| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 535029 | A. BUILDING _____ B. WING _____ | C 05/14/2009 |

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| CROOK COUNTY MEDICAL SERVICES | BOX 517 SUNDANCE, WY 82729 |

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| F 250 SS=D | 483.15(g)(1) SOCIAL SERVICES<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident, family, staff and physician interviews, and review of medical records, the facility failed to involve social services in the care of 2 of 2 sample residents (#18, #22) who had expressed a wish to die. In addition, interventions were not implemented for resident #18 who demonstrated intermittent delusional thoughts. The findings were:<br><br>1. During an interview on 5/13/09 at 10 AM, resident #18 stated s/he was "ready to die" and was depressed because s/he could no longer work and was of "no use to anyone any more." At this time the resident also stated s/he was "embarrassed" to see other people. Interview with a family member on 5/13/09 at 4:35 PM revealed a good work ethic was very important to the resident. The family member also provided verbal evidence that the resident experienced some delusional thoughts.<br>Review of the physician's 3/13/09 history and physical examination showed the resident had expressed the wish to die and, in the past, wanted the physician to actively assist in this process. Review of the resident's medical record showed a social service note dated 4/27/09, which did not address the resident's wish to die or his/her delusional thinking. The only social services' documentation prior to this was the | F 250 | F250<br>The facility will provide needed medically related Social Services which will be appropriately documented in writing as part of the Interdisciplinary Team (IDT) process and in the resident record.<br><br>Medical Staff will be inserviced at the next scheduled meeting.<br><br>The new Social Services Worker has been inserviced regarding this requirement.<br><br>The IDT Team will review documentation and make determinations regarding the most appropriate intervention for the individual resident.<br><br>A quarterly chart review process will include social service resident documentation.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>RF 6/11/09 | 6/1/09<br><br>6/26/09<br><br>6/1/09 |

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

Doris Brown | CEO/Administrator | 6/05/2009

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

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| F 250 | Continued From page 1<br>admission assessment in 2005. On 5/13/09 at 11:15 AM, the current social service director (SSD) confirmed there had been no interventions developed or implemented by social services to address this patient's psychosocial issues. The SSD further stated she was just getting to know the resident and had not discussed these issues with him/her. The SSD stated she had discussed the resident's wish to die with the physician, but had not suggested nor instituted any interventions. Interview with the physician on 5/14/09 at 10:13 AM revealed the resident was still "angry" that s/he was living.<br><br>2. Review of the physician's 4/20/09 progress note showed resident #22 remained severely depressed with "passive suicidal ideation." Review of the 3/8/09 significant change Minimum Data Set (MDS) assessment showed the resident demonstrated mood and behavior symptoms indicative of depression. Review of the comprehensive assessment for that MDS showed the resident had displayed symptoms of depression since December of 2008, the anniversary month of his/her spouse's death. Review of the entire medical record showed no evidence social services was involved in the resident's care. Interview with the SSD on 5/13/09 at 11:30 AM confirmed the previous social worker's awareness of the resident's depression and the lack of interventions. | F 250 | F250 Continued:<br><br>Residents #18 and 22 mental status reviewed by Social Services, Licensed Certified Social Worker and attending physician. Recommendations on resident chart. Weekly monitoring for these residents will be conducted until improvement noted for the next month, then monthly until incorporated into the quarterly MDS review process. Documentation will be placed in resident chart. | |
| F 272 SS=E | 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. | F 272 | RF 6/11/09 | |

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| F 272 | Continued From page 2<br>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:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews, the facility to complete comprehensive assessments in multiple areas for 7 of 10 sample residents (#3, #7, #11, #18, #22, #26, #30). The findings were:<br><br>1. According to the 2/15/09 annual MDS assessment for resident #7, resident assessment protocol (RAP) summaries were cited as containing comprehensive assessment information for falls, activities of daily living (ADL) | F 272 | F272<br>The Charge Nurse or DON will insure completion of all required documentation for each resident. Inservices have been completed with Charge Nurse. 6/1/09<br><br>This standard is currently in place and will continue to be monitored.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>Restraint/Safety Assessment for each resident will include [redacted] comprehensive data completed on admission, quarterly, annually and as needed for resident care. 6/1/09<br><br>A new form has been instituted. TO ASSESS RESIDENT SAFETY AND SIDE RAIL USE.<br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>R.F. PER TELE C DON 6/11/09 1650 MDT | |



