POC accepted 6/22/09pp

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

COPY

Printed: 06/04/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	pp 05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

(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 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to promote dignity related to publicly posted signs for two (#13, #19) of 15 sample residents, and one (#38) non-sample resident. In addition, the facility failed to cover from public view a catheter bag for one (#38) non-sample resident. The findings were: 1. Periodic observation on 5/18/09 and 5/19/09 revealed two signs were posted outside the room of resident #13 which instructed staff to use contact and droplet isolation precautions to prevent transmission of infection. The signs instructed visitors to "Report to nurses' station before entering room." It further detailed special protective equipment requirements needed to enter the room. Medical record review revealed the resident did not have a transmittable disease. In addition, review of the roommate's (non-sample resident #38) medical record revealed s/he did not have a infection or transmittable disease. Interview with the infection control preventionist (ICP) on 5/19/09 at 10:55 AM confirmed the residents did not have active infections. The ICP stated the staff on the unit posted the signs due to a coughing and spitting behavior that the resident exhibited. 2. Periodic observation on all days of the survey (5/18-5/21/09) showed a sign posted outside the room of resident #19 which instructed staff to use contact isolation precautions to prevent transmission of infection. The sign instructed	F 241	The Facility will assure an environment that maintains each resident's dignity by: 1. The process for reporting and initiating infection surveillance or transmission risk was revised 5/23/09. All suspected infection risks will be reported to a RN for assessment. By direct care staff, CNA, LPNs and activities staff. When indicated, the RN will complete a Resident Surveillance form and an Infection Prevention Surveillance form to report infection control issues to Infection Control Practitioner or designee who will be responsible for evaluation and determining Precaution signage. Signage will only be placed by the Infection Control Practitioner or designee to assure appropriateness. This process was added to the QAPI plan and compliance will be monitored by the DON or designee. 2. The Care Planning process will immediately address Infection Control issues and behavior issues, including a behavior modification plan and Pharmacy review for those residents with hygiene or body fluid concerns placing other residents at risk. These issues will be referred to the Infection Control Practitioner or designee for evaluation. The DON will assure compliance by weekly review of care plans. 3. There will be at least 2 catheter bag covers for each Resident with a catheter by ~~7/21/09~~ 6/30/09. This will assure constant availability of a cover for washing. Staff will be educated on the	Overall total tag element completed by: ~~7/21/09~~ 6/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Rowell | TITLE: Administrator | (X6) DATE: 6/13/09

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

RECEIVED
Wyoming Dept of Health
JUN 22 2009
Office of Healthcare Licensing and Surveys

1:20 pm
Revised Corp POC accepted 6/22/09 per Phone
6/24/09 Called & adv Requested revised signed copy. Phone

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F 241	Continued From page 1 visitors to, "Report to nurses' station before entering the room." Additionally, the sign showed the special protective equipment that was required for resident contact. Medical record review revealed the resident had an infection in the past, but did not have a transmittable disease. 3. Observation on 5/19/09 at 1:55 PM revealed resident #38 was seated in a recliner in a common area of the 200 unit. The resident's uncovered catheter bag was attached to the foot rest of the recliner and the urine in the bag was visible to anyone in the area. During an interview with the interim director of nursing on 5/21/09 at 2:45 PM, she stated the catheter bag should be covered to preserve the resident's dignity.	F 241	availability of covers and the procedure, RN Coordinators will monitor for compliance on an on-going basis. ~~Staff~~ Have assured resident #38 has her catheter bag covered at all times and compliance assured by the RN Coordinator for that hall by 5/24/09 4. Signs have been removed from residents 13 and 19's rooms by 5/24/09 and compliance will be monitored by the Infection Control Practitioner weekly, or	
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: Based on staff interview, resident interview, and review of medical records and the facility's activity program list, the facility failed to ensure activities were provided to meet the needs of seven (#13, #19, #37, #34, #35, #50, #7) of seven sample residents who were assessed as requiring one-to-one activities. In addition, 13 (#3, #38, #67, #60, #11, #72, #25, #9, #68, #53, #12, #5, #26) non-sample residents who were part of the one-to-one program, were not being provided all of their activities. The findings were: 1. The following residents were identified as not having their activity needs met:	F 248	The facility will ensure the resident's needs of one-to-one activities, which were triggered through comprehensive assessments, will be met weekly and monthly. This will be accomplished by: and added to the QAPI plan for monthly review by 6/09 1. The Care Coordinator/Clinical Educator will identify those residents who have been triggered and compile those residents into a monthly calendar to be followed by Activity Professionals. Residents 13, 19, 37, 34, 35, 50, 7, 3, 38, 67, 60, 11, 72, 25, 9, 68, 53, 12, 5 and 26 will receive 1:1 activities per care plan. This will occur 2 or 3 times per week as identified Need in care plan, placed on the calendar and monitored by the Care Coord./Clinical Educator on a weekly basis to assure compliance beginning 6/12/09. or 2. The Activity Professionals will follow the individualized calendar and sign off daily as to which resident received the one-to-one services. 3. The Activity Professionals will then turn in their one-to-one sign off list into the Care Coordinator/Clinical	Overall total tag element completed by: ~~7/15/09~~ 6/30/09 or

