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

PRINTED: 12/04/2009
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
	53A043	A. BUILDING _____ B. WING _____	11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

(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=E	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 and resident interview, the facility failed to promote dignity for 3 of 8 sample residents (#14, #15, #19) who required assistance during dining. The findings were: 1. Observation in the main dining room on 11/16/09 showed the evening meal was served at 5:58 PM. The following concerns were noted with assistance provided at one table for three residents: a. Resident #14 was in the dining room when the meal was served; however, no assistance was provided until 6:29 PM, thirty-one minutes after the meal arrived. b. Resident #15 was seated at the dining room table when served, but was not assisted until 6:16 PM, eighteen minutes later. c. The covered meal for resident #19 was placed on the table at 5:58 PM, but the resident was not brought into the dining room until 6:06 PM; meal assistance was not provided until 6:16 PM. Certified nursing assistant (CNA) #2 left the table at 6:24 PM for two minutes. At 6:25 PM the resident reached for the silverware, but was unable to grasp it to eat independently. When asked on 11/17/09 at 11:05 AM, the resident stated it could take up to thirty minutes before meal assistance was provided. d. CNA #2 was helping the three residents	F 241	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding of the deficiencies cited are correctly applied. F241 All staff will be educated on importance of residents arriving to dining room and assisted with meal when meal arrives. Residents #14, #15, and #19 and other residents needing assistance will be assisted with meals when meal arrives in dining room. Wyoming state-approved Nutrition Support Assistant Program to train ancillary staff, volunteers, and students (23 total) was completed December 29 & 30. Instructor was the RN responsible for Staff Development & Infection Control. The additional staff will enhance dining room.	12/9/09 12/9/09 12/30/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Caulke — TITLE: Administrator — (X6) DATE: 1/7/10

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
JAN 08 2010
Office of Healthcare Licensing and Surveys

This POC accepted on 1/8/10. Voice Mail message left for Chris Kennedy, DON.

1/8/10 CM

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F 241	Continued From page 1 during the meal, but she kept jumping up and leaving for two to three minutes at a time. The CNA was making sandwiches or assisting other CNAs, but each of the residents had to wait for her return before receiving further assistance. 2. Observation of the breakfast meal on 11/17/09 at 8:17 AM revealed resident #15 was brought into the dining room at 8:30 AM. The resident was placed at the table where his/her meal was waiting; the food was covered with an insulated cover. The resident, who was totally dependant on staff for eating waited until 8:57 AM, twenty-seven minutes, for assistance to eat his/her meal. Interview with the resident on 11/18/09 at 10:46 AM revealed s/he did not like waiting for so long for assistance because the food would get cold and need to be re-heated. The resident stated it happened "quite frequently, many times a week." Interview with CNA #1 on 11/18/09 at 8:56 AM revealed that in the main dining room, there were eight residents that needed staff assistance to eat. At that time the other aide was still helping residents in their rooms. 3. During an interview on 11/18/09 at 10:55 AM, the resident care director (RCD) stated she was unaware of the delayed assistance residents were receiving during meals.	F 241	**F241, continued** staffing to support nursing. Residents will arrive on time and be assisted upon meal tray arrival to the table. DON or designee will monitor meal times to assure residents are being assisted at meals in a timely manner. DON or designee will monitor 3 meals/week (1 each meal time) for 1 month, and if compliance achieved then monitor 3 meals/month (1 each meal time.) If compliance not achieved, the monitoring of 3 meals/week will continue until compliance achieved. DON will report to QA team monthly for 3 months, then quarterly. Responsible Party: DON	12/30/09 1/15/10
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280		

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F 280	Continued From page 2 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to revise care plans to reflect the current status of 4 of 9 sample residents (#3, #8, #19, #21) and 1 non-sample resident (#12). The findings were: 1. Review of the current care plan for resident #19, last revised on 11/4/09, revealed inconsistencies in several areas or interventions which did not match the resident's current status. a. Observation during the initial tour on 11/16/09 at 10: 10 AM showed signage on the door that indicated precautions that staff and visitors should observe to prevent transmission of infections; a cart containing supplies was located outside the resident's door. Staff later identified the resident as having methicillin-resistant Staphylococcus aureus (MRSA) in wounds in his/her legs. Review of the 10/29/09 physician's	F 280	**F 280** Care plans for residents #3, #8, #12, #19, and #21 have been updated to match the residents' current status. All care plans will be reviewed and updated to reflect residents' current status. C.N.A. daily worksheets and C.N.A. documentation will be updated to be congruent with care plan. Changes in care plans are now being recorded on audio cassette. All nursing staff is required to listen to the tape upon reporting for duty and initial the sign-in sheet stating they have listened to the tape prior to participating in resident care. The Charge Nurse is responsible for ensuring this is done. Staff meeting on 12/22/09 communicated this information to the staff. After all care plans are updated, each care plan will be reviewed during the quarterly care plan schedule to include annual reviews with random monthly chart reviews. All initial care plans, those care plans up for quarterly review and those with significant change in resident's condition will be communicated to staff via the care plan audio tape as described above.	12/9/09 1/15/10 12/22/10 1/15/10

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F 280	Continued From page 3 orders showed "contact & drainage precautions for open leg wound" had been ordered since 7/14/08. However, this information was not included in the resident's care plan or in the daily information sheet used by staff. b. The activities of daily living (ADL) plan documented the right half side rail was for security as the resident could use his/her left hand to hold onto the rail for positioning. The intervention documented that staff were to raise the right half rail. However, the intervention for fall prevention was to raise the left half side rail for security. c. The pressure ulcer care plan indicated the resident still had a PICC line (intravenous line left in place for a period of time) which required flushing. Observation showed the resident did not currently have a PICC line, and review of the physician's orders showed the line had been discontinued several months prior. d. The plan for incontinence failed to identify the manner in which the resident was assisted with use of the bedpan. Observation on 11/16/09 at 3:30 PM showed the resident was raised in a sling, then left hanging from the sling while urinating in the bedpan. On 11/17/09 at 11:08 AM the resident stated this was the easiest way for him/her to use the bedpan. This same plan also showed the resident was to be toileted upon arising, before and after meals, and at bedtime, but the daily information given to staff at the start of each shift showed the resident was able to tell staff when s/he needed to urinate and that staff were to offer to toilet the resident after breakfast. e. The plan for mood identified the resident "enjoys helping with sewing." The activity care plan had "enjoys sewing" crossed out.	F 280	**F 280, continued** Compliance will be monitored by DON or designee throughout the following week. Reports will be submitted to QA Committee for review. Failure to comply will be addressed through disciplinary process as appropriate.	1/15/10

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F 280	Continued From page 4 2. Review of the 9/22/09 care plan for resident #21 revealed the following inconsistencies or interventions that did not reflect the resident's current status: a. Although it was documented on the incontinence care plan that the resident had polyuria, no times for toileting the resident had been identified. Observations on 11/16/09 at 1:25 PM and at 4:50 PM revealed the resident's incontinence pad was saturated when changed, and the resident's clothing was wet at 4:50 PM. b. The plan for cardiac care showed the resident was on a 2 gram sodium diet as well as a regular diet. c. The care plan for continence indicated the resident was continent of bowel. Observation on 11/16/09 at 1:25 PM showed the resident was incontinent of bowel. During the observation, certified nursing assistant (CNA) #1 stated the resident frequently had smears of feces on him/herself or on the incontinence pad. 3. Review of the 10/28/09 updated care plan related to continence for resident #3 showed the resident was frequently incontinent of bladder, was aware of the urge to urinate and responded well to prompted voiding. Interventions included establishing a voiding pattern and toilet right before lunch. Observations on 11/16/09 revealed the resident went for a 3 hour and 48 minute period of time after lunch without being toileted, and s/he was incontinent. Refer to F315 for additional details. Interview with the unit secretary on 11/17/09 at 11:55 AM revealed a voiding pattern was not found, it was used only as a work sheet. 4. Refer to F315 for information regarding the	F 280		

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F 280	Continued From page 5 facility's failure to develop a care plan for resident #8 that addressed his/her assessed need for restoring as much bladder function as possible. Refer to F318 for information related to the facility's failure in providing restorative services for resident.	F 280	F 281 Medication orders for residents #9 and #12 have been clarified as to time to be given. Staff will be educated to clarify any physician orders that are questionable. Training was held on 12/8/09 via written procedure given to nurses. Competency checks began 12/8/09 and will be completed by 1/7/10 per working schedule. Competency checks will be done monthly on each nurse to ensure the 5 rights are met. This includes the 3 safety checks for administration of meds. Competency checks will be done during med pass times. Any incorrect procedures will be corrected at this time. DON, or designee with verified competency by DON, will conduct competencies. Once competencies are achieved, audits will be conducted randomly, with each med nurse evaluated each quarter. Failure to achieve and maintain competency will result in removal from medication admin duty. Competency review audits and med error rates will be computed monthly on each med nurse and the overall rate reviewed by QA team monthly. Medical Director and Pharmacist will review med error rates at QA meetings quarterly.	12/9/09 1/7/10 1/15/10 1/15/10
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, medical record review, and staff interview, the facility failed to assure staff maintained professional standards of practice related to medication administration. Orders were not clarified for 2 of 7 residents (#9, #12) observed during the medication passes and labels were not compared with physician orders for all 7 residents (#1, #4, #9, #12, #13, #20, #24) included in the medication passes. The findings were: 1. According to the 2004 Sixth Edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, if an order "is questionable for any reason, the physician must be notified for clarification." Failure to follow this standard of practice was identified in the following instances: a. Observation on 11/16/09 showed registered nurse (RN) #2 prepared and administered ibuprofen at 5:42 PM for resident #9. Reconciliation of the medication pass with the most recent recapitulation of orders showed the physician specifically ordered the medication at bedtime. Review of the medical record failed to	F 281		