RF 6/11/09

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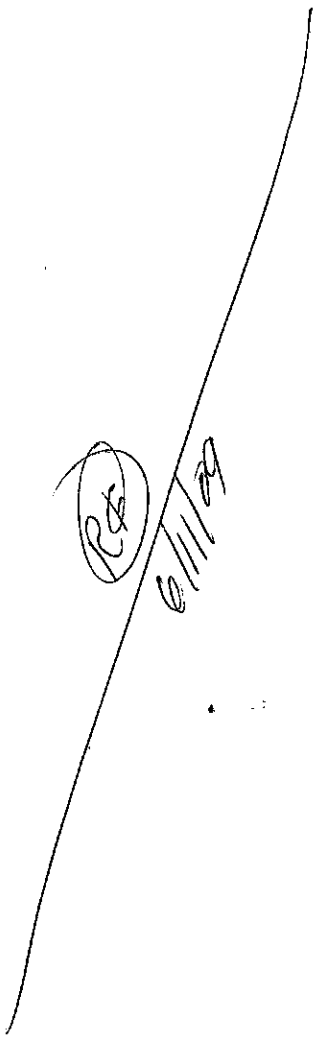
| F 272 | Continued From page 3<br>functional/rehabilitative potential, urinary incontinence, and psychotropic drug use. Review of the associated RAPs showed them to be incomplete, lacking a clear and complete assessment of contributing conditions and risk factors, impact on the resident's health, and decisions for proceeding to care planning.<br><br>2. The 3/23/09 annual MDS for resident #11 indicated comprehensive assessment information was contained in RAP summaries for bowel and bladder retraining and pain management. Review of these RAPs revealed them to be incomplete, lacking a comprehensive summary of the resident's condition and whether the resident's care plan would be modified based on the risk factors identified through the assessment process<br><br>3. According to the 3/17/09 annual MDS assessment, resident #18 required comprehensive assessments for cognitive loss, communication, mood state, behavioral symptoms, ADL functional/rehabilitation potential, urinary incontinence, activities, falls, nutritional status, and psychotropic drug use. Review of Section V showed all the comprehensive information was located in the RAP summaries. Review of those summaries showed the ones for cognitive loss, communication, mood state, and behavioral symptoms were blank, and the RAPS for activities and nutritional status were not current. Furthermore, the assessments for urinary incontinence, ADLs, falls, and psychotropic drugs were not comprehensive. They repeated the information already present on the MDS assessment. On 5/13/09 at 3:40 PM, the director of nursing (DON) confirmed the blank RAP summaries and that the completed RAP summaries were not comprehensive | F 272 |  | |

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| F 272 | Continued From page 4<br>assessments. On 5/14/09 at 9:15 AM, the dietary manager (DM) verified the nutrition RAP for that MDS assessment was not done.<br><br>4. Review of resident #3's medical record revealed an incomplete self-administration of medication assessment. The assessment tool, dated 4/3/09, failed to include an outcome to note if the resident was or was not found to be capable of self-administration of his/her medications, or what limits were in place to manage the resident's compliance and safety.<br><br>5. Review of the 3/8/09 significant change MDS assessment showed resident #22 required comprehensive assessments for ADL functional/rehabilitation potential, falls, and nutritional status. Review of Section V showed the comprehensive assessments were located in the RAP summaries. Review of that information revealed the assessments for psychotropic drugs and falls were not comprehensive. In addition, the assessment for nutritional status was not completed. On 5/13/09 at 3:40 PM, the DON confirmed the RAP summaries were not comprehensive assessments. On 5/14/09 at 9:15 AM, the dietary manager verified the nutrition RAP was not completed.<br><br>6. Review of a restraint safety assessment for resident #30 dated 2/15/09 revealed s/he had two 1/2 side rails on her/his bed. The safety assessment stated the side rails were used for mobility and transfers. However, staff had not assessed the safety of the side rails.<br><br>7. Review of the annual MDS for resident #26 dated 12/30/09 showed s/he was occasionally incontinent of bowel. Review of a bowel retraining | F 272 | RP 6/11/09 | |

