STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	08/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST CASPER, WY 82601

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F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to notify a physician of blood sugar changes for one (#87) of 5 sample residents with a diagnosis of diabetes. The	F 157	F157 Notification of changes 1. Correction: Resident #87 is having their blood sugar checked per physician order and any values outside of the parameters have been reported to the physician as ordered. 2. Identification: Resident currently residing in the facility, who are receiving blood sugar checks, are at potential risk. 3. Systemic: DON/designee will complete an audit of all residents who are receiving glucometer checks to ensure that they have parameters set for notification to the physician of abnormal values. Care plans will be updated. DON/designee will in service the nurses on the Diabetic policy, with emphasis of notifying physicians of abnormal values,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dennis Tofani	Administrator	9/19/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. Revisions made 9/1/08 per telephonic call with Dennis Tofani / Primer, RN. 9/1/08

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F 157	Continued From page 1 findings were: Review of the August 2008 physician's order recapitulation for resident #87 revealed the resident had diagnoses including diabetes. Review of physician orders revealed an order dated 5/14/08 for blood sugars to be taken before each meal and at bedtime. Further review of the physician's order revealed instructions for staff to call if the resident's blood sugar was below 70 mg/dL (milligrams per deciliter). Review of the tracking sheet revealed the resident's blood sugar was 59 mg/dL at 9 PM on 8/3/08, was 56 mg/dL at 6 AM on 8/22/08, and was 64 mg/dL at 6 AM on 8/27/08. Review of the medical record revealed there was no evidence the physician was notified of these low values. Interview with the director of nursing DON) on 8/28/08 at 1:40 PM revealed the physician should have been notified as ordered.	F 157	values, documenting abnormal values on the 24 hour report and utilization of the Glucometer check sheets.. 4. Monitoring: DON/designee will monitor Glucometer checks by completing a bi-weekly review to ensure that physician notification is being done as ordered. IDT will monitor for abnormal values through review of the 24-hour report process at the AM stand up meeting. DON/designee will provide a report from the weekly reviews to the QA&A committee monthly X3 then quarterly thereafter, to make sure compliance is sustained. 5. Date of Compliance: October 12, 2008.	
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of employee personnel files, staff interview, and review of policy and procedures, the facility failed to adequately screen 2 of 5 employees prior to hire, to ensure they were safe to work with the residents. The findings were: According to the facility policy and procedure entitled: Abuse & Neglect Prohibition, revised in	F 226	F226 Staff Treatment of Residents 1. Correction: Employee #1 and #2 have had a background screen completed and both employees have meet criteria. 2. Identification: Residents currently residing in the facility are at potential risk	

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F 226	Continued From page 2 June 2008, "The facility will screen for employees with a history of abusive behavior or who may be at risk for being abusive." Interview with the human resource (HR) coordinator on 8/28/08 at 9:50 AM revealed the facility screened all employees. In addition, a criminal background check, reference checks, drug screen, and license verification was completed for licensed positions. The following concerns were identified: a. Review of the personnel files for employee #1 revealed s/he was hired on 8/11/08 to work in the kitchen. Other than two checks with personal references, there was no evidence any background screening was completed. Interview with the HR coordinator on 8/28/08 at 9:50 AM confirmed the back ground screening was not done. b. Review of the personnel files for employee #2 revealed s/he was hired on 6/17/08 to work in housekeeping. Other than two checks with a personal reference, there was no evidence any background screening was completed. Interview with the HR coordinator on 8/28/08 at 9:50 AM confirmed the back ground screening was not done.	F 226	3. Systemic Changes: The facility has hired a new SDC, who has been in serviced on completing the hiring process, along with the facility HR coordinator. This in service will be done by the Regional HR Director, and will include obtaining background checks per the facility policy. HRC/designee will review all employee files to ensure that background checks have been completed 4. Monitoring: The Staff Development Coordinator will review the status of new hires at the AM stand up meeting. A report will be provided to the QA&A committee monthly regarding completion of new hire files, to ensure compliance is maintained. 5. Date of Compliance: October 12, 2008	
F 244 SS=E	483.15(c)(6) PARTICIPATION IN RESIDENT & FAMILY GROUPS When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of the resident council meeting	F 244	F244 Participation in Resident & family Group: 1. Correction: The facility has held a Resident Council meeting to provide feedback on the plan to resolve the issue of having a long wait to be served once seated in the dining room. Reference F362. 2. Identification: Residents currently residing in the facility are at potential risk.	