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F 248	Continued From page 2 a. Review of the April and May 2009 activity logs for resident #37 showed the resident was scheduled to have one-to-one activities twice a week. Further review of this information showed the resident received two of these activities during the six weeks, one on 4/8/09 and another on 4/27/09. Interview with the resident on 5/20/09 at 2:50 PM revealed s/he got "bored", and didn't like to leave his/her room much. b. Review of the April and May 2009 activity logs for resident #13 showed the resident was scheduled to have one-to-one activities two times per week. Additional review showed that during the previous six weeks, the resident received one of these activities on 5/8/09. c. Review of the April and May 2009 activity logs for resident #19 showed the resident was scheduled to have one-to-one activities twice a week. Further review of the previous six week period showed the resident received one of these activities on 5/11/09. 2. Review of the activity program list showed sample residents #34, #35, #50, and #7 were also assessed as requiring one-to-one activities. According to an interview on 5/21/09 at 9:20 AM with the activities director, these residents were not receiving their activities as scheduled. 3. In addition, 13 non-sample (#3, #38, #67, #60, #11, #72, #25, #9, #68, #53, #12, #5, #26) residents were also identified by the activities director as not having their one-to-one activities provided to meet their assessed needs. Interview with the activities director on 5/21/09 at 9:20 AM confirmed there was a problem with providing one-to-one activities. She stated the department was short a staff member and they had been unable to get the activities done as	F 248	Educator each Friday for review. 4. Document activities in the chart by the Activity Professional. Threshold of 90% of the time the activity time should be addressed by documentation. and monitored in the QAPI plan on a monthly basis by the CC/CE to assure compliance. 5. Monthly audit of activity portion of resident charts by Care Coordinator/Clinical Educator. for all residents noted above needing 1:1 activities, qm 6. Full staffing in the Activities Department by June 15 with training completed by ~~July 15~~ June 30, 2009 qm by the Activities Professional and Care Coordinator/Clinical Educator.	

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F 248	Continued From page 3 scheduled and care planned for the 20 residents who were assessed as needing these types of activities.	F 248		
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: Based on observation, staff interview and review of medical records, the facility failed to ensure care plans were developed for two (#35, #37) of four sample residents, and three (#23, #57, #58) non-sample residents who were on isolation precautions related to infections. The findings were: 1. Observation on 5/20/09 at 2 PM revealed resident #35 had a stop sign posted outside his/her room. Interview with RN #1 at that time	F 279	The Facility will assure a comprehensive care plan for each resident with infection precautions by: 1. The process for reporting and initiating infection surveillance or transmission risk was revised 5/23/09. All suspected infection risks will be reported to a RN for assessment. When indicated, the RN will complete a Resident Surveillance form and an Infection Prevention Surveillance form to report infection control issues to Infection Control Practitioner. The Resident Surveillance form will be used by the RN coordinators to address the infection precautions and care in the Care Planning process. The RN Coordinators will document, communicate and evaluate the plan to assure compliance. The Resident Surveillance form is now an element of the Resident's medical record to support the Care Plan and infection control/prevention measures. This process has been added to the QAPI (6/4/09) process. Care plans will be reviewed weekly by the DON (new care plans each week) to ensure compliance. This will be reported to QAPI every month. QM 2. Residents 35, 37, 23, 57 and 58 all have care plans developed that include information/needs specific to their infection status as appropriate to each. YE4711 The new/ changed care plans are monitored weekly by the DON to assure compliance. QM	Overall total tag element completed by: 5/23/09

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F 279	Continued From page 4 revealed the resident was on both contact and droplet isolation precautions due to an upper respiratory illness (URI). Review of the current (5/13/09) care plan showed it did not include any information related to isolation precautions. 2. Periodic observation on all days of the survey (5/18-5/21/09) showed a sign posted outside the room of resident #37 which instructed staff to use contact isolation precautions to prevent transmission of infection. According to the May 2009 infection log, this resident was being treated for a URI. However, review of the current (12/20/09) care plan revealed it did not include information about the infection or the transmission precautions. 3. Three non-sample residents (#23, #57, #58) were identified on the May 2009 infection log as having contact and droplet isolation precautions in effect due to URIs. The precautions for resident #23 were started on 5/11/09, and for residents #57 and #58 precautions were started on 5/18/09. Review of the residents' care plans showed infection and isolation precautions were not addressed until 5/21/09. 4. Interview with the interim director of nursing on 5/21/09 at 9:35 AM revealed the care plans for the residents with URIs were in the process of being developed to reflect the infection control care needs and appropriate protective measures.	F 279		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: Based on observation and staff interview, the	F 281	The Facility will assure staff follows standards of nursing practice for medication preparation and administration by: 1. Licensed nursing staff will attend	Overall total tag element completed by: 7/1/09

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F 281	Continued From page 5 facility failed to ensure staff followed accepted standards of nursing practice for medication preparation and administration. The practice of administering pre-poured medications affected the 17 residents on one (300 unit) of three units. The findings were: 1. Observation of the medication pass on 5/18/09 at 4:25 PM revealed medications had been removed from the packages and placed loosely in unlabeled medicine cups in the drawers of the medication cart. Continued observation revealed licensed practical nurse (LPN) #1 administered the medications to the residents on the 300 unit. Interview with the LPN at that time, revealed she routinely pre-poured medications because it saved time when the unit was short of staff. She said earlier that day at 2 PM she pre-poured all the medications that were scheduled to be administered from 3 - 9 PM, except for the insulin injections. 2. Review of the facility's policy and procedures for medication administration/unit dose system and interview with the interim director of nursing on 5/21/09 at 3 PM revealed the nurse should not have pre-poured the medications. 3. According to "Nursing Interventions and Clinical Skills", 2007 3rd edition, by authors Elkin, Perry and Potter, page 420, the, "tablets and capsules should be kept in their wrappers and opened...at the resident's bedside."	F 281	mandatory education on medication preparation and administration with successful (100%) pass rate of a medication test to demonstrate competency by 7/1/09. Re-education and re-administration of testing will occur as needed to assure the 100% pass rate. 2. Newly hired licensed nursing staff will receive the medication preparation and administration education and testing with successful completion prior to their first medication pass. 3. The Pharmacist in charge will review the rules and regulations with licensed nursing staff by 7/1/09. 4. Ongoing assurance of proper medication preparation and administration will be included in the QAPI plan by 6/29/09 and reviewed monthly by the DON. The DON and RN coordinators will each randomly monitor staff med. prep and admin on a weekly basis (at least 4 times a week total) to assure compliance by 7/1/09. or-	
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	The Facility will ensure staff follows Care plans for weekly skin assessments by: 1. A comprehensive skin assessment form was implemented 5/20/09 and weekly skin assessments for all Residents initiated. RN Coordinators are responsible for monitoring	Overall total tag element completed by: 6/12/09