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| F 272 | Continued From page 5<br>assessment for resident #26 dated 12/30/08 showed the assessment was incomplete; the evaluation for bowel retraining potential was blank. | F 272 | F281<br>#1. LPNs will function within their scope of practice. Inservices will be conducted. TO CLARIFY THE SCOPE OF PRACTICE FOR CNAs, LPNs AND RNs. RN will complete all assessment data. 6/19/09<br>All MDS forms will be completed in a [redacted] timely fashion.<br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings. | |
| F 281 SS=F | 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS<br>The services provided or arranged by the facility must meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and medical record review, the facility failed to ensure professional standards of practice were maintained related to completion of assessments, clarification of orders, and medication administration. Assessments for 9 of 10 sample residents (#3, #7, #9, #11, #18, #22, #26, #30, #33) were completed by non-professional staff. In addition, oxygen was not administered as ordered for resident #22; nor was the order clarified. Further, 2 of 4 opened insulin vials lacked the date they were opened. The findings were:<br>1. Review of Chapter III Wyoming State Board of Nursing's of the July 2005 "Nursing Practice Act" and November 2003 "Administrative Rules and Regulations" showed:<br>Section 3. Standards of Nursing Practice for the Licensed Practical Nurse (a) Standards related to the licensed practical nurse's contribution to the nursing process.<br>(1) The licensed practical nurse shall:<br>(A) Contribute to the nursing assessment by:<br>(I) Collecting, reporting and recording objective and subjective data in an accurate and | F 281 | R.F. PER TAG I DON 6/11/09, 1640 MDT.<br>6/11/09 | |

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| F 281 | Continued From page 6<br>timely manner. Data collection includes:<br>(1.) Observation about the condition or change in condition of the client;<br>(2.) Signs and symptoms of deviation from normal health status.<br><br>Medical record reviews revealed LPNs functioned outside this scope of practice in the following documented instances:<br>a. Review of required assessments for resident #3 revealed bowel and bladder retraining, self-administration of medications, and pain assessments were completed by a licensed practical nurse (LPN).<br>b. Review of required assessments for resident #7 revealed required assessments for falls, activities of daily living (ADL) functional/rehabilitative potential, urinary incontinence, and psychotropic drug use were completed by an LPN.<br>c. The 4/29/09 pain assessment for resident #9 was completed by an LPN.<br>d. Review of required assessments for resident #11 revealed bowel and bladder retraining, restraint safety, self-administration of medications, and pain assessments were completed by an LPN.<br>e. Review of required assessments for resident #18 related to urinary incontinence, psychotropic drug use, falls, and ADL functional/rehabilitation potential were completed by an LPN.<br>f. Review of required assessments for resident #22 related to urinary incontinence, psychotropic drug use, falls, dental care, and ADL functional/rehabilitation potential were completed by an LPN.<br>g. Review of required assessments for resident #26 showed urinary | F 281 | F281<br>#2. Registered Dietician has been inserviced regarding standards of practice.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>THE REGISTER DIETICIAN (RD) WILL BE RESPONSIBLE FOR COMPLETING ALL NUTRITION ASSESSMENTS IN AN ACCURATE AND TIMELY MANNER. THE RD WILL REVIEW ALL THE DIETARY MANAGER'S DOCUMENTATION IN RESIDENT RECORDS.<br><br>R.F. PER TELE C DON 6/11/09, 1650 MDT. | 6/1/09 |



