accurate for five of twelve sample residents (#2, #3, #6, #8, and #9), and one supplemental sample resident (#13). Specifically the facility failed to ensure the documentation of the administration of ordered medications (resident #6) and failed to ensure the documentation of the effectiveness of PRN (as needed) medications in accordance with professional nursing standards. Residents often receive various types of medications, different doses and different combination of medications. Documentation of the effectiveness of PRN medications is important in the determination of the best medication (pain and anxiety/behavior) management regime for each resident. Findings include: PROFESSIONAL STANDARD: Standards for nursing practice for administration of medication provide, in pertinent part that: The physician is responsible for directing medical	F 514	F514 continued 1. The intravenous Vancomycin for resident #6 was discontinued per Physician order on 06/16/2011. The effectiveness of PRN (as needed) medication cannot be documented retroactively. 2. Residents with PRN medication orders will have effectiveness of administered doses documented on the Medication Administration Record (MAR) or Pain Flow record. 3. Licensed Nurses received additional inservice education on June 26, 2011 on the documentation requirements of medication administration. The Director of Nursing or designee will audit MARs and Pain Flow records each week for completed documentation. Issues identified will be addressed immediately. 4. Weekly audits of medication administration documentation will be reviewed by the Quality Assurance committee each month for continued compliance and direct further corrective action as needed.	

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treatment. Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients. Medications must be accurately administered and documented. See generally: Lippincott, Nursing Drug Guide, 1998 (Lippincott) and Perry & Potter, Clinical Nursing Skills & Techniques; 1998, (Perry & Potter).

Fundamentals of Nursing, Potter and Perry, Fourth Edition, 1997: "(Chapter 35, pp. 804): "PRN ORDERS: The physician may order a drug on a PRN basis (when a resident requires it). The nurse uses objective assessments, subjective assessments, and discretion in determining the client's need. Often the physician sets minimal intervals for the time of administration. This means that a drug cannot be given any more often than what is prescribed. Examples of PRN orders are 'morphine sulfate 2 mg SQ (subcutaneous) q 3 to 4 h (every 3 to 4 hours) PRN for incisional pain' and Maalox 30 ml PRN for gastric discomfort' When medications are administered, the nurse documents the assessment made and the time of drug administration. The nurse should make frequent evaluation of the effectiveness of the drug and record findings in the appropriate place. This may be on the medication administration record or in the client's medical record."

According to "Fundamentals of Nursing," by Harkreader & Hogan, 2nd Edition, (2000), page 411, it states, "After administering a medication to a client, chart it immediately on the Medication Administration Record (MAR) or computerized medical record. "

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1. Review of the facility policy titled "Administering Medications", indicated documentation should include date/time the medication was given, dosage, route, injection site if applicable, reason (resident complaint or symptom) for giving medications, effectiveness or result (with time of this observation) and the signature and title of the person giving the medication.

2. In an interview with the Director of Nursing on 6/16/11 at approximately 12:30 PM she indicated she had been working with the nursing staff regarding documentation of medication administration including PRN medications. She confirmed the effectiveness of PRN medications was to be documented on the back of the MAR or the Pain Flow Sheet.

3. In a 6/16/11 interview with the medication nurse passing medications on the 100 hall, she indicated information regarding PRN pain medications were charted on the Pain Flow Sheet and other PRN medications were recorded on the back of the MAR.

A. Documentation of Administration of Antibiotic:

Review of the medical record for sample resident #6 revealed the resident had an infection which was being treated with intravenous Vancomycin, an antibiotic, based on the blood levels of the medication. Review of the MAR for May 2001 and June 2011 showed no documentation the ordered medication was given on 5/11/11 (3:00 AM dose), 5/13/11 (3:00 AM dose), 5/14/11 (3:00 AM dose), 6/3/11 (8:00 PM dose), 6/7/11 (8:00 PM dose), 6/10/11 (8:00 PM dose), and 6/13/11 (8:00 PM

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dose).

B. Documentation of PRN Medications:

Review of the Pain Flow Sheet and the MAR from March 2011 through June 2011 revealed the effectiveness of PRN medications was not consistently documented as required by professional standards of practice and facility policy as indicated:

1. Review of the medical record for sample resident #6 revealed the resident was identified as having issues with frequent\chronic pain and anxiety. The resident had physician orders for medications for PRN use to manage breakthrough pain and anxiety. The PRN medications included Ativan, Hydrocodone, and Tylenol.

a. On 3/8/11, 3/10/11 (two doses), 3/11/11, 3/12/11 (two doses), 3/13/11 (two doses), 3/15/11, 3/16/11, 3/17/11, 3/18/11, 3/19/11 (two doses), 3/20/11, 3/21/11 (two doses), 3/22/11, 3/24/11, 3/25/11 (first dose), 3/26/11 (two doses), 3/27/11, 3/29/11, and 3/31/11 Tylenol was administered without documentation of reason for the medication (location of the pain) or effectiveness of the medication.

b. In April 2011 Tylenol was given on 4/5/11, 4/7/11, 4/9/11 (one dose), 4/10/11, 4/14/11, 4/15/11 (one dose), 4/17/11 (one dose), 4/21/11, 4/22/11, 4/23/11 (one dose), 4/25/11, 4/26/11 (two doses) and 4/27/11 without documentation of effectiveness of the medication.