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F 281	Continued From page 6 show evidence staff clarified the administration time. b. On 11/17/09 RN #2 was observed to prepare and administer calcium and a multivitamin at 8:30 AM for resident #12. Reconciliation of the medications with the physician's orders showed both medications were specifically ordered to be administered at noon. Further review of the medical record failed to reveal clarification of the administration times. c. On 11/19/09 at 8:05 AM, the resident care director stated the orders should have been clarified; she confirmed they were not. 2. Observation of medication passes for 7 residents (#1, #4, #8, #12, #13, #20, #24) showed staff pulled out color coded medication cassettes and administered the medications according to the time the color indicated. They failed to compare each medication label with the medication administration record (MAR) three separate times. During observation of the medication pass on 11/17/09 from 7:25 AM to 8:45 AM, licensed practical nurse (LPN) #2 stated she did not routinely consult the MAR when administering medications because she administered the same medications to the same residents every day and automatically knew what to administer. Review of the 2004 Sixth Edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin revealed that the first of the safety rules for medication administration was "compare drug container label to the medication sheet (MAR) three times." The reference defined those times as "When retrieving the medication from storage area. When preparing the medication. When returning the medication to storage area."	F 281	**F 281, continued** QA committee will evaluate patterns in errors, investigate for root cause of errors, and make any necessary changes in policy.	

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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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of medical records, the facility failed to assure care plans for 4 of 9 sample residents (#8, #19, #21, #28) were followed as developed. The findings were: 1. Review of the care plan showed resident #21 was to receive a shower twice a week, and, under the continence plan, staff were to offer "special occupational therapy (OT) exercises as needed. "Staff were also to "encourage complete bladder emptying by using Crede maneuver." Failure to follow the care plan was identified in the following instances; a. Review of the 2009 CNA daily documentation sheets showed the resident did not receive a bath from September 5th through the 14th (a 10 day period), from October 2nd through the 8th (6 days), and from October 22nd through the 26th (5 days). The documentation provided no evidence the resident refused a bath, but there was a star on September 8th. On 11/19/09 at 2:10 PM, CNA #4 stated a star indicated the bath was not done. b. Observation on 11/16/09 at 4:50 PM showed the resident used the bedside commode. However, OT exercises were not offered and the resident was not encouraged to perform the Crede maneuver. On 11/19/09 at 8:50 AM CNA #3 stated she had no idea what "special OT	F 282	**F 282** A. Care plan for resident #21 has been updated. The resident will be toileted and bathed according to care plan. Resident #28 will be toileted according to care plan. Charge nurse on duty will monitor toileting is being done as directed in plan of care. Resident #3 will be offered assistance at all meals at frequent intervals. CNA will monitor resident's progress during dining and assist as necessary. Resident will be informed of food position on plate using a method the resident will understand, e.g., top, left, right, bottom. Resident #19 will be toileted according to care plan. B. All staff will be informed of any changes in plan of care as changes occur via audio cassette communication. C. CNA Documentation Sheets and Daily Worksheets will be updated as changes occur by the care plan team.	12/22/09 1/15/10

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F 282	Continued From page 8 exercises" entailed and she had never offered them to the resident. 2. Review of the care plan, updated on 10/28/09 for resident #28 showed s/he was incontinent of urine. According to this update, the resident would be checked for incontinence every two hours around the clock. Observation on 11/16/09 from 1:40 PM to 4:28 PM showed the resident was not checked as planned. At 1:40 PM the resident was checked and the incontinence brief changed by CNA #1 when she laid him/her down. At 4:28 PM, 2 hours and 48 minutes later, the resident was gotten up by CNA #1 who in an interview at 5:40 PM, revealed the resident was wet when she checked at 4:28 PM. Refer to F 315 additional details. 3. Review of the care plan dated 10/29/09 for resident #3 showed staff were to offer assistance for the resident. The care plan also showed the resident had poor vision and needed adaptive equipment at meals. Interventions listed were to assist at mealtime, use a red plate, and describe the placement of the food items on the plate by the clock. Observation on 11/16/09 from 6:10 PM to 6:30 PM showed the resident was served his/her meal. The meal was served on a yellow plate, and there was no adaptive equipment provided. There was an aide assisting two other residents at the same table, and only one time during the observation did she check to see if the resident was in need of assistance. 4. During an interview on 11/16/09 at 1:55 PM, resident #19 stated s/he was last toileted at 10:30 AM that morning. According to the continence care plan last revised on 11/4/09, the resident was to be toileted upon arising, before and after meals, and at bedtime. Observation showed the	F 282	**F 282, continued** D. CNA "Documentation Sheet" will be monitored (using audit tool) monthly until competencies achieved, then once/quarter to ensure ongoing compliance. Any failure to follow policy will be addressed on an individual basis by administration. General Resident satisfaction with ADL's will be addressed in resident council (after approval obtained from the council) and during Social Services rounds with each resident to assure needs are consistently being met. Social Services and/or Activities Director will report to the QA Committee monthly. Residents unable to communicate will be assessed by the care plan team during care plan meetings with the family. Information will be communicated to the care plan team to revise the plan of care if needed and recorded in Social Service's notes and Resident Council minutes (if permission to add to minutes is first approved by the resident council.) 1/15/10	

1/8/10 CM

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F 282	Continued From page 9 resident was not toileted again that day until 3:30 PM. Further observation revealed the resident was not toileted prior to the evening meal at 6 PM. On 11/18/09 at 1:20 PM certified nursing assistant (CNA) #3 stated the care plans were current.	F 282	F 312 *Related to Incontinence Care:*	
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Related to incontinence care: Based on observation and staff interview the facility failed to assure staff provided appropriate perineal (incontinence) care for 1 of 8 incontinent residents (#21) who required staff assistance for completion of perineal care. The findings were: Observation on 11/16/09 at 4:50 PM showed resident #21 was incontinent of urine. While providing perineal care, certified nursing assistant (CNA) #1 cleansed the resident's buttocks and then used the same area of the wipe to cleanse the perineal area. Interview with the CNA at 5 PM that day revealed she was not taught to provide perineal care in that manner. She stated she "just forgot" to use a clean area of the wipe to cleanse the perineal area. Review of the 9th Edition of "Nursing Assistant A Nursing Process Approach" by Hegner, Acello, and Caldwell showed "Always wipe from clean to dirty with a single wipe, then turn or discard the cloth."	F 312	Resident #21 will be toileted according to plan of care and any necessary incontinence care will be provided according to facility policy. Staff will be educated and re-competencied on peri-care and importance of following the peri-care policy as trained. DON or designee will assure 100% of staff providing resident care will be educated and competencied on peri-care using audit tool for one month. DON or designee will conduct random peri-care competency checks on at least 3 staff members each month. Responsible Person: DON or designee DON or designee will report to the QA Committee monthly.	1/15/10 1/15/10 1/15/10

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	53A043	A. BUILDING _____ B. WING _____	11/19/2009

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F 312	Continued From page 10 Related to lack of bathing: Based on confidential resident interviews, review of medical records, and interviews with staff, the facility failed to assure 3 of 9 sample residents (#3, #21, #28) received baths as planned. These three residents required extensive or total staff assistance with bathing. The findings were: 1. Review of the 7/2/09 significant change and 9/24/09 quarterly Minimum Data Set (MDS) assessments showed resident #21 required extensive assistance from staff with bathing. Review of the care plan showed the resident preferred baths three times a week, but was to receive them at least twice weekly. Review of the 2009 CNA daily documentation sheets showed the resident was not bathed from September 5th through the 14th (a 10 day period), from October 2nd through the 8th (6 days), and from October 22nd through the 26th (5 days). The documentation provided no evidence the resident refused a bath, but there was a star on September 8th. On 11/19/09 at 2:10 PM, CNA #4 stated a star indicated the bath was not done. 2. Review of the 10/29/09 quarterly MDS assessment for resident #3 showed s/he required some physical assistance for bathing. Review of the October 2009 bathing documentation showed the resident preferred baths on Mondays and Thursdays. According to the record, the resident received a bath on Monday 10/5, and not again until Thursday 10/15, 10 days later. Additionally there was another 10 day period between baths from 10/15 to 10/26/09.	F 312	**F 312, continued** *Related to Bathing:* Residents #3, #21, & #28 will receive baths according to plan of care. If resident refuses bath it will be documented as a refusal and resident will be asked again at a later time. An additional CNA will be added to the day shift as a designated bath aide 5 days/week. General Resident satisfaction with ADL's will be addressed in resident council (after approval obtained from the council) and during Social Services rounds. Social Services will perform resident rounds to determine resident satisfaction with ADL's including bathing. Preferences will be addressed at this time. Rounds on all residents will be completed by 1/15/10. Information will be communicated to the care plan team to revise the plan of care if needed and recorded in Social Service's notes and Resident Council minutes (if permission to add to minutes is first approved by the resident council.) Charge nurse will monitor baths daily to assure baths are completed using audit tool.	1/15/10 1/15/10 1/15/10 1/15/10 1/15/10