6/11/09

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| F 281 | Continued From page 7<br>incontinence/indwelling catheter, psychotropic drug use, falls, dental care, dehydration/fluid maintenance, ADL functional/rehabilitation potential, and pain assessment were completed by an LPN.<br>h. Review of required assessments for resident #30 showed urinary incontinence/indwelling catheter, psychotropic drug use, falls, dehydration/fluid maintenance, ADL functional/rehabilitation potential, and pressure ulcers assessments were completed by an LPN. Additional evaluations for bowel and bladder retraining, self-administration of medications, and pain management were also completed by an LPN.<br>i. Review of required assessments for resident #33 showed assessments for urinary incontinence/indwelling catheter, psychotropic drug use, falls, and ADL functional/rehabilitation potential were completed by an LPN. The LPN also completed additional assessments for bowel and bladder retraining, and fall risks.<br>Interview with the director of nursing (DON) on 5/15/09 at 3:40 PM confirmed the LPN completed comprehensive nursing assessments for all residents and had been doing so for a year. The DON stated she was unaware LPNs could not perform comprehensive nursing assessments.<br><br>2. According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of | F 281 | F281<br>#3. Physician orders will be monitored through the quarterly chart audit and IDT review processes. Inservices will be completed for nursing staff.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>ALL QUESTIONS ON ORDERS WILL BE CLARIFIED IMMEDIATELY BY THE NURSING STAFF.<br><br>R.F. PER TELE C DON 6/11/09, 1650 MDT | 6/19/09 |



6/11/09

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| F 281 | Continued From page 8<br>obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals ...for nutrition risk factors. ..It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients."<br><br>Failure to follow this standard of practice was identified in the following instances:<br>a. Review of the most recent annual minimum data set (MDS) for residents #7, #26, and #30 revealed their current nutritional status assessment was completed by the facility's dietary manager (DM).<br>b. Review of resident #11's medical record showed a nutritional status assessment completed by the DM. The resident's medical history was significant for morbid obesity and insulin-dependent diabetes.<br><br>3. Review of the May 2009 physician's orders showed resident #22 was to receive oxygen continuously at 2 liters per minute per nasal cannula. Observations on 5/11/09 5:45 PM and 6:14 PM, 5/12/09 from 7:55 AM until 9:22 AM, and 5/13/09 at 9:30 AM showed the resident was not using oxygen. On 5/13/09 at 11:05 AM, the DON confirmed the order. She stated the resident only used oxygen at night, and she was unaware of the order to use it continuously. The DON reviewed the record and confirmed the order had been present for almost a year. She stated staff | F 281 | F281<br>#4. Inservices will be completed for all appropriate nursing staff. Multi-use vials will be marked as to date, time and nurse initials upon opening of vial. Weekly checks will be conducted by the DON or Charge Nurse at random times.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>NURSING STAFF WILL ALSO NOTE THE EXPIRATION DATE AND, IF APPROPRIATE, THE OPEN VIAL EXPIRATION FOR ALL MULTI USE MEDICATIONS.<br><br>R.F PER TELE C DON 6/11/09 1650 MDT. | 6/19/09 |



RP 6/11/09

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| F 281 | Continued From page 9<br>should have clarified the order, as the resident did not require oxygen continuously.<br><br>4. Observation on 5/13/09 at 8:20 AM of the medication room refrigerator at the nurse's station revealed two opened vials of insulin that were not dated as to when they were opened or entered.<br>In an interview with registered nurse (RN) #1 on 5/13/09 at 8:20 AM she stated that, without the dates on opened vials, it could not be determined if the medication in the vial was outdated.<br>According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, page 552: "If multiple-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials." | F 281 | | |
| F 309 SS=D | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and medical record review, the facility failed to effectively control pain for 1 of 2 residents (#9) identified as having pain. The findings were:<br><br>According to the 10/31/08 annual and 4/29/09 quarterly Minimum Data Set assessments, resident #9 suffered with moderate daily joint | F 309 | F309<br>Pain assessments will be placed in all MARs of residents receiving pain medication with a pain scale.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>Resident #9 has had pain assessment reviewed and documented within chart. This will continued to be monitored through daily resident pain assessments. | 6/19/09 |