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F 282	Continued From page 6 This Requirement is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed the care plan for performing weekly skin assessments for 8 (#16, #73, #4, #21, #13, #35, #37, #55) of 8 sample residents who were assessed as being at risk for developing pressure sores. The findings were: Interview with the interim director of nursing on 5/19/09 at 4:25 PM revealed the weekly skin checks for residents at risk for developing pressure sores should be documented per the care plans. However, she stated this was not always being done or being documented in a consistent way. The following residents were identified as not having their care plans followed related to weekly skin checks: 1. Refer to F314 for information regarding failure to perform weekly skin assessments for resident #16. 2. Refer to F314 for information regarding failure to perform weekly skin assessments for resident #73. 3. Review of the 3/18/09 Braden Scale (risk assessment) for resident #4 revealed the resident was at risk for developing pressure sores. According to the 3/18/09 care plan, interventions to prevent skin breakdown included weekly skin checks with documentation. Review of the medical record and treatment administration record revealed no weekly skin checks on the resident during April and May 2009. 4. Review of the 3/10/09 active care plan for	F 282	compliance with this expectation using a weekly audit process, reported to the DON. 2. A schedule assigning the day of each Resident's weekly assessment will be established by 6/12. Residents 16, 73, 4, 21, 13, 35, 37 and 55 had weekly assessments ongoing as assured by 6/12/09, weekly skin assessments are included in their care plans and weekly review of documents by the DON have assured this, gm 3. The skin assessment (weekly) process has been included in the QAPI process by 6/12/09 and weekly review with monthly reporting by the DON will assure compliance. gm	

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F 282	Continued From page 7 resident #21 showed risk factors for pressure ulcer formation that included history of pressure ulcer on admission to the facility, anemia, hypertension, and low weight with a history of significant weight loss. The care plan further showed skin checks should be done weekly and documented. Review of the March, April and May 2009 treatment record revealed no evidence of the skin checks. 5. Review of the 3/17/09 risk assessment for resident #55 revealed the resident was at moderate risk for developing pressure sores. According to the 4/1/09 care plan, interventions for the prevention of skin breakdown included weekly skin checks with documentation. Review of the medical record and treatment administration record showed no weekly skin checks for April and May 2009. 6. Review of the current care plan last reviewed 3/10/09 showed resident #13 was at moderate risk for pressure ulcer development based on the 3/3/09 risk assessment. Multiple interventions were listed including weekly skin checks with documentation. Review of the medical record revealed there were no weekly skin checks done for April and May 2009. 7. Review of the care plan last reviewed on 5/13/09 showed resident #35 was at risk for pressure ulcer development based on a 1/31/09 risk assessment. The interventions showed weekly skin checks with documentation. Review of the medical record revealed there were no weekly skin checks being documented for the resident for April and May 2009. 8. Review of the care plan last reviewed on 2/24/09 showed resident #37 was at high risk for	F 282	This page left blank intentionally	

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F 282	Continued From page 8 pressure ulcer development according to the 5/19/09 risk assessment. Interventions included weekly skin checks with documentation. Medical record review revealed there were no weekly skin checks were documented for the resident in the last two months.	F 282		
F 314 SS=K	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 have an effective system in place to prevent, identify, monitor, and provide treatment related to pressure sores. This failure resulted in an immediate jeopardy for four (#16, #73, #13, #37) of four sample residents who were assessed at risk for pressure sores and developed avoidable pressure sores while at the facility. The findings were: 1. Review of the 4/23/09 quarterly minimum data set (MDS) assessment and 10/23/08 resident assessment protocol (RAP) summary for resident #16 revealed the resident had a history of pressure sores. Review of the 4/30/09 care plan revealed interventions that included weekly skin assessments with documentation. Review of the the 3/1/09 - 5/19/09 treatment administration records revealed no skin assessments were	F 314	The facility will ensure prevention of avoidable pressure sores by: 1. CNA education regarding observation, documentation on rounding logs and reporting to nursing staff was 77% completed on 6/3/09, full completion by 6/30/09. Education was provided by a FNP. 2. CNA training regarding sanitization of resident equipment, shared equipment and high-touch areas will be completed by the FNP by 6/30/09. 3. Weekly skin assessments will be conducted as noted with tag F282 and compliance assured by RN Coordinators, verified by the DON and the QAPI process, or 4. Based on the weekly skin assessments, all at-risk Residents will be identified in the Care Plan process with interventions initiated as appropriate to the risk, i.e. turning schedule, pressure relief, protective devices, etc (currently in place for 45 Residents). The DON will review new/changed care plans weekly to assure compliance. or 5. A multi-disciplinary Wound Care team (DON, PT, RN Coordinators, Wound care nurse, Medical Director, Restorative Care, Dietitian, Pharmacist	Overall total tag element completed by: 6/30/09

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F 314	Continued From page 9 documented or completed during that time. Review of the 4/1/09 - 5/19/09 nurses notes revealed the most current assessment of the resident's skin was performed on 4/17/09. The documentation at that time, said the resident's bottom was "very raw," he/she had "profuse bleeding," and a dressing was applied. Review of the most recent physical therapy documentation, dated 4/30/09, said, "sacral area is red with two small open areas on each side of the coccyx and a small vertical open area between them." Further review of the medical record showed no additional assessments of the pressure sores after 4/30/09. The following concerns were identified: a. Observation on 5/19/09 at 8 PM revealed CNA #1 removed a urine soiled disposable brief from resident #16 and exposed an uncovered stage II pressure sore on the resident's buttock. Red excoriated areas covered most of the resident's sacrum and coccyx, and bloody drainage oozed from a dime-sized, darker red area on the left buttock. When the resident sat to urinate, the draining pressure sore had direct contact with the toilet seat. After the resident urinated, the CNA provided perineal cleansing and put a clean disposable brief on the resident. As the CNA transferred the resident to her/his wheelchair and bed, the resident told the CNA two times that the pressure sore "hurts." Continued observation revealed the CNA left the pressure sore uncovered and did not report it to the charge nurse. b. Interview with the charge nurse, licensed practical nurse (LPN) #1, on 5/19/09 at 8:15 PM revealed she knew the resident had a history of a methicillin-resistant Staphylococcus aureus (MRSA) infection, but she did not know whether the resident had an active infection. LPN #1 also said she did not know about the care or condition	F 314	and Infection Control Practitioner) was established 5/13/09. The team met again 5/21/09 and will meet monthly. 6. An order form for Physical therapy and a Dietary consult was developed to expedite referrals for these services when indicated and approved by the Resident's physician. 7. Physical therapy orders for Evaluation and Treatment will be obtained in a timely manner and the referral initiated immediately 8. Nursing staff education regarding wound care and wound care products was completed by a FNP on 6/30/09. Nursing will provide wound care and dress/redress wounds per the Care Plan and Physical therapy instruction during times PT is not available. 9. A form was developed for Physical Therapy communication to nursing staff regarding end-of-care treatment and cares needed. This discharge form will be reviewed and signed by the RN Coordinator responsible for the Resident's care. 10. Residents 16, 73, 13 and 37 have had their pressure sores addressed via the above process by 5/23/09, Orders and treatment plans were current as verified by the DON. apr 11. The wound care ~~team~~ will monitor the process monthly and report to the QA PI Team. The DON will ensure compliance with weekly verification of documentation by 6/12/09 apr	