1/8/10

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F 312	Continued From page 11 3. Review of the quarterly 10/29/09 MDS assessment showed resident #28 was dependant on staff for bathing. Review of the bathing documentation for October and November 2009 showed resident #28 did not receive a shower/bath for 13 days between 10/21- 11/3/09. During confidential interviews on 11/17/09, 10 residents stated that baths were not always done as planned when the facility was short staffed. Dining: Based on observation and staff and resident interviews, the facility failed to ensure dining assistance was provided as necessary for 1 of 8 residents (#3) who required assistance with dining. The findings were: Review of the care conference summary dated 10/29/09 for resident #3, showed the resident's dietary needs were assessed. According to this summary, the resident had asked to be fed due to difficulty eating. The note showed staff were to offer assistance for the resident. Review of the care plan showed the resident had poor vision and needed adaptive equipment at meals. Interventions listed were to assist at mealtime, use a red plate, and describe the placement of the food items on the plate by the clock. Interview with the resident on 11/16/09 at 1:05 PM and on 11/17/09 at 10:40 AM revealed s/he was blind and was not satisfied with the amount of assistance provided at meals. During the 11/17/09 interview the resident stated s/he could not understand the clock method used because there was too much information to remember. The resident stated s/he had spoken	F 312	**F312, continued** *Related to Dining:* Resident #3 will be assisted using simple top/bottom/left/right method. Resident will be monitored frequently and assisted as needed by CNA at resident's table. Care plan has been updated to address the need to assist resident frequently during meals and staff have been informed of the changes to the plan of care. Responsible Party: DON Residents will be asked at monthly Resident Council meetings if dining needs are being met. Responsible Party: Activities Director	1/15/10 1/15/10 1/15/10

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F 312	Continued From page 12 to staff about these issues and they were going to feed him/her. Observation on 11/16/09 from 6:10 PM to 6:30 PM showed the resident was served his/her meal. The meal was served on a yellow plate, and there was no adaptive equipment provided. In addition, the aide who delivered the meal explained what items were on the table in front of the resident using the clock method. The resident stated s/he understood. The aide then told the resident to yell if she needed any help. During the observation there were six times when the resident would lift the fork to his/her mouth with nothing on it. There was an aide assisting two other residents at the same table, but during the observation the aide checked to see how the resident was doing only one time.	F 312		
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, medical record review, and review of policies and procedures, the facility failed to establish and implement an effective wound treatment program. Additionally, the facility failed to require staff to follow standard and contact isolation precautions	F 314	**F 314** Resident #19 has all wound care supplies in room or taken from treatment cart outside room for dressing changes. All reusable items such as scissors and wound cleaner will be sanitized with facility approved sanitizing wipes prior to replacing on treatment cart. All residents receiving wound care, including #14, #15, #21, and #26 will have supplies for wound care on the treatment cart which will remain outside of the residents' rooms. Necessary supplies will be brought into room from the treatment	12/9/09 12/9/09 12/9/09

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F 314	Continued From page 13 during wound treatments provided by the wound team for 1 of 1 sample residents (#19) with known methicillin resistant Staphylococcus aureus (MRSA) in the open wounds. The facility further failed to ensure a system was in place to reduce the likelihood of transmitting MRSA to 4 other sample residents (#14, #15, #21, #26) currently receiving wound treatments by the wound team. These 5 people represented 100% of the residents being treated by the wound team at the time of survey. Finally, the facility failed to follow the physician's orders for wound treatment. These inappropriate practices resulted in an immediate jeopardy situation called on 11/18/09 at 4:45 PM. Immediate jeopardy was abated on site on 11/19/09 at 2 PM. Refer to F441 for actions taken by the facility to accomplish this. The findings were: 1. Observation during the initial tour on 11/16/09 at 10:10 AM showed signage on the door of resident #19 that required staff and visitors were to observe precautions for preventing the spread of potentially infectious organisms. An enclosed cart containing supplies was located outside the resident's door. Review of a wound culture and sensitivity report dated 2/4/09 revealed the resident had MRSA in a wound on the right leg. Review of physician's orders, dated 10/29/09, showed "Contact & drainage precautions for open leg wounds" had been ordered for this resident since 7/14/08. Further record review showed the resident had been treated for the infection with several different antibiotics, but a culture showing the infection had cleared was never obtained. Review of the facility's policy and procedure, "Screening for and Management of Methicillin Resistant Staphylococcus Aureus in the Hospital and Nursing Home," effective 3/26/07, revealed	F 314	**F 314, continued** care for wound care. Re-usable items will be cleaned with facility-approved sanitizer prior to replacing on the treatment cart. All physician orders will be followed as written. If wound care team recommends different wound care regimen the physician will be notified for approval of the recommendation. Until approved by the M.D., the wound care will remain unchanged. A treatment cart will be used to avoid clutter in resident room due to lack of space and to avoid institutional environment in the resident's room.	1/15/10

11/19

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F 314	Continued From page 14 isolation precautions would "be discontinued after 2 consecutive negative cultures" were obtained. Interview with the resident care director (RCD) on 11/18/09 at 2:25 PM revealed the resident was still on contact precautions. Review of a physician's communication form dated 10/12/09 showed staff requested Bactroban for the wounds on the resident's left foot and right leg with an adaptic dressing applied afterward, but the physician only ordered Bactroban. Review of orders dated 10/29/09 showed the wound on the left foot was to be cleansed with normal saline, dressed with prisma moistened with normal saline and covered with gauze, three times a week. The same orders indicated the wound on the right leg should be cleansed with Hibiclens and 4X4 gauze, rinsed, dried, and then a thin coat of triamcinolone cream applied before applying an adaptic dressing and a covering of gauze. Interview with RN #2 on 11/17/09 at 7:45 AM revealed the dressings on the wounds were changed daily by the nursing staff and weekly by the wound team. The wound team was composed of physical therapist #1, registered nurse #3 and certified nursing assistant (CNA) #3. Observation on 11/18/09 at 1:20 PM revealed the following discrepancies: a. On 11/18/09 at 10 AM RN #3 reviewed the orders for wound care and stated they were not following the physician's orders dated 10/29/09, but were instead using Bactroban and adaptic covered with Tegaderm per the 10/12/09 communication. The RN had no reply when the surveyor pointed out that the physician only wrote the order for Bactroban; he did not include adaptic on the written reply to that communication. b. During the observation, the therapist donned non-sterile gloves to remove the old	F 314	**F 314, continued** In the event of communicable condition, supplies taken into room will remain in the room with the exception of Sharps--which will be disinfected per CDC guidelines. All staff, contracted employees, and therapists providing wound care have been competencied by the nurse consultant, DON, and MDS Coordinator on wound care procedure. Random staff, contract employees, and therapists providing wound care will be audited weekly by DON, Infection Control Nurse, or Wound Care Nurse for 3 months. If 100% compliance with wound care protocol after 3 months is achieved, Infection Control Nurse will monitor quarterly. Any staff not following procedure will be removed from the wound care and re-educated and/or disciplinary process implemented as appropriate.	11/19/09 1/15/10