RF 6/11/09

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| F 309 | Continued From page 10<br>pain. Review of the 10/29/08 pain assessment showed the resident received the narcotic, Vicodin, for pain from surgery on the right knee. According to the pain assessment dated 4/29/09, the resident took one Vicodin 5/325 milligrams at bedtime and had recently added Tylenol 1 gram at 9 AM and 2 PM. The patient's goal for pain control was not identified and the only non-pharmacological measure listed was "rest." The care plan did not list any interventions other than the narcotic. Review of the 4/3/09 physician's progress documented the resident's right knee had been injected since surgery and that s/he would only take the narcotic at bedtime.<br>Observation throughout the survey showed the resident walked around the facility much of the day and enjoyed helping prepare the dining room for meals. On 5/13/09 at 12:45 PM the resident stated his/her knees hurt and rated the pain as 6 on a scale of 0 to 10 (0 = no pain, 10 = the worst pain). When asked what the s/he would like as a pain score, the resident replied s/he would like "no pain." When asked if s/he would like medication for the current pain, the resident refused and stated s/he did not like the narcotic, and Tylenol made him/her "so tired." The resident visited for about four minutes then said s/he had to sit down because "my knees hurt."<br>On 5/13/09 at 4:03 PM the DON confirmed the resident's pain was not being treated effectively. The DON stated the resident has had days where s/he "can't get out of bed." The DON stated the resident liked heat to his/her knees, but it was not used often. She also stated that non-steroidal, anti-inflammatory drugs had not been tried and that a pharmacist had not been consulted about controlling the resident's pain. | F 309 | | |
| F 315 SS=D | 483.25(d) URINARY INCONTINENCE | F 315 | | |

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| F 315 | Continued From page 11<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to provide appropriate treatment and care to restore as much normal bladder function as possible and prevent urinary tract infections for 1 of 3 sample residents (#26) with a urinary catheter. The findings were:<br><br>Observation of resident #26 on 5/11/09 at 6:30 PM showed s/he had a urinary catheter attached to bedside drainage.<br>Review of the resident's medical record showed a physician's order dated 2/6/08 to insert a Foley catheter to bedside drainage. Review of an inpatient progress note dated 4/5/07 showed the resident's physician "talked with her/him about having a catheter put in, which the resident does not want to have done, and the director of nurses is reluctant to do that because she says we really do not have a good indication...I am urging the director of nurses to try and find a different solution, i.e., a Foley catheter, rather than continue with this charade." The 4/5/07 physician's progress note also stated, "urinary incontinence, whether intentional or accidental is | F 315 | F315<br>Reviews for necessity of Foley catheterization will be done as part of the MDS review process. Appropriate documentation will be retained in the resident record in event of resident refusal. The MDS team will be inserviced.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>Conference held with resident #26 and provider regarding foley catheter status. Documentation will be placed in chart regarding bladder retraining. Resident will be monitored as part of the bladder retraining program.<br><br>RP 6/11/09 | 6/19/09 |



RP 6/11/09

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| F 315 | Continued From page 12<br>not known." Review of a bladder retraining assessment dated 12/30/08 showed the resident had "frequent urinary tract infections (UTIs)" and the perception of the need to urinate was marked as being "present." Review of a urinary incontinence/indwelling catheter resident assessment protocol dated 12/30/08 had "yes" marked for the question, "Is the resident motivated to stay dry or participate in a bladder training program?"<br>Review of the resident's laboratory results revealed three urinary tract infections with positive laboratory culture findings since insertion of the urinary catheter. The medical record revealed no documentation to define rationale for the insertion of a urinary catheter.<br>According to the DON - who was interviewed on 5/12/09 at 2 PM, the resident had a urinary catheter "because the physician and patient wanted it." | F 315 | | |
| F 323 SS=D | 483.25(h) ACCIDENTS AND SUPERVISION<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to ensure 2 of 4 sample residents (#26, #30) with side rails were assessed for safety. The facility also failed to maintain a resident environment as free from accident hazards as possible. The findings were: | F 323 | | |