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F 314	Continued From page 10 of the resident's skin because the physical therapy staff was responsible for the care, treatment, and monitoring of the pressure sore. c. Interview with CNA #1 on 5/19/09 at 6:20 PM revealed she was not aware of any directions for applying a dressing to the resident's pressure sore. d. Interview with the physical therapist and therapy assistant on 5/20/09 at 11:15 AM revealed the physical therapy staff stopped providing treatment for the pressure sores on the resident's coccyx and sacrum on 4/30/09. The therapy staff said they thought the nursing staff continued the treatments after that date. e. Interview with the acting chief executive officer on 5/20/09 at 11:15 AM revealed the facility was in the process of revising their system for preventive skin care, but implementation was scheduled for 6/1/09. She said currently no person or committee was responsible for ensuring staff consistently performed routine skin assessments, performed ongoing evaluations for the effectiveness of interventions and provided appropriate pressure sore treatments. f. Interview with LPN #2, LPN #3 and RN #1 on 5/20/09 at 2:10 PM revealed the nursing staff had not provided treatments for the pressure sore on the bottock of resident #16 because they did not know the therapy staff were no longer doing it. All stated the draining pressure sore should have been covered with a dressing. 2. Review of the 2/17/09 quarterly MDS assessment for resident #73 revealed the resident did not have a pressure sore. Review of the 2/24/09 care plan showed the resident was at risk for developing pressure sores. The interventions in the care plan included weekly skin checks with documentation. Review of the 3/1/09 -5/19/09 treatment administration records	F 314	This page left blank intentionally	

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F 314	Continued From page 11 revealed staff performed the weekly skin assessment one time in March. No skin assessments were conducted for this resident in April and May 2009. The following concerns were identified: a. Observation of LPN #3 and CNA #2 as they provided incontinence care for resident #73 on 5/19/09 at 8:40 PM revealed the resident had a stage II pressure sore on the buttocks. b. Interview with LPN #4 on 5/21/09 at 11:50 AM confirmed the pressure sore was first identified on 5/12/09. The LPN stated she obtained the physician's order for the physical therapy evaluation on 5/15/09 because the pressure sore worsened. She said staff provided the standing orders treatments until the therapy staff completed the evaluation to determine the most effective treatment. She said the physical therapy staff did not evaluate the pressure sore on the resident's buttocks until 5/19/09 (seven days after the area was first noted). Review of the medical record revealed the resident did not have pressure sores prior to 5/12/09 and the physician's order and physical therapy evaluation occurred as stated by the LPN #4. 3. Observation of resident #13 during cares provided by LPN #4 on 5/19/09 at 8:40 PM revealed the resident had a stage II pressure sore on the sacrum. Review of the care plan with a review date of 3/10/09 showed the resident was at moderate risk for pressure ulcer development based on the 3/3/09 risk assessment. Multiple interventions were listed on the care plan including weekly skin checks and documentation. Review of the medical record revealed there had been no weekly skin checks documented for the resident. Furthermore, the open area that was observed was not addressed anywhere in the resident's medical record.	F 314	This page left blank intentionally	

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F 314	Continued From page 12 4. Observation on 5/19/09 at 8:30 PM revealed resident #37 had a stage I pressure ulcer on the left buttock. Review of the care plan last updated on 2/24/09 showed the resident was at a moderate risk for pressure ulcer development based on the 5/19/09 risk assessment. Multiple interventions were listed including weekly skin checks and documentation. Review of the medical record revealed no weekly skin checks had been documented for the resident in April and May 2009. 5. Interview with the interim director of nursing (IDON) on 5/19/09 at 4:25 PM revealed the facility did not have an effective system for assessing, monitoring and providing care for pressure sores due to recent changes in administrative staff. The IDON said the facility's current system did not include a multidisciplinary approach for evaluating effective interventions and providing treatment for pressure sores. She stated the system required the nurses to perform weekly skin assessments and document the assessment and respond to assessed changes. However, staff had not done the requirements consistently. She said the system also required the nurses to obtain a physician's order for physical therapy evaluation as soon as they identified a worsening or newly developed pressure sore. She said the physical therapy staff were responsible for treatments and monitoring. She also said communication between nursing and therapy staff was poor at times which made the system less effective. Due to the facility's failure to have an effective system in place to prevent, identify, monitor, and provide treatment related to pressure sores, avoidable pressure sores developed for the four (#16, #73, #13, #37) residents identified.	F 314	This page left blank intentionally	

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F 314	Continued From page 13 Furthermore, if the failed system was allowed to continue, the practices were likely to cause serious harm for the other 45 residents who were assessed by the facility on 5/21/09 as being at risk for developing avoidable pressure sores. Immediate jeopardy was called on 5/20/09 at 9:35 AM. On 5/21/09 at 4:30 PM, the immediate jeopardy was removed on-site by the following actions: a. The nursing staff performed complete head-to-toe assessments on all of the residents in the facility. b. A physical therapy evaluation and dietary assessment was completed for all residents identified with pressure sores c. A physician's order for a physical therapy evaluation was obtained to treat the pressure sore identified on resident #16. d. A wound culture for resident #16 was sent to the laboratory. The preliminary results were negative. e. Mandatory education was provided regarding skin care and infection control for all staff who were on duty on 5/20/09-5/21/09, and resident care plans were revised. After the IJ was removed on 5/20/09 at 4:30 PM, the scope and severity was determined to be a pattern of noncompliance that resulted in a negative outcome.	F 314		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371	The facility will ensure that the food is stored, prepared, distributed and served under sanitary conditions. 1. The fan was taken out of the area on 5/21/09 and cleaned before	Overall total tag element completed by: ~~5/21/09~~ 6/12/09