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F 314	Continued From page 15 dressing on the resident's left foot. The wound was scabbed, but still open around the edges. Without removing the gloves, the therapist then felt the wound and surrounding tissue to check for bogginess, measured the wound, and then cleansed and re-dressed it while still wearing the same gloves. After touching the wound and while wearing the same gloves, the therapist reached into a Ziploc bag of 4X4 gauze pads, thus contaminating the remaining gauze pads with potentially infectious material from the resident's wound. The Ziploc bag had been in a tray on an open, mobile treatment cart that was brought into the resident's room. The Ziploc bag was placed back onto that cart. The RN used scissors taken from the tray to cut the adaptic dressing that was placed on the wound, as well as the gauze used to wrap the foot. The adaptic dressing, itself, was obtained from an opened package on the tray. Both the opened package of adaptic dressing and the scissors were put back onto the tray. The scissors used to cut the dressing were not cleansed either prior to or after use. The therapist stated she did not apply Bactroban as it was "not needed" and prisma, which was also part of the current order, was not mentioned. c. While still wearing the same gloves used to treat the resident's left foot, the therapist next removed the dressing from the wound on the resident's right leg, measured the wound, and cleansed it by again reaching into the plastic bag and obtaining one of the contaminated gauze pads, which she sprayed with wound cleanser instead of Hibiclens. The therapist then applied Bactroban and an adaptic dressing and covered the entire wound with gauze. The same pair of scissors was used to cut the adaptic and gauze, again without being cleansed before or after use. Both the adaptic and the scissors were placed in	F 314	**F 314, continued** All opened uncontaminated supplies will be placed in a Ziploc bag in the original packaging with the bag sealed and on the treatment cart. If the supplies become contaminated they will be discarded immediately. No supplies will be removed from the room if the resident has a communicable disease. Wound Care Nurse will ensure supplies are available on treatment cart at time of weekly wound rounds. DON or Wound Care Nurse will report to the QA Committee monthly.	12/9/09 1/15/10 1/15/10

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F 314	Continued From page 16 the tray on the treatment cart. d. At 1:43 PM the therapist confirmed she had not changed her gloves during or between the dressing changes. e. After completing the dressing change, the entire treatment cart was taken into the room of resident #21 where that resident's dressing was changed at 1:45 PM. The therapist reached into the same Ziploc bag and obtained contaminated 4X4 gauze pads, that contained contaminated gauze pads, and used one of the pads to cleanse this resident's open wound. Again the adaptic dressing, was cut from the open package with uncleansed scissors; the bag of 4x4's, adaptic dressing, and scissors were placed back on the treatment cart and taken to the room of yet another resident (#14) where the team prepared to change that resident's dressing. At 2:15 PM, the surveyor stopped the wound team from continued use of the contaminated 4X4 gauze pads and the potential spread of material from a resident with culture-confirmed MRSA who was currently under infection control precautions. f. On 11/18/09 at 3:20 PM the RCD stated the entire wound team was aware resident #19 had been diagnosed with MRSA. She further stated she had attended wound rounds "two or three weeks ago" and a mobile cart containing the supplies was taken from room to room. During this interview, the RCD stated dressing changes completed by the licensed staff were not monitored for compliance with infection control practices. 2. According to the physician's orders dated 10/29/09, the wound of resident #21 was to be cleansed with wound cleanser, covered with Allevyn thin, and the entire area covered with	F 314		

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F 314	Continued From page 17 Tegaderm. Observation of a dressing change for the resident on 11/16/09 at 1:45 PM showed licensed practical nurse (LPN) #1 took a tray containing supplies into the resident's room. The LPN donned non-sterile gloves, cleansed the sacrococcygeal wound with wound cleanser, then cut a strip from an opened dressing package obtained from the tray. The LPN applied the dressing and covered the wound with Tegaderm. The LPN failed to cleanse the scissors from the tray either before or after use, and she replaced them into the tray. Immediately after the dressing change the LPN verified she had not cleansed the scissors. Although the name of the dressing had been removed from the opened package, the LPN identified it as Allevyn. This same package of dressing material was identified by RN #3 as adaptic during the resident's dressing change on 11/18/09 at 1:45 PM. The RN produced a package of Allevyn to verify that it was different than the dressing used by LPN #1. 3. Observation of the dressing change for resident #19 on 11/18/09 and review of the physician's orders showed the therapist changed the treatment without authorization from the physician. During an interview on 11/19/09 at 1:15 PM, RN #3 stated there was nothing in the facility's wound care program allowing the physical therapist to direct the treatment used on wounds. At 2:40 PM, the clinical consultant confirmed the therapist did not have approval from the physicians to change wound treatment orders. Review of the facility's undated policy and procedure entitled "Skin Integrity: Prevention and Early Management of Partial Thickness Skin Breakdown" showed only that a wound care specialist would be consulted.	F 314		
F 315	483.25(d) URINARY INCONTINENCE	F 315		

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F 315 SS=E	Continued From page 18 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate care and services to address urinary incontinence was provided for 3 of 8 sample residents (#3, #8, #28) with bladder incontinence. The findings were: 1. Review of the 8/5/09 annual Minimum Data Set (MDS) assessment and the 11/5/09 quarterly MDS assessment for resident #8 showed the resident had multiple daily episodes of urinary incontinence and was totally dependent upon staff for toileting and incontinence care. Review of the care plan for the resident, last updated on 11/5/09, showed the following interventions: a. Toilet every two hours, before and after meals and at bedtime; b. "Toilet schedule between 6 and 6:30 AM...Toilet between 3 and 4 PM." Continuous observation of the resident on 11/16/09 from 12:50 PM until 4:45 PM (almost 4 hours) showed the resident remained supine in bed. During that time staff did not assess the	F 315	F 315 Residents #3, #8, and #28 will be toileted according to care plan. Staff will have current toileting care plan available on Daily Care Sheets and access to care plans on residents' charts if questions. Current Plan of Care will be reflected on CNA Documentation Record. Care plans will be re-evaluated quarterly and as needed with condition changes. Daily Care Sheets and CNA documentation will be updated to reflect changes. MDS Coordinator will audit, using a quality monitoring tool, to ensure toileting and/or incontinent care is carried out according to the care plan. MDS Coordinator or designee will report findings to the QA Committee monthly for 3 months, then quarterly.	12/9/09 1/15/10 1/15/10 1/15/10 1/15/10

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F 315	Continued From page 19 resident for incontinence, ask the resident if he/she needed to use the bathroom or attempt toileting. At 4:45 PM certified nurse aide (CNA) #5 removed the resident's urine soiled clothing and bed linen and provided incontinence care. At that time, the CNA said staff did not routinely assist the resident with toileting, nor was there a scheduled time interval for assessing the resident for incontinence. During an interview on 11/17/09 at 11 AM, the MDS coordinator said some of the resident's care plan interventions regarding toileting and incontinent care were not accurate. She said it was important for staff to keep the resident clean and dry by checking the resident more frequently than at four hour intervals. 2. Observation on 11/16/09 at 1:08 PM showed resident #3 was laid down after lunch by CNA #1. At that time the aide stated she did not toilet the resident because it was done right before lunch. According to the aide the resident was able to let them know when s/he needed to go to the bathroom. At 3:50 PM the aide responded to the resident's call light, and said she would return in 45 minutes to get him/her up. At 4:32 PM the aide returned and assisted the resident into the bathroom. During the observation and the CNA's interview at that time, it was revealed the resident was incontinent of urine during the three hour and 24 minute time frame. 3. Observation on 11/16/09 from 1:40 PM to 4:28 PM showed at 1:40 PM resident #28 was checked and the incontinence brief changed by CNA #1 when she laid him/her down. At 4:28 PM, 2 hours and 48 minutes later, the resident was gotten up by CNA #1 who, in an interview at	F 315		

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	53A043	A. BUILDING _____ B. WING _____	11/19/2009

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F 315	Continued From page 20 5:40 PM, revealed the resident was wet when she checked at 4:28 PM. Review of the continence care plan showed the resident was to be checked every two hours around the clock.	F 315		
F 318 SS=G	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to ensure 2 of 5 sample residents (#19, #28) and 1 non-sample resident (#12) who had orders for restorative services received those services as planned. This failure resulted in actual harm for resident #19 who experienced an avoidable decline in range of motion. The potential for harm was also present for newly admitted resident #12, who did not receive appropriate treatment to prevent possible injury or decline. The findings were: 1. Medical record review showed resident #19 was admitted with diagnoses, which included end stage rheumatoid arthritis. Review of the 2/12/09 annual Minimum Data Set (MDS) assessment showed the resident had bilateral limited range of motion (ROM) with partial loss of voluntary movement in the arms, hands, legs, and feet. Comparison of that assessment with the 11/5/09	F 318	**F 318** Residents #12, #19, and #28 as well as all other residents on restorative plan will receive restorative services according to restorative plan. A dedicated Restorative Aide will be on duty five days per week and CNA staff will perform restorative services in the absence of the restorative nurse aide. Restorative Services will be provided a minimum of 5 days/week. Staff will be educated regarding change in daily staffing and reinforced that CNAs will be required to perform restorative care in the absence of the dedicated Restorative Nurse Aide. A Registered Nurse has been identified to oversee the Restorative Program. The certified RNA has provided written guidelines outlining basic restorative care. These written guidelines and verbal communication were provided at the 12/22/09 staff meeting.	1/15/10 1/15/10 1/15/09 12/22/09