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F 244	Continued From page 3 minutes, confidential resident interview, and staff interview, the facility failed to provide resolution or feedback to residents concerning the long wait times for meal service. The findings were: Review of the 5/20/08, 6/17/08, and the 7/22/08 resident council meeting minutes revealed residents had verbalized a concern with the long wait to be served once seated in the dining room. One resident stated it sometimes took up to an hour to be served. In addition, residents stated some residents were served prior to those who had been seated longer. Confidential interview with fifteen residents on 8/26/08 at 1:30 PM confirmed they had to wait long periods of time prior to receiving their meal once seated in the dining room. Interview with the DON on 8/28/08 at 1:40 PM revealed the facility was aware of the problem and they were working on resolution. She stated the facility did not have enough staff to allow for additional service in the dining room. She acknowledged neither she nor any other manager had provided a status report or feedback on the progress towards resolution to residents.	F 244	3. Systemic changes: The Regional Clinical Director regarding the Resident Council and TLC program will in service department heads. The Activities Director/designee will assign to the appropriate discipline, any identified concerns during the AM stand up meeting. Follow up will be completed with in 72 hours. Dietary Manager has in serviced the dietary staff on the meal times, as well as, the appropriate order for serving the meal. Activities will schedule an activity to be held in the dining room at 3:15 pm for residents who arrive prior to the start of meal at 4:00pm. All staff was in serviced regarding the Resident Council and the TLC program and utilization of the 24-hour report. NHA/designee will review the last 6 months of the resident council minutes to identify any unresolved concerns brought up by the residents.	
F 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure psychosocial service needs were met for 4 (#2,	F 250	4. Monitoring: The department heads will monitor for concerns not identified through the 24 hour report process at the AM stand up meeting. The NHA/designee will ensure concerns identified through resident council and the TLC program will be reviewed at the AM stand up meeting until they are resolved. Tracking and trending of these will be done monthly by the SSD and submitted to the QA&A committee monthly.	

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F 250	Continued From page 4 #22, #60, #113) of 21 sample residents. The findings were: 1. Review of the 4/14/08 significant change Minimum Data Set (MDS) assessment for resident #22 revealed the resident exhibited repetitive health complaints, a change in usual sleep pattern, sad, pained, worried facial expressions, and withdrawal from activities of interest up to five days a week. In addition review of the 4/14/08 MDS revealed the resident's mood had declined. Review of a social service note dated 6/6/08 showed the resident was having signs and symptoms of depression, had a decreased appetite, was sad, and had a score of 13 on the Cornell geriatric depression scale indicating likely depression. The note further showed the physician was faxed with a recommendation to start the resident on an anti-depressant. Review of the June, July and August medication administration records showed the resident was receiving Cymbalta (antidepressant).However, review of the medical record revealed there was no monitoring or evaluation of the effectiveness of the Cymbalta in treating the resident's depression and sad mood since it was started on 6/18/08. Interview with the DON on 8/28/08 at 1:40 PM revealed there was no other documentation to review related to the resident's depression and sad mood. 2. Review of the 2/15/08 annual and the 5/12/08 and 8/5/08 quarterly MDS assessments for resident #60 revealed s/he was able to understand and be understood. Review of the 11/26/07 nursing notes revealed the resident's "son died last week." Review of the social service notes revealed there was no evidence the resident received any counseling, support, or	F 250	5. Date of Compliance: October 12, 2008 F250 Social Services: 1. Correction: Resident #22 has been reviewed by the IDT for the effectiveness of their antidepressant medication and has been visited by the Social Services Director. The Social Services director regarding their feelings on the loss of their son has seen Resident #60. The Social Services Director in regards to their terminal diagnosis has seen Resident #113. Resident #2 has been seen by the SSD, regarding his depression. 2. Residents currently residing in the facility are at potential risk. 3. Systemic change: The facility has hired a new Social Services Director. The NHA will in service the SSD on the need to offer the option of counseling or visits to assist residents with their emotional needs at the loss of a loved one or when s/s of depression are noted.. IDT will be in serviced by the Regional Clinical Director on the need to review residents, after initiation of an antidepressant to ensure that it is beneficial to the residents needs, as well as completing a review of residents needs when experiencing a change of condition, such as going on hospice care. Nurses will be in serviced on documenting referral	