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F 371	Continued From page 14 This Requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to prevent potential cross-contamination from dirty equipment to resident food during three of three meal service observations. The facility prepared meal trays for 73 residents. The findings were: a. Observation during the evening meal on 5/18/09, the breakfast meal on 5/19/09, and the lunch meal on 5/20/09 revealed a large black plastic fan being used to cool the kitchen staff as they worked at the steam table in the servery. Additional observation revealed the fan blewdirectly onto the resident's food. The vent on the back of the fan had an accumulation of dirt, grease and dust. According to Food Code 2005, U.S. Public Health Service 3-307.11, Miscellaneous Sources of Contamination, Food shall be protected from contamination that may result from a factor or source not specified under Subpart 3-301 to 3-306. b. Interview with the kitchen manager and the facility dietitian on 5/21/09 at 11:48 AM confirmed the kitchen staff was responsible for cleaning the fan. In addition, they also confirmed the presence of dirt on the fan represented a possible source of food contamination during food preparation and distribution.	F 371	being put back into the servery . 2. At the dietary meeting held on May 21, 09 the staff were informed that the early tray would need to take the fan down and clean it twice a month and clean it to remove any dirt or grease build up on it. 3. This task was placed on the servery work list for the early tray to initial after cleaning every two weeks. It will be checked by the dietary manager on a weekly basis. 4. Weekly monitoring of sanitary conditions/cleaning in the food service area will be added to the QAPI plan by 6/12/09 and Compliance assured/reported by the dietary manager.	
F 441 SS=K	483.65(a) INFECTION CONTROL 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	F 441	The Facility will ensure an effective Infection Control Program by: 1. The process for reporting and initiating infection surveillance or transmission risk was revised 5/23/09. All suspected infection risks will be reported to a RN for assessment. When indicated, the RN will complete	Overall total tag element completed by: 6/30/09

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F 441	Continued From page 15 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. This Requirement is not met as evidenced by: Based on observation, staff interview, review of medical records, policy and procedures and infection control data, the facility failed to establish and implement an effective infection control program. The facility further failed to require staff to follow appropriate precautions when entering resident rooms posted with precautionary signs during a potentially infectious upper respiratory illness (URI) outbreak at the time of survey. Four (#13, #34, #35, #37) of 15 sample residents, and four (#23, #57, #58, #69) non-sample residents were identified as having transmission-based precautions in effect. The facility also failed to recognize and treat a draining pressure sore for one (#16) sample resident with a history of methicillin-resistance Staphylococcus aureus (MRSA) infection and take appropriate steps to minimize the risk of infection to his/her roommate. In addition, the facility failed to ensure non-sample resident (#44) was safeguarded against entering resident rooms posted with precautionary signs. These findings resulted in an immediate jeopardy situation. The findings were: 1. Observation during the initial tour on 5/18/09 revealed seven resident rooms were posted with precautionary signage requiring specific actions on the part of staff and visitors to minimize the risk of transmission of infection. The infection control preventionist (ICP) stated in interview on 5/19/08 at 11:55 AM that she was aware of an outbreak of URI in the facility and that these	F 441	a Resident Surveillance form and an Infection Prevention Surveillance form to report infection control issues to Infection Control Practitioner or designee who will be responsible for evaluation and posting Precaution signage. Staff will be educated by the ICP regarding precautions at the time of the posting. 2. CNA staff was instructed on resident observation and reporting by the FNP, completed 6/30/09. 3. Education to direct care staff regarding Precaution signage was initiated 5/27/09 and will be completed by 6/30/09. 4. The Resident Surveillance form will be maintained as a part of the resident chart after review by the RN Coordinator or DON and be used during the Care planning process. The DON will verify documents on a weekly basis to assure compliance on 5. Infection Prevention Surveillance forms will be forwarded to the ICP on a daily basis Monday through Friday and the RN Coordinator will consult with the ICP daily, including weekends when possible, or will initiate appropriate precautions and staff education if needed on weekends. 6. The Infection Prevention Surveillance forms will be used by the ICP to maintain a real-time log of all infections for on-going tracking and trending. The log will be maintained	

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F 441	Continued From page 16 residents were being tracked in the infection control program. When asked for a current infection surveillance log, the ICP stated she did not compile a log until the end of the month. The ICP stated she was able to track and trend for infections by visiting the facility daily. She further stated nursing staff were supposed to complete a form identifying any residents with infections or prescribed antibiotics. However, she noted staff compliance with the reporting process was inconsistent and not always timely. At the request of the survey team, the ICP compiled an infection control summary for May 2009 on 5/21/09. These data revealed 8 (#13, #23, #34, #35, #37, #57, #58, #69) of 73 residents required infection control precautions related to an ongoing illness. Of these eight residents, seven (all except resident #13) lived in rooms posted with droplet precaution signage related to a healthcare-acquired URI. Interview with the ICP on 5/21/09 at 9:25 AM revealed she had identified this as an outbreak and reported the cluster of cases to the state epidemiologist on 5/21/09. Her report indicated the onset of cases began 5/11/09. 2. Observation on 5/18/09 at 2 PM and again on 5/19/09 at 4:05 PM, revealed resident #13 had signs posted outside his/her door indicating contact and droplet precautions were necessary to prevent infection risk to staff and visitors. The posted precautions required the facility to provide an individual room if available or to consider cohorting as an alternative. The precautions required staff to wear gloves, gown, and mask when entering the room and perform hand hygiene after contact with potentially infectious secretions. Staff was further directed to wash hands immediately after glove removal and before leaving the resident's room. An infection	F 441	on the Banner Health "I" drive as a protected document; editing rights are limited to the ICP and designee, Risk and Quality Manager and DON. Viewing rights are limited to these and the RN Coordinators, CNO, Medical Director and Executive staff. 7. Infection Prevention education including hand hygiene, proper glove use and personal protective equipment was initiated 5/20/09 and completed 6/30/09 for all direct care staff. 8. Education on sanitizing/cleaning equipment for direct care and environmental services staff was conducted 5/21/09. 9. The above process added to the QAPI plan by 6/29/09 with monthly review of compliance by the DON. The DON will verify documentation weekly with monthly reporting to assure compliance and follow-up. qpr 10. Residents 13, 34, 35, 37, 23, 57, 58 and 69 were addressed with appropriate surveillance and precautions by 5/27/09. The ICP and DON are responsible for ongoing monitoring and compliance. The ICP and DON will assure appropriate follow-up with the RN coordinators for each resident. qpr	