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| F 323 | Continued From page 13<br><br>1. Observation on 5/11/09 at 6 PM showed resident #26 was in bed with two half side rails elevated. Observation on 5/12/09 at 8:10 AM revealed resident #30 was also in bed with two half side rails elevated.<br>Review of the medical record for resident #26 showed s/he had no safety assessment for the use of side rails. Review of the medical record for resident #30 showed s/he had a restraint safety assessment dated 2/11/09. The assessment documented the resident's "use of 2 half side rails up while in bed." However, the assessment failed to document any assessment for safety.<br>Interview with the DON on 5/14/09 at 9 AM revealed the facility's restraint safety assessment was inadequate, and she would change the assessment to ensure it actually assessed resident safety.<br><br>2. Observation on 5/11/09 at 5:10 PM and on 5/12/09 at 1:48 PM revealed the heads of five drywall screws (sharp-edged flat heads) protruded approximately one inch from the dining room half-wall. The screws were four feet from the floor, which was noted to be shoulder height for residents seated at adjacent tables. The screws were spaced about five feet apart along the wall. The protruding screw heads created a safety hazard to residents getting up from their chairs and possibly brushing up against the wall.<br>Interview with the facility's maintenance manager on 5/12/09 at 1:49 PM confirmed the above findings. The manager stated he was unaware the screws were present. | F 323 | F323<br>#1. Restraint/Safety Assessment for each resident will include [redacted] comprehensive data completed on admission, quarterly, annually and as needed for resident care.<br><br>A new form has been instituted. TO ASSESS RESIDENT SAFETY AND S.R. USE. 6/19/09<br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>Restraint/Safety assessments have been made for residents #26 and 30 with appropriate adjustments made. Documentation within chart.<br><br>#2. Screws located in dining room half wall have been removed by maintenance personnel. Maintenance staff will monitor as part of monthly walk through. 5/14/09<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings. | |
| F 428<br>SS=D | 483.60(c) DRUG REGIMEN REVIEW<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed | F 428 | R.F. PER TELE. DON 6/11/09, 1650 MDT | |

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| F 428 | Continued From page 14<br>pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the pharmacist failed to identify an irregularity when performing monthly medication regime reviews (MRRs) for 1 of 10 sample residents (#18). The findings were:<br><br>Review of physician's orders and the medication administration records showed resident #18 had been receiving the antidepressant, Zoloft, 50 milligrams, since 9/19/08. Review of the monthly MRRs since September 2008 showed no evidence the pharmacist identified the medication as an irregularity. On 5/13/09 at 3:55 PM the DON stated the pharmacist was out of town. However, she confirmed the irregularity was not identified and reported as required. | F 428 | F428<br>DON will review as part of chart audit process to insure appropriate pharmacist oversight and appropriate documentation on record.<br><br>Inservices will be conducted regarding this requirement with pharmacist and appropriate nursing staff.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>Resident #18's medication will be reviewed by pharmacist and documented within the MMR. Appropriate follow up and documentation will be completed by the DON. | 6/19/09 |
| F 431 SS=E | 483.60(b), (d), (e) PHARMACY SERVICES<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. | F 431 | RS 6/11/09 | |