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F 250	Continued From page 5 monitoring in regard to the loss of his/her son. During an interview with the DON on 8/28/08 at 1:40 PM, she stated there was no evidence any counseling, support, or monitoring was provided for the resident. 3. Review of the 8/13/08 admission face sheet for resident #113 revealed s/he had diagnosis including terminal metastatic lymphoma and was awaiting admission to a hospice program. Review of the social service notes revealed there was no evidence the resident was provided any counseling, support, or monitoring to assist the resident in transition to hospice and end of life concerns. 4. Review of the physician orders for resident #2 revealed an 11/20/07 order for referral to social services regarding depression and weight loss. Review of the social service notes revealed no evidence social services did an evaluation. 5. During an interview with the DON on 8/28/08 at 1:40 PM, she confirmed there was no evidence social services was provided regarding the above noted concerns. She further stated the facility was currently without a full time social worker and had been since 7/2/08.	F 250	needs or new onset/change of Residents level of depression on the 24 hour report, by the DON/designee. 4. Monitoring: The department heads will monitor through review of the 24-hour report process, telephone orders and review of pending admissions at the AM stand up meeting. A report will be submitted by the SSD on Residents who have had a change of condition, that require increased Social Services involvement, to the QA&A committee. 5. Date of Compliance: 10/12/08 F279 Comprehensive Care Plans 1. Correction: Resident #87 now has a plan of care for his dialysis care. 2. Identification: Resident receiving dialysis may be at potential risk. 3. Systemic: DON/designee will complete a care plan audit of all residents currently residing in the facility to ensure that all resident treatments are care planned. The Regional Clinical Director on the Care Planning Process, Policies OP4 0207.00, 0208.00, 0209.00, will in service IDT. Nursing staff will be in serviced on the care planning process, with emphasis on initiation, making changes, how to	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		

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F 279	Continued From page 6 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a care plan was developed regarding dialysis for one (#87) of one sample resident who received dialysis. The findings were: Review of the care plan for resident #87 revealed dialysis was not addressed. Interview with the DON on 8/28/08 at 1:40 PM confirmed there was no care plan that addressed the resident's need for dialysis.	F 279	read and follow. IDT will complete a full house care plan audit to ensure that all their needs are being met. 4. Monitoring: IDT will monitor for changes in the Residents care needs through review of the 24-hour report process, telephone orders at the AM stand up meeting. Residents are reviewed by the IDT on admission, quarterly, annually and with change of condition following the RAI/MDS process. Results of the audit will be presented by the IDT to the QA&A committee, as well as a monthly review of the action team minutes. Any issues noted would be action planned to ensure compliance is maintained. 5. Date of compliance: October 12, 2008 F281: Comprehensive Care Plans 1. Correction: Resident #87 is receiving finger sticks as ordered and the physician is being notified if ranges are outside the parameters. Resident #113 is receiving finger sticks as ordered and the physician is being notified if ranges are outside the parameters. 2. Identification Resident who are diabetics who currently reside in the facility are at potential risk.	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed physician orders regarding glucose monitoring for two (#87, #113) of five sample residents who had	F 281		

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F 281	Continued From page 7 a diagnosis of diabetes. The findings were: 1. Review of the August 2008 physician order recapitulation for resident #87 revealed s/he had diagnoses including diabetes. Review of physician orders revealed an order dated 5/14/08 for blood sugars before each meal and at bedtime. Review of the August 2008 blood glucose tracking record revealed the resident's blood sugar was not checked as ordered 10 times during the month. In addition the physician's order instructed staff to call if the resident's blood sugar was below 70 mg/dL (milligrams per deciliter). Review of the tracking sheet revealed the resident's blood sugar was 56 mg/dL at 6 AM on 8/22/08, was 64 mg/dL at 6 AM on 8/27/08, and was 59 mg/dL at 9 PM on 8/3/08. Review of the medical record revealed there was no evidence the physician was notified of these low values. Interview with the DON on 8/28/08 at 1:40 PM revealed she was working with staff to ensure they were following physician orders regarding blood sugar testing for residents on regular glucose monitoring. 2. Review of the physician orders for resident #113 revealed an order dated 8/19/08 for a blood sugar test daily on a staggered basis. Review of the 8/18/08 through 8/27/08 blood glucose tracking record revealed there had been four occasions when there were no glucose test values documented in the record. Interview with the DON on 8/28/08 at 1:40 PM revealed she was working with staff to ensure they were following physician's orders regarding blood sugar testing for residents on regular glucose monitoring. According to "Clinical Nursing Skills", 5th edition, by authors Smith, Duell, and Martin, page 4,	F 281	3. Systemic changes DON/designee will in service the nurses on the diabetic policy with emphasis on notification to the physician of blood sugars that are out of range. IDT will review all the diabetics currently in the facility to ensure that they have parameters in place. DON/designee will review the diabetic flow sheets on a bi weekly basis to ensure that the physician is being notified as ordered. Disciplinary action will be given if nurses are not following physician orders. 4. Monitoring: DON/designee will monitor through review of the 24-hour report process and telephone orders at the AM stand up meeting. Residents are reviewed by the IDT on admission, quarterly, annually and with change of condition following the RAI/MDS process. The DON/designee will present results of the bi weekly audit to the QA&A committee. Any issues noted would be action planned to ensure compliance is maintained. 5. Date of compliance: October 12, 2008	