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F 318	Continued From page 21 quarterly MDS assessment revealed the resident had declined; on the quarterly assessment, the facility's documentation showed full loss of voluntary movement in all itemized areas. Review of the physician's orders for restorative care, from July through October 2009, showed the resident was to receive passive range of motion (PROM) daily to all extremities, s/he was to sit independently for ten minutes three times a week, a magazine reading adaptor was to be set up twice weekly, and physical therapy (PT) was to evaluate the restorative plan routinely and as needed. Review of the last PT evaluation dated 2/25/09 showed the resident was to continue receiving PROM daily. Review of the care plan, last updated on 11/4/09, and the daily staff information sheet showed staff were to provide PROM every day. The following concerns with implementation of the plan were identified: a. On 11/18/09 at 12:07 PM the MDS coordinator verified the resident had declined in ROM capability. The coordinator stated this was due to the restorative aide (RA) frequently being assigned to provide resident care during the past quarter. b. Interview with the RA on 11/19/09 at 8:50 AM confirmed the restorative program for this resident had not been provided as planned and, therefore, the resident had declined. The RA stated that when she was assigned to provide resident care, each certified nursing assistant (CNA) was supposed to complete the restorative program for his or her assigned residents. She further stated the sitting exercises were not being completed as the CNAs were not taught to perform this activity. Finally, the RA stated using the magazine adaptor was not successful, so some time ago staff stopped trying to have the resident perform this exercise.	F 318	**F 318, continued** CNAs will be trained in basic restorative care. Competency checks on each nurse aide will be done by observation using monitoring tool by 1/15/10. If the C.N.A. is verified at competent with restorative care, random monitoring will be done by the Restorative Nurse or designee. If competency is not verified, additional education will be provided by the Restorative Nurse or approved designee, and re-competencied until competency is verified, then at least quarterly, to assure restorative care is completed as ordered. 10% of restorative plans will be reviewed monthly but no less than 3/month, Responsible Party: Restorative Nurse Restorative documentation will be revised to assure documentation is clear. DON or designee will report to QA Committee quarterly.	1/15/10 1/15/10 1/15/10 1/15/10

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F 318	Continued From page 22 c. Sitting for ten minutes three times a week and using the magazine adaptor were not included in the care plan or the daily staff information sheet. d. Review of the restorative documentation for September, October, and November 2009 showed the sitting exercise had not been completed as ordered. Use of the magazine adaptor was not included on the documentation. e. On 11/19/09 at 11:20 AM the resident stated the sitting exercises had not been completed for "several months." The resident further stated that the resultant loss of mobility and strength made him/her feel "kind of depressed." 2. Review of the 10/06/09 admission Minimum Data Set (MDS) assessment for resident #12 showed s/he required extensive assistance with transfers, dressing and personal care due to having had a stroke. Review of the 10/13/09 care plan for the resident showed movement and position of his/her right leg and right hand triggered the resident's pain. Review of nurses' notes, dated 9/28/09, showed the resident had swelling in the right hand and a sling was used during transfers to protect the resident's right arm. Review of the occupational therapist's (OT) note, dated 10/28/09, showed the OT trained nursing staff on how to protect the resident's right shoulder and arm while positioning. Review of the November 2009 restorative service delivery record showed the right hand splint was to be worn when the resident was up, but nothing was documented to indicate whether or not it was being done. Additional review of this record	F 318		

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F 318	Continued From page 23 showed the resident was supposed to have range of motion exercises, but again nothing was documented to indicate whether or not they were being done. Review of the patient care assignment sheet used by the CNAs showed no information regarding the resident's ROM, hand splint, or sling. In addition, the documentation by the therapist, restorative aide and nursing staff did not address the resident's contracted fingers on the right hand. Observation on 11/16/09 at 10:30 AM showed the resident sat in his/her wheelchair with a stuffed toy positioned under his/her right arm. The stuffed toy provided support for the resident's arm, but did not reduce the pressure in his/her contracted fingers. Observation of the resident's room revealed a sign posted on the wall with the following instructions: "To protect arm please wear sling during transfers." A second sign posted on the closet door gave specific instructions for therapeutic restorative exercises. Observation on 11/16/09 at 1:30 PM, showed two CNAs (#1, #4) transferred the resident from the wheelchair to the bathroom using a mechanical lift. During the transfer the resident's right arm hung flaccid, without support from staff, a sling, or a splint. Observation showed the resident's arm remained unsupported and unprotected as it dangled while the resident sat on the toilet and was later was transferred with the lift from the bathroom to bed. Periodic observations of the resident from 10:30 AM till 6:50 PM also showed the resident did not wear a splint or other therapeutic device in his/her contracted hand, but his/her arm rested on the stuffed toy. Interview on 11/18/09 at 11:15 AM, with registered nurse (RN) #3 revealed the resident did not like the sling, but if staff did not use the sling they were supposed to support the	F 318		

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F 318	Continued From page 24 resident's shoulder and arm during transfers. The RN verified the information the OT posted on the wall in the resident's room was not in the care plan, but it should have been added. The RN stated the resident's restorative program required staff to apply splints and supportive devices as directed by the therapist. The RN also stated she did not understand why staff did not do this consistently. 3. Review of the 10/29/09 quarterly Minimum Data Set (MDS) assessment for resident #28 showed s/he had range of motion limitations of the arm, hand, leg and foot on one side. Review of the November 2009 restorative service delivery record showed a brace was to be applied to the resident's right hand daily. Random observation on 11/16/09, 11/17/09 and 11/18/09 revealed the brace was not being worn by the resident. Interview with the restorative aide on 11/19/09 at 8:40 AM revealed the brace was to prevent contracture of the resident's right hand. She stated when she was working as the restorative aide, she would put it on in the morning and it would be worn for a few hours. She then stated most of the time the direct care nurse aides were responsible to follow the restorative plans, and this was to be documented in the record when done. Review of the November 2009 records with the restorative aide showed there was not any way to tell if a brace was being applied to the right hand. In an interview with CNA #1 on 11/17/09 at 1:37 PM, it was revealed the brace was not put on that day or the day before because a restorative aide was not working. She further stated she did not do it because she had not been taught how to put it on. 4. Interview with the restorative aide on 11/19/09	F 318		

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F 318	Continued From page 25 at 8:40 AM revealed that due to the facility's staffing needs, most days she worked as a CNA, and two days a week she worked as a restorative aide. She stated the direct care CNAs were responsible for implementing the restorative care plan for residents when there was not a specific person assigned to work as a restorative aide. Related to the sling listed for resident #12, she stated a stuffed animal was being used instead of the sling to provide some support for the resident's arm. The restorative aide stated this change in the plan of care was not discussed with the occupational therapist who assessed the resident's needs, and it was not reflected on the plan of care. Related to the sitting exercise for resident #19, the RA revealed this was not being consistently done. She stated in the past two months she was the only one that would have the resident do the exercise. Other aides did not attempt it, and there had been no education provided on how to accomplish the therapy.	F 318	F 329 Medications for residents #19 and #21 have been reviewed by a physician. A statement of risk and benefit will be completed by 1/15/10. All medications will be reviewed monthly by the consulting pharmacist. Any irregularities will be addressed with the physician for review. Drug Regimen Reviews (DRRs) will be reviewed by the DON or designee monthly to assure all recommendations or concerns are addressed and report to the care plan team.	12/9/09 1/15/10 1/15/10
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	A meeting with the consulting pharmacists was held 12/9/09 to review documentation issues and duties.	12/9/09

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F 329	Continued From page 26 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and interview with the consultant pharmacist, the facility failed to assure the medication regimens for 2 of 10 sample residents (#19, #21) were free of unnecessary medications. The findings were: 1. According to the 2/12/09 annual Minimum Data Set (MDS) assessment, resident #19 had diagnoses which included depression. Further review of all the MDS assessments since that date showed the resident expressed no indicators of depression. Review of the physician's orders and the medication administration records (MARs) showed the resident had received the antidepressants Wellbutrin XL 150 mg daily since 7/14/08 and Zoloft 100 milligrams (mg) daily since 8/6/08 . However, there was no evidence in the medical record that reducing the dosages of either medication had been considered. Nor was there any rationale from the physician for continuing the medications at the same doses. On 11/18/09 at 10:10 AM the resident care director (RCD) confirmed the lack of dose reductions or a physician's rationale which identified the risks versus the benefits of continuing the medications. Review of the 11/5/09	F 329	**F 329, continued** Psychotropic drug review will be done quarterly to evaluate effectiveness of monitoring criteria and medications. DON or designee will report to QA Committee quarterly. Medical Director will be notified if medical staff is not following pharmacist's recommendations. Medical Director will be asked to educate medical staff regarding DRRs. If a physician does not want to follow the pharmacist's recommendations, the MD must write a statement addressing risk vs. benefits of not following the recommendations. Resident Behavior Logs will be reviewed by the Psychotropic Drug Team monthly to ensure target behaviors are appropriately identified. This team is comprised of the Administrator, DON, Social Services Director, and MDS Coordinator. Care Plans and Behavior Logs will be made available to the consulting pharmacists and physicians to review to ensure appropriate plan of care including medication regimen.	1/15/10 1/15/10 1/15/10 1/15/10 1/15/10 1/15/10