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| F 431 | Continued From page 15<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure stored medications were not outdated. The findings were:<br><br>Observation of the medication room behind the nurses' station on 5/13/09 at 8:20 AM showed 3/4 of the medications stored did not have expiration dates listed on the label. The medications were stored in bottles (approximately 80 bottles) with 30-60 doses in each bottle.<br>During an interview with the DON on 5/13/09 at 9 AM she spoke with a pharmacist via | F 431 | F431<br>Inservice with pharmacist regarding appropriate labeling for medications to include expiration has been conducted.<br><br>Charge nurse or DON will review as part of weekly audits of medication room. Nursing staff will be inserviced regarding this requirement.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>THE PHARMACIST WILL ENSURE THE EXPIRATION DATE APPEARS ON ALL MEDICATION CONTAINERS.<br><br>R.F. PER TELEC DON 6/11/09, 1630 MDT | 6/1/09<br><br>6/19/09 |

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| F 431 | Continued From page 16<br>telephone. The DON stated, "the pharmacist said they did not put expiration dates on the stored medications because the medications were for residents." | F 431 | | |
| F 441 SS=E | 483.65(a) INFECTION CONTROL<br><br>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of infection control logs and the certified nurse aide (CNA) notebook, and staff interview, the facility failed to ensure staff properly disinfected 1 of 1 whirlpool tubs after use. The findings were:<br><br>The facility's whirlpool tub was observed to be partially filled with water on 5/13/09 at 12:20 PM. The water level was six inches below the soap residue line left from a previous bath. Review of the CNA notebook revealed four residents (#3, #5 #18, and #30) received baths the morning of 5/13/09. Of these four residents, three were listed on infection control logs as having experienced epidemiologically-significant infections: residents #3 and #5 were listed in the facility's infection control logs as having prior infections with methicillin-resistance Staphylococcus aureus | F 441 | F441<br>All CNAs will be inserviced on utilization of appropriate disinfectant procedures for whirlpool tub after each resident use. Weekly randomly timed checks will be conducted.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br><br>THE WEEKLY CHECKS WILL MONITOR FOR PROPER EXPOSURE TIME, ADEQUATE WATER VOLUME, AND THE CORRECT AMOUNT OF DISINFECTANT HAS BEEN USED.<br><br>R.F. PER TELE C DON 6/11/09, 1650 MDT. | 6/19/09 |

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| F 441 | Continued From page 17<br>(MRSA) and resident #30 was noted as having a previous infection with a vancomycin-resistant enterococci (VRE).<br>Interview with the DON in the tub room on 5/13/09 at 12:35 PM revealed the tub contained a disinfecting solution. She confirmed the solution did not adequately fill the tub in order to disinfect all surfaces of the tub routinely exposed during resident baths. CNA #1 joined the DON in the tub room; she stated the disinfectant solution was to remain in the tub during lunch to achieve the minimum required ten minute exposure time. When asked by the DON, CNA #1 confirmed the level of disinfectant was not sufficient to cover the area of the tub used during resident baths. The CNA stated she would add more water to the tub to bring the level up to the soap residue line. The CNA also stated she was not sure how much concentrated disinfectant was added to the water, nor if it was sufficient to accommodate the added volume of water. | F 441 | RC 6/11/09<br>F520<br>Physician was present at the second quarter meeting, documented within the meeting minutes. Physician will be present quarterly at future scheduled quality improvement meetings, documented within the minutes.<br><br>Tracking and monitoring will be conducted and reported at the quarterly quality improvement meetings.<br>RC 6/11/09 | |
| F 520 SS=B | 483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require | F 520 | | 5/20/09 |



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| F 520 | Continued From page 18<br>disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and review of the minutes from quality assurance (QA) committee meetings, the facility failed to ensure the QA committee met quarterly or that a physician was present. The findings were:<br><br>Interview with the DON on 5/14/09 at 8:30 AM revealed the QA committee usually met quarterly, but did not meet during April 2009 at the routine time. The DON further stated that a physician was not always present at the QA meetings. Review of the QA meeting minutes for the past year showed the committee was scheduled to meet in January, April, July, and October; however, there were no meeting minutes after 1/28/09. Further review of the minutes showed a physician was not present at the 1/28/09 meeting. | F 520 | | |