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F 441	Continued From page 17 control cart containing gloves, gowns, masks, and trash bags was located immediately outside the room. The following concerns were identified: a. Observation on 5/18/09 at 6:22 PM revealed licensed practical nurse (LPN) #2 delivered a meal tray to the resident. The nurse failed to observe any of the required precautions when entering the room or setting up the meal. The nurse was observed to shield herself with the resident's clothing protector when the resident coughed. The LPN stated she did not wear the protective equipment because she believed the resident was not actually infectious; the precautions were implemented because the resident frequently spit and spread phlegm around his/her room. b. Observation on 5/19/09 at 10 AM showed certified nurse aide (CNA) #6 entered the room to deliver laundry to the resident without taking any precautions. The CNA deposited several clean items in the room and placed the remaining clean clothes under one arm. The CNA then picked up the resident's water pitcher from the bedside table and assisted the resident with taking a drink from the pitcher with a straw. She then assisted the roommate (#38) to take a drink from his/her water pitcher, handling the straw to orient it toward the resident's mouth. The aide then entered the room across the hall, where she handled another resident's water cup and deposited the remainder of the clothing she carried from under her arm. At no time during the observation did the CNA wash her hands. c. Interview with CNA #6 on 5/19/09 at 10:15 AM revealed she didn't always adhere to the precautions posted outside the resident's room. She stated her actions depended on why she was going into the room, and not on the posted precautions. She then stated the resident did not actually have an infection, the posting was	F 441	This page left blank intentionally	

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F 441	Continued From page 18 because of the resident's habit of coughing and spreading mucous around the room. The CNA stated she should have washed her hands. d. Observation on 5/19/09 at 10:12 AM revealed CNA #5 entered the resident's room to stock supplies; she did not complete any of the precautions displayed on the posted infection control signage. e. Interview with the ICP on 5/19/09 at 11:55 AM revealed the resident had a chronic, productive cough and did not cover his/her mouth or properly dispose of the phlegm. She stated the resident did not have an active infection; staff posted the precaution signs in response to the resident's behavior, and the precautions were not necessary. The ICP further stated staff did not consistently comply with transmission-based precautions. f. Review of the resident's medical record showed there was no mention of the coughing and spitting behavior, a current infection, or the rationale for posting contact and droplet precautions. According to facility's policy for infection and exposure control, last reviewed on 4/2006, "Transmission based precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions exceeding standard precautions are required in order to prevent disease transmission within the health care setting." The policy required staff to notify the ICP when isolation or precautions were initiated or discontinued. 3. Observation on 5/18/09 at 5:10 PM revealed resident #44 wandered from his/her room across the hall into a room posted with contact precautions. The resident was unattended and	F 441	This page left blank intentionally	

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F 441	Continued From page 19 got into the other resident's bed. Five minutes later CNA #3 and three additional staff assisted the resident from the room. Interview with CNA #3 on 5/18/09 at 5:40 PM revealed staff were aware the resident wandered and needed close supervision. 4. Observation on 5/19/09 at 8 PM showed CNA #1 wore gloves when she assisted resident #16 to the toilet. When the resident sat to urinate, a draining pressure sore had direct contact with the toilet seat. After the resident urinated, the CNA provided perineal cleansing and put a clean disposable brief on the resident. The CNA left the pressure sore uncovered and did not report it to the charge nurse. The CNA also failed to clean and sanitize the toilet seat to protect the resident's roommate (non-sample resident #45) from possible transmission of infection. Interview with the charge nurse, LPN #1, at 6:15 PM revealed she knew the resident had a history of MRSA infection. The CNA stated she should have cleaned the toilet seat with sanitizing wipes. She said the posted sign regarding transmission precautions meant staff were required to wash their hands and use gloves when they assisted the resident to the toilet. The CNA was not aware of any further measures or practices for preventing the transmission of infection from a draining sore. Interview with the ICP on 5/20/09 at 10:05 AM revealed she was not aware that resident #16 had a draining pressure sore; the resident was not included in the current surveillance log. She added the facility did not routinely culture draining sores for residents with a history of MRSA. She stated sanitizing the toilet seat was an appropriate practice to minimize transmission risk to the roommate.	F 441	This page left blank intentionally	

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	53A049	A. BUILDING _____ B. WING _____	05/21/2009

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F 441	Continued From page 20 Based on observation, staff interview and review of infection control data, the facility failed to incorporate a system to determine appropriate placement of roommates for four (#13, #16, #34, #37) of four sample residents, and two (#23, #57) non-sample residents who shared a room and were identified as having active infections or identified risk factors related to the spread of infection. This failure resulted in an immediate jeopardy situation. The findings were: 1. Refer to tag F442 in regard to issues related to resident placement to prevent the spread of infection. Based on observation and staff interview, the facility failed to have an effective monitoring approach in the infection control program to ensure staff used appropriate hand hygiene during three random observations. The findings were: 1. Refer to Tag F444 in regard to the lack of proper hand hygiene Due to the facility's failure to protect a vulnerable resident population at high risk for infection, immediate jeopardy was called at 9:35 AM on 5/20/09.	F 441		
F 442 SS=K	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This Requirement is not met as evidenced by:	F 442	The Facility will assure the prevention of the spread of infection to other residents by: 1. Education as noted with tag 441 for direct care staff and environmental services staff. 2. Implementation of a process for	Overall total tag element completed by: 6/30/09