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F 329	Continued From page 27 "Psychotropic Drug Review" showed the facility tracked the number of episodes of anger (3), decreased social interaction (0), and negative statements about self or crying (0) occurring in the last 3 months. However, evidence was lacking that this data was evaluated for appropriateness of continued monitoring. On 11/19/09 at 11:30 AM, the consultant pharmacist stated he reviewed the monitoring but did not evaluate the criteria being monitored to determine if improvements or declines were related to the effectiveness of the medications. 2. Review of the physician's orders showed resident #21 had diagnoses which included depression. Further review of the orders and the MARs showed the resident had received the antidepressant Zoloft 150 mg daily since 2/7/08. Review of the 3/26/09, 7/2/09, and 9/24/09 MDS assessments showed the resident continued to exhibit persistent anger and crying. Review of the 11/5/09 "Psychotropic Drug Review" showed the facility monitored for the number of episodes of crying (34), increased cognitive impairment (many), negative statements about self (73), self isolation (4), and repetitive picking at the skin (many) observed during the past quarter. Review of the medical record showed no evidence the physician had evaluated the risks versus the benefits of continuing the medication. On 11/18/09 at 10:10 AM, the RCD confirmed the lack of a physician's rationale for continued use of a medication that was not controlling the resident's symptoms. On 11/19/09 at 11:30 AM the pharmacist stated the resident was "not stable." However, he offered no explanation for continued use of the medication, or use at a dosage that had not proven to be effective.	F 329	**F 329, continued** A Pharmacy Oversight Team consisting of the DON, Pharmacist, Administrator, and Medical Director will review the pharmacy policies and procedures, making sure they are written according to current standard, the DRRs are current and being addressed, medication use is addressed by the prescribing MDs, and that F329 is addressed for unnecessary drug use. The team will review med error rates and identify trends or system deficiencies.	

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F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain an error rate under 5 percent (%). Out of 50 opportunities for error, seven errors were committed, resulting in an error rate of 14%. The findings were: 1. Observation on 11/16/09 showed registered nurse (RN) #2 prepared and administered medications, including Citracal 630 milligrams (mg) with vitamin D 500 mg, at 5:24 PM for resident #13. When questioned immediately after the administration, the RN had no explanation for the lack of the dosage on the medication administration record (MAR). The RN stated that before 11/1/09 the resident only received 600 mg of Citracal. Reconciliation of the medication with the physician's order showed "Citracal+D" twice daily with meals was ordered on 10/13/09. The order lacked the amount of either calcium or vitamin D or the number of tablets to be given. On 11/17/09 at 9:50 AM the resident care director (RCD) confirmed the error. 2. Observation on 11/17/09 showed RN #2 prepared and administered medications for resident #1 at 8:21 AM. These medications included Clear Lax (generic Miralax) 15 milliliters (ml). Reconciliation of the medication pass with	F 332	**F 332** Orders have been clarified as to dosage for residents #13, #1, #24, #20 and all other residents affected. Staff will be educated to clarify any physician orders that are questionable. Training was held on 12/8/09 via written procedure given to nurses. Competency checks began 12/8/09 and will be completed by 1/7/10 per working schedule. Competency checks will be done monthly on each nurse to ensure the 5 rights are met. This includes the 3 safety checks for administration of meds. Competency checks will be done during med pass times. Any incorrect procedures will be corrected at this time. DON, or designee with verified competency by DON, will conduct competencies. Once competencies are achieved, audits will be conducted randomly, with each med nurse evaluated each quarter. Failure to achieve and maintain competency will result in removal from medication admin duty. Competency review audits and med error rates will be computed monthly on each med nurse and the overall rate reviewed by QA team monthly. Medical Director and Pharmacist will review med error rates at QA meetings quarterly.	12/9/09 1/7/10 1/15/10 1/15/10

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F 332	Continued From page 29 the physician's orders showed the most current order for Miralax was for 5 ml instead of the 15 administered. The orders also showed two medications, Meclizine and Floranex, were ordered, but the observation showed they were omitted. The RN confirmed the omissions at 9:10 AM that day. The RN stated Meclizine had not been administered since the resident's arrival in September 2009, and the facility was out of Floranex. Ten minutes later (9:20 AM) the RN confirmed she administered 15 ml of Clear Lax instead of 5 ml. Three errors occurred during this medication pass. 3. On 11/17/09 at 8:30 AM, RN #2 was observed to prepare and administer medications, including Clear Lax 25 ml in 4 ounces (oz) of juice, for resident #12. Reconciliation of the medication pass with physician orders revealed the order for Clear Lax was 17 grams (Gm) in 8 oz of fluid. At 9:30 that morning the RN measured out 17 Gm of Clear Lax and found that amount equaled 30 ml, thus confirming the medication error. The RN also confirmed she did not use 8 oz of fluid as ordered. 4. During observation of the medication pass on 11/17/09 from 7:25 to 8:45 AM, licensed practical nurse (LPN) # 2 said she did not routinely consult the medication administration record when administering medications because she administered the same medications to the same residents every day and automatically knew what to administer. Observation on 11/17/09 at 8:30 AM showed LPN #2 administered 1/2 ounce (according to the medication label this was the equivalent of 8.5 grams of Miralax) of	F 332		

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	53A043	A. BUILDING _____ B. WING _____	11/19/2009

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F 332	Continued From page 30 polyethylene glycol to resident#24. Reconciliation of the medications with the orders showed the physician ordered 17 grams of Miralax. Interview with the LPN at that time showed she made the decision to give less than the prescribed amount because she determined the prescribed amount was too much for the resident. She also said staff had not discussed this with the resident's physician.. 5. Observation on 11/17/09 at 8:45 AM showed LPN #2 administered 100 milligrams of Colace to resident #20. Reconciliation of the medications with the orders showed the physician ordered 200 milligrams of Colace to be administered each morning.	F 332		
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed	F 353	**F 353** Ads for staffing needs have been placed in local papers, radio station and CareerLink. Wyoming state-approved Nutrition Support Assistant Program to train ancillary staff, volunteers, and students (23 total) was completed December 29 & 30. Instructor was the RN responsible for Staff Development & Infection Control. The additional staff will enhance dining room staffing to support nursing. Residents will arrive on time and be assisted upon meal tray arrival to the table. All available trained staff will assist in bringing residents to meals assisting with feeding as needed. At 12/22/09 meeting staff reminded of importance of washing residents' hands before and after meals. All staff competencied on proper hand washing techniques.	1/15/10 12/30/09 1/15/10 12/22/09 1/15/10

1/15/10

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F 353	Continued From page 31 nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to ensure there was an adequate number of staff to provide the necessary care and services for a census of 28 residents. Specifically, for 2 of 5 sample residents (#19, #28) and one non-sample resident (#12) who required restorative services that were not provided as planned, for 3 of 8 sample residents (#3, #8, #28) to maintain urinary continence, and for 3 of 8 residents (#15, #19, #14) who required assistance with meals. In addition, call lights were not answered in a timley manner during two random observations; and bathes were not provided as planned for 3 of 9 sample residents (#3, #21, #28). The findings were; Staffing concerns were identified in the following areas: a. Refer to F 318 for details related to a lack of restorative therapy/services. b. Refer to F241 and F312 for details related to lack of dining assistance and bathing. c. Refer to F315 for details related to lack of assistance to maintain urinary continence. d. In addition, call lights were not answered in a timley manner. Observation on 11/16/09 at 5:16 PM showed resident #5 activated his/her call light. While waiting for staff to respond, at 5:40 PM, the resident began to call out, "Help me, help me..." and repeated the words for eight minutes until 5:48 PM, when certified nurse aide (CNA) #5 responded and assisted the resident to the dining room.	F 353	**F 353, continued** Residents #19, #28, and #12 will receive restorative services according to restorative plan. A dedicated Restorative Aide will be on duty five days per week and CNA staff will perform restorative services in the absence of the restorative nurse aide. Restorative Services will be provided a minimum of 5 days/week. Staff will be educated regarding change in daily staffing requirements and reinforced that when RNA is not available CNA will be performing restorative care. All restorative plans will be reviewed for accuracy. Restorative CNA will be monitored weekly for 1 month, then randomly but at least quarterly, to assure restorative care is completed appropriately. CNAs will be trained on RNA duties to serve as alternate when dedicated RNA is off duty. Restorative documentation will be revised to assure documentation is clear.	1/15/10 1/15/10 1/15/10 1/15/10 1/15/10 1/15/10