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c. In May 2011 Tylenol was given on 5/3/11, 5/5/11 (two doses), 5/6/11, 5/7/11, 5/9/11, 5/10/11, 5/11/11, 5/13/11, 5/14/11 and 5/22/11 without documentation of effectiveness of the medication.

d. In May 2011 Hydrocodone (Lortab) was given on 5/5/11, 5/12/11 and 5/23/11 without documentation of the medication on the front of the MAR. The resident was given Hydrocodone on 5/6/11 (two doses), 5/7/11 (one dose), 5/8/11 and 5/11/11 (one dose) without the documentation of the effectiveness of the medication.

e. In June 2011 Tylenol was given on 6/2/11, 6/3/11, 6/4/11 (two doses), 6/5/11 and 6/13/11 (two doses) without documentation of effectiveness of the medication.

2. Review of the medical record for sample resident #3 revealed the resident was identified as having issues with frequent/chronic pain and bladder spasms. The resident had physician orders for regular pain medications and medications for PRN (as needed) use to manage breakthrough pain. The PRN medications included Tylenol and Ultram (Tramadol). The resident also had an order for Ditropan XL PRN for bladder spasms.

a. On 3/13/11, 3/18/11 and 3/19/11 Ultram was administered without documentation of effectiveness of the medication.

b. In April 2011 Ditropan was given on 4/3/11, 4/4/11, 4/5/11, 4/7/11, 4/9/11, 4/11/11, and 4/27/11 without documentation of effectiveness of

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the medication.

c. On 5/29/11 Tylenol was administered without documentation of effectiveness of the medication.

d. In June 2011 Tylenol was given on 6/5/11 and 6/12/11 without documentation of effectiveness of the medication.

3. Review of the medical record for sample resident #9 revealed the resident was identified as having issues with frequent and chronic pain. The resident had physician orders for medications for PRN use to manage breakthrough pain including Lortab, Tylenol and Naproxen.

a. On 3/5/11, 3/19/11 and 3/31/11 Lortab was administered without documentation of effectiveness of the medication.

b. In April 2011 Lortab was given on 4/18/11 and 4/21/11 without documentation of effectiveness of the medication.

c. In May 2011 Naproxen was administered on 5/23/11 and 5/24/11 without documentation of effectiveness of the medication. Lortab was given on 5/12 /11 and 5/24/11 without documentation of effectiveness of the medication.

4. Review of the medical record for sample resident #8 revealed the resident was identified as having issues with pain and disruptive behaviors. The resident had physician orders for Tylenol for PRN use to manage breakthrough pain and Ativan for agitation.

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F 514	Continued From page 20 a. On 6/5/11 and 6/13/11 (two doses) Tylenol was administered without documentation of effectiveness of the medication. b. Ativan was administered on 6/8/11 (two doses), 6/9/11, 6/10/11 (two doses), 6/11/11 (two doses), 6/12/11 (three doses), and 6/13/11 (three doses) without documentation of effectiveness of the medication. 5. A review of the medical record was completed for resident # 2 on 6/16/11. The MAR for March, April and May of 2011 revealed that the resident had been given PRN doses of oxycodone and tramadol for relief of pain. a. On 4/27/11, 4/29/11, 4/30/11, 5/1/11, and 5/3/11 oxycodone was administered without documentation of the effectiveness of the medication. b. On 3/12/11, 3/13/11, 3/19/11, 3/20/11, 4/13/11. 4/13/11, and 4/18/11, tramadol was administered without documentation of the effectiveness of the medication. 6. A review of the medical record was completed for supplemental resident # 13 on 6/16/11. The MAR for March of 2011 showed that the resident had been given PRN doses of Tylenol for relief of pain. a. On 3/6/11, 3/12/11, and 3/21/11 Tylenol was administered without documentation of the effectiveness of the medication.	F 514		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency	F 518	**F518**	**7/22/2011**

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F 518	Continued From page 21 procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of five personnel files for newly hired staff, the facility failed to ensure 1 of five staff (staff A) reviewed had received training on emergency procedures when he/she began to work in the facility. The findings were: 1. In a staff interview with the social service staff F on 6/15/11 she indicated the orientation of new employees was conducted monthly but had been cancelled in May 2011 due to the state survey. She indicated the form titled "Orientation Checklist" would be completed when the employee had finished the orientation. 2. Review of the list of recent hires and the personnel files on staff members A through E showed no evidence (Orientation Checklist) of training on emergency procedures. The facility was able to provide the survey team with evidence staff members B through E had attended training on emergency procedures. 3. The personnel file for Employee A indicated this staff member had been hired 2/10/11, over four months prior to the survey but had no evidence of emergency procedures training.	F 518	F 518 continued 1. Employee A was trained on Disaster Preparedness on June 17, 2011. 2. Personnel files will be audited to ascertain employees have completed disaster preparedness training. 3. Department managers with hiring responsibilities will be inserviced on training requirements for new employees before first assignment. Training documentation will be reviewed by the Administrator or designee before a new employee receives first assignment. Personnel files for new employees will be audited by the Business Office Manager or designee each month. 4. Personnel file audits of training documentation will be reviewed by the Quality Assurance Committee each month for continued compliance and will direct corrective action as needed.	07/22/2011