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F 442	Continued From page 21 Based on observation, staff interview and review of infection control data, the facility failed to consistently establish and monitor conditions to minimize the transmission of infections for roommates of ill residents. This failure resulted in an immediate jeopardy situation for the roommates of four (#13, #16, #34, #37) of four sample residents, and two (#23, #57) non-sample residents who shared a room and were identified as having active infections or identified risk factors related to the spread of infection. The findings were: 1. Observation on 5/19/09 at 8 PM showed CNA #1 wore gloves when she assisted resident #16 to the toilet. When the resident sat to urinate, a draining pressure sore on the resident's buttock came into direct contact with the toilet seat. After the resident urinated, the CNA provided perineal cleansing and put a clean disposable brief on the resident. The CNA left the pressure sore uncovered and did not report it to the charge nurse. The CNA also failed to clean and sanitize the toilet seat to protect the resident's roommate (non-sample resident #45) from possible transmission of infection. Interview with the charge nurse, LPN #1, on 5/19/09 at 8:15 PM revealed she knew the resident had a history of methicillin-resistance Staphylococcus aureus (MRSA) infection. The CNA stated she should have cleaned the toilet seat with sanitizing wipes after contact with the draining pressure sore. She said the posted sign regarding transmission precautions meant staff were required to wash their hands and use gloves when they assisted the resident to the toilet. The CNA was not aware of any further measures or practices for preventing the transmission of infection from a draining sore. Interview with the infection control	F 442	evaluation of risk factors for roommates of residents with infections. An addendum to the policy MANAGEMENT OF CLIENTELE WITH RESISTENT ORGANISMS was developed 5/28/09 that outlines the criteria related to residents with an infection and cohorting. 3. Staff will be educated on the criteria in the above policy addendum by 6/30/09. 4. Care plans for residents with infections and the roommates will reflect consideration and evaluation of risk for the room mates. This process will be monitored by the ICP and DON for follow-up and compliance. or 5. The reporting of infection surveillance is added to the QAPI plan by 6/29/09 for monitoring. The DON is responsible to ensure compliance by verifying documentation. or 6. Residents 13, 16, 34, ~~and~~ 37, 23, 57 were assessed for active infections and the roommates of these residents were assessed with the criteria in the policy addendum referenced in #3 above. Appropriate action taken and identified in each resident's careplan. This was monitored and compliance assured by the	

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F 442	Continued From page 22 preventionist (ICP) on 5/20/09 at 10:05 AM revealed she was not aware resident #16 had a draining pressure sore; the resident was not included in the current surveillance log. She added the facility did not routinely culture draining sores for residents with a history of MRSA. She said sanitizing the toilet seat was an appropriate practice to minimize transmission risk to the roommate. According to the facility policy and procedure for infection and exposure control, both contact and droplet precautions indicate residents should be placed in a private room or a semi-private room with appropriate cohorting for residents with infections. If a resident is placed on either of these precautions, the staff shall "Notify the infection control coordinator when a patient is placed into isolation and again when isolation is discontinued." 2. Observation on 5/18/09 at 2 PM and again on 5/19/09 at 4:05 PM revealed resident #13 had a roommate, and posted outside the resident's door was signage that showed contact and droplet precautions were in effect. Interview with the ICP on 5/19/09 at 11:55 AM revealed resident #13 had a behavior that included spitting and indiscriminately spreading mucous. ICP stated she had not considered the infection risks to the resident's roommate (#38). 3. Interview with the ICP on 5/21/09 at 9:25 AM revealed there was no determination made to prevent the transmission of illnesses to the roommates of residents (#23, #34, #57) who, according to the May 2009 infection control log, were being treated for active upper respiratory illnesses. Due to the facility's failure to protect a vulnerable	F 442	This page left blank intentionally	

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F 442	Continued From page 23 resident population at high risk for infection, immediate jeopardy was called at 9:35 AM on 5/20/09.	F 442		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This Requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff used appropriate hand hygiene during three random observations. The findings were: 1. Observation on 5/18/09 at 6:25 PM revealed a sign posted outside the room of resident #19 which instructed staff to use contact isolation precautions to prevent transmission of infections. Continued observation showed CNA #4 entered the resident's room, removed the resident's hearing aides, hugged the resident and departed from the room with the hearing aids in her pocket. The CNA then pushed resident #50 from the hallway into his/her room and transferred the resident to bed. The CNA did not perform hand hygiene at any time during the observation. 2. Observation on 5/20/09 at 2:35 PM revealed CNA #7 was passing ice and water from a cart located in the hallway of the 300 unit. The aide entered the room of resident #35, who according to the infection control data had an active upper respiratory infection (URI). The room was posted with a stop sign outside the doorway, requiring staff and visitors to report to the charge nurse prior to entering the room. The following concerns	F 444	The Facility will assure the prevention of the spread of infection by appropriate hand hygiene and equipment handling by: 1. Completion of education to direct care staff regarding hand hygiene, proper glove use and personal protective equipment by 6/30/09. 2. Development and implementation of a new water pass process that separates the retrieval of dirty cups by one staff member from the distribution of ice and water in clean cups by another staff member, avoiding cross-contamination and using hand washing at all appropriate times. This process was implemented 5/23/09 and staff education completed by 6/30/09. 3. Monitoring and reporting of compliance with the water pass process is added to the QAPI plan 6/29/09. Random weekly observation by the RN Coordinators will verify compliance and follow up with reporting to QAPI, or 4. Residents 19 and 50 are protected from breaks in hand hygiene via the education initiated 5/23/09 or 5. Resident #35 and all residents are protected from infection precaution breaks and breaks in hand hygiene by 5/29/09. or	Overall total tag element completed by: 6/30/09