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F 353	Continued From page 32 Observation on 11/16/09 at 6:20 PM, showed resident #13 activated his/her call light. At that time s/he told the surveyor that s/he needed assistance with toileting. Observation of staff in the area showed only one staff person, CNA #5 who was in the restorative dining room assisting five residents. Interview on 11/16/09 at 6:35 PM with CNA #5 revealed when assisting residents in the dining room, they were instructed not to leave. She stated this was problematic because when staff brought residents back to their rooms from the main dining room after supper they left the residents in their rooms and would return to the main dining room. No one was present in the area to respond to the residents call lights. Continuous observation revealed resident #13 waited for a response to his/her call light until 6:43 PM, 23 minutes. Review of the 10/22/09 care plan for the resident showed s/he was dependent upon staff for transfers with a mechanical lift to the commode. The care plan also showed the resident had occasional incontinence due to not being placed on the commode in time. An interview with the RCD on 11/18/09 at 10:55 AM confirmed the CNA in Memory Lane was not to leave the dining room during meals. The RCD stated the licensed nurse was to answer any call lights activated in Memory Lane during meal times. During confidential interviews on 11/17/09, 10 residents stated that baths were not always done as planned when the facility was short staffed. The interview also revealed that call lights were not answered in a timely manner, or were not answered at all.	F 353	**F 353, continued** A Bath Aide will be scheduled 5 days/week to provide all baths unless resident specifically requests an evening bath. Saturday bath day will schedule less intensive bath residents. General Resident satisfaction with ADL's will be addressed in resident council (after approval obtained from the council) and during Social Services rounds. Social Services will perform resident rounds to determine resident satisfaction with ADL's including bathing and restorative care. Preferences will be addressed at this time. Rounds on all residents will be completed by 1/15/10. Documentation/compliance audits will be done monthly by QA team members. A contract has been signed with Stanley Senior Technologies to install a wireless Arial Call Light system. Projected installation date is January 2010. This will enable Administrator to monitor call light response times. If response times are >5 minutes for C.N.A. the nurse is then paged. If nurse response time is >5 minutes, ancillary staff & DON are paged. If no response after 5 minutes, Administrator is paged. If an employee's response time is	1/15/10 1/15/10 1/15/10 1/15/10
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency	F 425		

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F 425	Continued From page 33 drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assure routine medications were available for use for 1 of 7 residents (#1) observed during medication passes. In addition, expired medications were available for resident use in 2 of 3 medication storage areas. The findings were: 1. Observation on 11/17/09 showed RN #2 prepared and administered medications for resident #1 at 8:21 AM. Reconciliation of the medication pass with the physician's orders showed Floranex was also ordered daily; however, it had not been included in the administered medications. The RN stated the	F 425	**F 353, continued** consistently >5 minutes, employee may be subject to disciplinary action. **F 425** All residents (Resident #1 has been discharged) will receive medications as ordered by the physician. Medications will be re-ordered in a timely manner to ensure delivery from residents' pharmacies. Contracted pharmacy providing services to residents shall indicate meds will be delivered on an emergency basis. If medication is not available from the pharmacy the medication request form will indicate why med was not available and anticipated delivery date. Physician will be notified if medication will not be available to administer. Pharmacy audits will include evaluation of pharmacy medication requests, availability of meds, expired meds, med room inspection, and pharmacists' DRR documentation.	12/9/09 1/15/10 1/15/10

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F 425	Continued From page 34 facility was out of Floranex and that the resident had not received it the previous day. Review of the medication administration record verified the medication had not been given on 11/16/09. 2. Observation of the medication room on 11/18/09 at 11:20 AM revealed the refrigerator contained a partially used stock jar of glycerin suppositories with an expiration date of 6/2009. Registered nurse (RN) #3 confirmed the expiration date at the time of the observation and verified the suppositories were available for resident use. 3. Observation of the medication cart used in the front hall on 11/18/09 at 11:53 AM showed a tube of miconazole ointment for resident #20 was in one of the drawers. This medication expired on the last day of October 2009. At the time of the observation, RN #4 confirmed the expiration date and that the medication was available for use.	F 425	DON or designee will report to QA Com monthly for 3 months, then quarterly. Consulting Pharmacist is currently working with State Pharmacy Board to supply emergency drug box for emergency and after hour medications. Our goal is to have this in place as soon as possible.	1/15/10
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428	F 428 All residents including #19 and #21 will have monthly medication reviews by consulting pharmacists. All irregularities will be reported to the DON and physician. The physician will review recommendations from the pharmacists and determine if changes are indicated. Physician has reviewed the drug regimen for residents #19 and #21. Monthly chart audits on 10% of resident charts will be done by QA team for 3 months, then quarterly.	1/15/10 12/9/09 1/15/10

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F 428	Continued From page 35 Based on medical record review, staff interview, and interview with the consultant pharmacist, the facility failed to assure irregularities were identified and reported as required for 2 of 10 sample residents (#19, #21). The findings were: 1. According to the 2/12/09 annual Minimum Data Set (MDS) assessment, resident #19 had diagnoses which included depression. Review of the physician's orders and the medication administration records (MARs) showed the resident had received the antidepressants Zoloft 100 milligrams (mg) daily since 8/6/08 and Wellbutrin XL 150 mg daily since 7/14/08. Review of the pharmacist's medication regimen reviews (MRRs) for the past year showed no evidence the pharmacist had identified and reported the continued use of these medications at the same dose as irregularities. On 11/18/09 at 10:10 AM the resident care director (RCD, the facility's director of nursing) stated she had no reports of irregularities. During an interview on 11/19/09 at 11:30 AM, the pharmacist stated he was "very liberal" on the use of antidepressants; he confirmed he had not identified or reported irregularities with use of the medications. 2. Review of the physician's orders showed resident #21 had diagnoses that included depression. Further review of the orders and the MARs showed the resident had received the antidepressant Zoloft 150 mg daily since 2/7/08. Review of the pharmacist's monthly MRRs for the past year showed no evidence the pharmacist identified the continued use of Zoloft at the same dose as an irregularity. At 10:10 AM on 11/18/09 the RCD stated she had received no reports of an	F 428		

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F 428	Continued From page 36 Irregularity. Interview with the pharmacist on 11/19/09 at 11:30 AM confirmed he had not identified any irregularities related to the medication as he was "very liberal" on the use of antidepressants.	F 428	**F 431** All multidose vials will be dated when opened and discarded after 30 days or as recommended by manufacturer. All medications will be labeled with expiration dates and discarded when expired.	1/15/10
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES 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. 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. 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. 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.	F 431	All medications will be secured in a locked medication room at all times. Unauthorized personnel will not be left unattended in med room. A meeting was held with the pharmacists on 12/9/09 to review these requirements. Med Room was inspected on 12/8/09. Consulting pharmacists will inspect med room monthly. Med room door will be self closing and locking. New door was ordered on 12/9/09. Staff has been instructed to leave the med carts locked. This will be monitored until 100% compliance is obtained. Staff has been re-educated to date multiuse vials and discard any expired meds. Will perform Med Room door and med cart audit checks for expired meds and dated multiuse vials during med pass audits. DON or designee will report to QA Committee monthly for 3 months, then quarterly.	1/15/10 12/9/09 12/8/09 1/15/10 1/15/10 1/15/10

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F 431	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications in 3 of 3 storage areas were labeled in accordance with professional principles. In addition, the medication room door was left open on 1 of 4 days during the survey, resulting in the medications being unsecured. The findings were: 1. On 11/18/09 at 11:20 AM observation showed a 30 milliliter multidose vial of Lidocaine was stored in a bag in the medication room. The vial had been partially used, but the date it was opened was not indicated. Interview with registered nurse (RN) #3 at the time of the observation revealed she had no idea when the vial was opened, but she confirmed the medication was used in combination with an intramuscular medication. The RN stated she did not know how long the medication could be used after the vial was opened. On 11/19/09 at 10 AM the resident care director (RCD) stated that all multidose vials should be dated when opened as they were only good for 30 days. 2. Observation of both medication carts on 11/18/09 revealed each contained medications without expiration dates on the labels. a. At 11:48 AM two jars of the compounded medication, Triamcinolone 0.1% cream/ Eucerin cream, were found on the back hall medication cart. At the time of the observation, RN #4 confirmed the medication was being used for resident #2. The RN stated the pharmacy did not put expiration dates on their labels. b. At 11:53 AM a tube of Triamcinolone 0.1%	F 431		

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F 431	Continued From page 38 cream for resident #19 was found on the front hall medication cart. At the time of the observation, RN #4 confirmed the medication lacked an expiration date. 3. Upon entering the facility on 11/17/09 at 6:52 AM, observation showed the medication room door was wide open; no staff were in the area. At 7:05 AM licensed practical nurse (LPN) #2 entered and then left the medication room. However, she left the door completely open. At 7:16 AM, RN #2 entered the room and a housekeeper came in to mop the floor. At 7:18 AM the RN left, but the housekeeper completed mopping. When questioned on 11/18/09 at 11 AM, LPN #2 stated the medication room door was not supposed to be left open. According to the 2004 Sixth Edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, medication should be kept in a secure area.	F 431	**F 441** Resident #19 has all wound care supplies in room or taken from treatment cart outside room for dressing changes. Residents #14, #15, #21, and #26 will have supplies for wound care on the treatment cart which will remain outside of the residents' rooms.	11/19/09
			All staff performing wound care have been competencied on hand washing. All staff, contracted staff, and therapists performing wound care have been competencied on wound care as listed.	11/19/09
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 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, medical record review and review of infection control data	F 441	Random staff, contract employees, and therapists providing wound care will be audited weekly by DON, Infection Control Nurse, or Wound Care Nurse for 3 months. If 100% compliance with wound care protocol after 3 months is achieved, Infection Control Nurse will monitor quarterly. All wounds infected with MRSA will be re-cultured according to facility policy. All staff will be competencied on hand washing and hand sanitizer use until 100% compliance is achieved. All staff performing peri-care will be competencied until 100% compliance is achieved. Responsible party: Infection Control Nurse	1/15/10 1/15/10 1/15/10

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F 441	Continued From page 39 and policy and procedures, the facility failed to establish an ongoing system for monitoring infection control practices among staff. This failure resulted in an immediate jeopardy situation for 5 residents (#19, #14, #15, #21, #26) who were being treated for wounds. In addition, the facility failed to ensure staff used appropriate hand hygiene during 4 random observations. The facility's failure to conduct an ongoing surveillance program and monitor infection control practices among staff placed residents at increased risk for infections. Failure to practice and promote acceptable standards of hand hygiene presented a significant, and avoidable, risk to resident health. The findings were: 1. Refer to F314 for information related to use of contaminated items and the potential transfer of methicillin resistant Staphylococcus aureus (MRSA). 2. Due to the facility's failure to have an effective system for protecting a vulnerable resident population at high risk for infection, immediate jeopardy was called at 11/18/09 at 4:45 PM. On 11/19/09 at 2 PM, the immediate jeopardy was removed on-site by the following actions: a. Orders for wound cultures for resident #21 were obtained from the medical director. b. A memo was posted that stated, "Effective immediately. All residents with wound care orders will have their own stock of wound care supplies in their room. Do not share wound care supplies from resident to resident. Place dressing supplies in baskets that have been provided." c. Competency tools for hand washing/gloving and clean dressing change	F 441	**F 441, continued** Infection Control program will be developed and implemented to investigate, control and prevent infections. Protocol will be in place for determination of isolation procedure requirements. Records will be kept by Infection Control Nurse of any incidents and corrective procedures that were implemented. These records will include: a. circumstances associated with incident; b. situation or conditions surrounding incident; c. an evaluation and description of corrective measures taken All audits and tracking tools will be reviewed monthly by the Infection Control Nurse identifying any trends or corrective actions needed and stating what the corrective action will be.	1/15/10 1/15/10 1/15/10

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	53A043	A. BUILDING _____ B. WING _____	11/19/2009

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F 441	Continued From page 40 procedures were developed. d. Skills labs were set up for competency checks. e. The RN consultant educated the resident care director (RCD) and wound care nurse on hand hygiene/gloving and clean dressing change procedures. Their competency was evaluated by the consultant with 100% compliance achieved. f. The same education and competency testing was completed for the other RNs and LPNs on duty 11/8-11/19/09 by the RDC. A 100% compliance was achieved. g. The facility implemented a system that required contracted physical therapists and agency nurses to received education and perform return demonstrations to establish competency on hand hygiene and clean dressing change procedures. Agency nurses and physical therapists were required to complete the competency test prior to any resident contact. h. A schedule for performing weekly audits of education and competency evaluations was developed to gather information for submission to the Quality Assurance committee. 3. Review of the infection control policy and procedures showed the facility's failure to reculture the wound site after antimicrobial therapy violated the facility's policy for MRSA infections. 4. The following concerns were identified with hand hygiene: a. Observation on 11/16/09 at 4:35 PM showed certified nursing assistant (CNA) #1 donned gloves and completed perineal care for resident #3 who had been incontinent of bowel	F 441	**441, continued** The surveillance system will include tracking infections, antibiotic use, and employee sick calls. IC Nurse will communicate with the Wound Care Nurse on current wounds and treatments, progress of healing, any cultures or infectious process of wounds. 1/15/10 Responsible Party: Infection Control Nurse Infection Control Nurse will report to QA Committee monthly. 1/15/10	

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F 441	Continued From page 41 and bladder. Wearing the same contaminated gloves, the CNA then assisted the resident with dressing, transferring to a wheelchair and then a recliner, and attaching the call light within the resident's reach. The CNA also wore the same gloves while fastening the gait belt around herself for use with other residents. b. Observation of a dressing change for resident #21 on 11/16/09 at 1:45 PM showed licensed practical nurse (LPN) #1 took a tray containing supplies into the resident's room. The LPN cleansed the resident's wound with wound cleanser, cut a strip from an opened dressing package obtained from the tray of supplies, then applied the dressing and covered the wound with Tegaderm. The LPN failed to cleanse the scissors from the tray either before or after use, and she replaced them into the tray for use with other residents. c. Observation on 11/16/09 at 1:25 PM showed resident #21 was incontinent of urine while being transferred into bed. The linens on the side of the bed became wet during the transfer, but were not changed by CNA #1. Further observation at 4:50 PM showed the resident had again been incontinent of urine. CNA #1 assisted the resident to remove his/her clothing and then washed the resident's back, but not the perineal area and legs, which were also wet with urine. After the resident's request for a drink, the CNA removed her right glove and, using both hands, put clothing on the resident's lower body and then gave the resident a glass of water. The CNA failed to perform hand hygiene before handling the glass of water. 5. The RCD and wound care nurse stated in an interview on 11/18/09 at 3:30 PM that their	F 441		

11/18/09

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F 441	Continued From page 42 responsibility for the infection control program started after 10/31/09. They stated they had not had an opportunity to continue the surveillance data, monitoring and education that was ongoing prior to that date. They also stated the facility did not have a system for ensuring nurses and physical therapists were competent regarding the use of acceptable infection control practices during dressing changes. Review of the infection control data provided by the RCD verified the lack of monitoring, data collecting and education regarding hand hygiene after 10/31/09. 6. The facility's former infection control nurse stated in an interview on 11/19/09 at 11:45 AM, that her position as the facility's infection control nurse ended on 10/31/09. She stated prior to that date she had provided hand hygiene education for all the facility employees and conducted random observations of hand hygiene. She stated surveillance data and educational training regarding dressing changes for infected wounds was not included in the facility's infection control program. She also said during the time that she was the infection control nurse she had no involvement or interaction with the wound care team.	F 441		
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	F 520		

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F 520	Continued From page 43 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 quality assurance performance improvement (QAPI) program was effective in identifying problems and implementing actions to resolve problems. The failure specifically affected 2 of 5 residents (#21, #19) who were being treated for wounds, resulting in an immediate jeopardy situation. In addition, the facility failed to identify other care issues that were identified by the survey team as systemic in scope. The resident census was 28. The findings were: 1. Interview with the resident care directory (RCD)and administrator on 11/19/09 at 1:30 PM revealed the facility's QAPI program had not been effective since April 2009 due to a change in administrative staff and committee members. The RCD said data and information had been	F 520	F 520 A Quality Assurance program is in place that includes but is not limited to F-tags identified in this survey. The QA Committee includes the DON, Infection Control Nurse, Medical Director, MDS Coordinator, and at least two other staff members. The QA Committee will meet monthly for 6 months to assure new program's effectiveness then at least quarterly. Goals of the QA Committee are to monitor & evaluate quality of care, oversee systems related to improving quality of care, promote consistent systems in resident care, identify negative outcomes & resolve them appropriately. Expectations: Improve quality of care Criteria: The committee will review at a minimum the quality indicator reports and all audited F-tag results. Tracking: The QA Record will include: problem identified, plan of action, person responsible, expected date of completion, any follow-up action, and whether or not the problem was resolved. QA Committee will scrutinize reports presented at each meeting and summarize findings in committee minutes	1/15/10 1/15/10 1/15/10

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F 520	Continued From page 44 collected in some areas, but the committee had not used the information to identify problems, develop action plans, with the exception of falls, or established goals. The RCD stated data regarding infection control had been collected up until 10/31/09, but had not been used to address the facility's current problems. The RCD and administrator confirmed a QAPI plan needed to be developed and implemented. 2. During the survey, the following care areas were identified as requiring immediate action by the facility to correct significant issues: a. Refer to F314 for information regarding the facility's failure to implement skin care and wound treatment practices with acceptable infection control techniques. b. Refer to F441 for information regarding the facility's failure to develop and implement an effective infection control program. 3. The program failed to identify problems with restorative services that resulted in avoidable harm. Refer to F318 for details. 4. In addition, the program failed to identify systemic problems that were present in the following care areas: a. Refer to F312 for details related to failure to adequately assist dependent residents with dining, bathing, and incontinence care. b. Refer to F315 for details related to failure in maintaining urinary continence. c. Refer to F332 for details that pertain to medication errors	F 520		

1/8/10