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F 444	Continued From page 24 were identified: a. Continued observation revealed the aide entered the room wearing gloves without any other personal protective equipment. The aide brought the resident's water pitcher into the hallway and placed the cup onto the cart. She then removed the lid and used straw, handled the ice scoop to fill the cup, and returned the contaminated scoop into the ice chest directly onto the ice. b. Next, the CNA provided water and ice for other residents in the 300 unit without changing her gloves or washing her hands. c. Interview prior to this observation with RN #1 on 5/20/09 at 1:45 PM revealed the stop sign indicated contact and droplet isolation precautions had been initiated for the resident in the room. Staff was required to wash their hands when entering and leaving the posted room, wear a mask to minimize droplet exposure, and don a gown if contact with the resident was likely. 3. Observation on 5/20/09 at 3:13 PM revealed CNA #8 wore disposable gloves while using a scoop to transfer ice from the ice chest to a resident's drinking cup in the 200 hall. The CNA then took the cup into the resident's room and placed it on the bedside table. The CNA was returning to the hallway when the resident in the bathroom asked for help. The CNA opened the bathroom door by grasping the door handle with her gloved hand and then entered the bathroom. Upon returning to the ice cart the CNA used the ice scoop to fill another resident's cup without changing gloves or washing her hands.	F 444		
F 501 SS=F	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director.	F 501	F 501 tag begins on page 26	

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F 501	Continued From page 25 The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This Requirement is not met as evidenced by: Based on staff interview, observation, and review of the facility's quality assurance performance improvement (QAPI) program, the facility failed to ensure the medical director was effectively involved in identifying, evaluating and resolving clinical concerns and issues that affected resident care and quality of life. The failure affected four (#16, #73, #13, #37) residents who were impacted by the facility's deficient practices related to pressure sores, and ten (#13, #16, #23, #34, #35, #37, #44, #57, #58, #69) residents who were impacted by the facility's deficient practices related to infection control. The findings were: 1. Interview with the medical director on 5/21/09 at 10:45 AM revealed she accepted the position in December 2008 and attended the QAPI program committee meeting one time in February. She said issues related to staffing changes, surveillance programs and hourly rounds were discussed at the meeting, but no actions, plans for resolution or further problem identification resulted from the meeting. The medical director also said she was not aware of the facility's problems related to infection control and pressure sores. 2. Refer to F314 for information regarding deficient practices related to the care of pressure sores. 3. Refer to F441 for information regarding deficient practices related to infection control.	F 501	The administration will ensure the medical director will be involved in the implementation of resident care policies and coordination of medical care and this will be accomplished by: 1) The medical director has access to our Infection Surveillance Log on our shared "I" drive. The medical director will receive infection control reports each quarter through the Medical Staff committee process. The LTC Administrator will verify the medical director reviews infection surveillance data at weekly meetings. or 2) The medical director meets weekly with our Director of Nursing and/or Administrator after wound care rounds. During this meeting the medical director will be given updates on resident medical care and policies. The medical director will give feedback and request information, changes, education that he/she would like us to implement. These weekly meetings will ~~provide~~ include oversight/monitoring of IC and wound prevention practices or 3) The medical director will be involved in the QAPI Program. The QAPI plan is in progress identifying all of the areas for pressure sores and infection control. The medical director attended the meeting on June 2 to implement all of the changes to the plan. The team will meet monthly. The LTC Administrator will monitor medical director attendance at QAPI and address non-compliance immediately. or 4. Residents 16, 73, 13, 37, 23, 34, 35, 44, 57, 58 + 69 have been addressed by medical director review of documentation with the POC for appropriate clinical care RE: pressure sores and infection control by 6/2/09 or	Overall toral tag element completed by: 6/2/09

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F 501	Continued From page 26 4. Refer to F520 for information regarding the facility's ineffective quality improvement program.	F 501		
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE 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. 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. A State or the Secretary may not require 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: Based on staff interview, medical record review and observations of care, the facility failed to ensure the quality assurance performance improvement (QAPI) program was effective in identifying problems and implementing actions to resolve problems. The failure affected four (#16, #73, #13, #37) residents who were assessed as at risk for developing pressure sores and ten (#13, #16, #23, #34, #35, #37, #44, #57, #58,	F 520	The facility will ensure that 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 is maintained, this will by accomplished by: 1) On June 2, 2009 the Administrator, Chief Executive Officer, Director of Nursing, Medical Director and all other leaders from the Goshen Care Center held a QAPI meeting to add the new monitoring for pressure ulcers and infection control. The updated QAPI plan includes all items for the IJ action plans that were accepted by the state. 2) The QAPI Committee will meet at least quarterly. The Administrator will be present at the meetings. When areas are identified that are not meeting threshold, action plans will be implemented immediately to improve outcomes for the resident. The DON and LTC Administrator will follow-up all areas below threshold and monitor improvement monthly or 3) The medical director or his or her physician designee will be present at the meetings. All resident care action plans coming out of QAPI will go to the medical director for sign off approval prior to implementation. 4, Weekly meetings between the medical director and DON and/or LTC Administrator will include oversight and monitoring of IC and wound care practices as well as any pertinent elements of the QAPI plan. Any follow-up indicated will be assured by the DON for compliance, or 5. Residents 16, 73, 13, 37, 23, 34, 35, 44 57, 56 and 69 have been addressed by medical director review of documentation with the DON for appropriate clinical care related to skincare, wound care and infection control by 6/2/09, or	Overall total tag element completed by: 6/2/09

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F 520	Continued From page 27 #69) residents who were had issues related to infection control. The findings were: 1. Interview with the interim director of nursing on 5/21/09 at 2:50 PM revealed the facility's QAPI program had not been effective during the past year due to the frequent changes in administrative staff and committee members. She said data and information had been collected, but the committee had not used the information to identify problems, develop action plans or established goals. She said the QAPI program had not identified infection control as an area of concern and the data regarding pressure sores had not been used to address the facility's current problems. Review of the 12/23/08 and 2/17/09 committee meeting minutes, QAPI quarterly reports, quality management reports, data completion reports and additional statistical reports revealed they had an ongoing system for collecting data, but no issues had been resolved or actions taken as a result of the data collection and statistical analysis. 2. Refer to F314 for information regarding the facility's failure to develop and implement effective skin care and pressure sore prevention practices. 3. Refer to F441 for information regarding the facility's failure to develop and implement an effective infection control program. 4. Refer to F501 for information regarding the facility's failure to ensure the medical director had an active involvement in QAPI program.	F 520	This page left blank intentionally	