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F 281	Continued From page 8 responsibilities that professional nurses perform in daily practice includes "administer treatments per physician's order."	F 281		
F 282 "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, family interview, and medical record review, the facility failed to ensure staff followed the care plan for measuring, staging and documenting pressure sores for two (#40, #112) of five sample residents who had pressure sores. In addition, the facility failed to ensure staff assisted 3 (#2, #10, #13) of 8 sample residents, with their toileting needs. The findings were: 1. Review of the 6/19/08 Minimum Data Set assessment revealed resident #40 had a stage II pressure sore. Review of the 6/13/08 care plan revealed interventions included measuring and staging the wound weekly using the pressure ulcer healing assessment form. Review of the pressure ulcer healing assessment forms revealed staff measured and staged the resident's wound on 2/11/08 (6 1/2 months ago) and did not do it again after that day. Interview with licensed practical nurse (LPN) #1 on 8/26/08 at 3:40 PM confirmed the 2/11/08 assessment was the most current and last documented assessment of the resident's skin and wounds. Interview with the DON and administrator on	F 282	F282 Comprehensive Care Plans 1. Correction: #40 PP Resident no#~~1~~ has been reviewed by the IDT, documentation has been completed on the status of the wounds and their care plan has been updated. Resident no#112 has had a complete skin assessment completed by a licensed nurse, which has been documented on. The resident's wound has been measured, documented on and the care plan has been updated. Resident #2 has been reviewed by the IDT and the care plan has been updated and communicated to staff to ensure toileting is being done as outlined. Resident #10 has been reviewed by the IDT, regarding needed assistance. Care plan has been updated to alert staff to level of assistance needed to meet his/her needs. Resident #13 has been reviewed by the IDT, regarding level of assistance needed to meet their needs. 2. Identification: Residents currently residing in the facility are at potential risk.	

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F 282	Continued From page 9 8/26/08 at 5:05 PM revealed weekly skin assessments, documentation, monitoring and ongoing evaluation had not been done because the facility was short of staff and the nurse who was previously the wound care nurse had to work as a charge nurse. The DON also confirmed staff had not followed the care plan interventions for documenting and assessing pressure sores. 2. Review of the 7/31/08 MDS quarterly assessment revealed resident #112 had a stage II pressure sore. Review of the 7/31/08 care plan revealed interventions included measuring and staging the wound weekly using the pressure ulcer healing assessment form. Review of the pressure ulcer healing assessment forms revealed staff measured and staged the resident's wound on 1/29/08 (approximately 7 months ago) and did not do it again after that day. Interview with LPN #1 on 8/26/08 at 1:25 PM revealed a complete skin assessment for the resident had not been done for several months because the facility did not have a wound care nurse. Interview with the DON and administrator on 8/26/08 at 5:05 PM revealed weekly skin assessments, documentation, monitoring and ongoing evaluation had not been done because the facility was short of staff and the nurse who previously was the wound care nurse had to work as a charge nurse. The DON also confirmed staff had not followed the care plan interventions for documenting and assessing pressure sores. 3. Review of the 9/25/07 initial and the 3/7/08 and 5/28/08 quarterly MDS assessments for resident #2 revealed s/he was frequently (daily with some control) incontinent of urine. Review of the care plan for incontinence revealed the resident required toileting before and after meals, at	F 282	3. Systemic: IDT will complete a full house review of the residents to ensure that the interventions are appropriate for these residents and the care plans, C.N.A. care cardexes will be updated. DON/designee will in service the facility staff regarding the use of care plans, following the interventions out lined. Nursing staff will be in serviced on implementation and updating of care plans. Department heads will be assigned Ambassador rounds weekly; to ensure that observed residents are having their needs met. 4. Monitoring: IDT will complete review of Residents, on admission, quarterly, annually and with change of condition following the RAI process. NHA/designee will ensure that the Ambassador rounds are reviewed at the AM stand up meetings. Issues identified through this process will be addressed and trended and brought before the QA&A committee to ensure compliance is maintained. 5. Date of Compliance: October 12, 2008	

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	535024	A. BUILDING _____ B. WING _____	08/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 10 bedtime, and as needed. The following concerns were identified: a. Continuous observation on 8/26/08 from 9:30 AM until 1:30 PM (4 hours) revealed resident was not toileted or checked for incontinence. Interview with certified nurse aide (CNA) #1 on 8/26/08 at 3:15 PM revealed she had not checked or provided any services for the resident since she got him/her up and dressed that morning. The CNA further stated the facility was short staffed and it was difficult for the CNAs to accomplish all of their assigned tasks. b. Interview with CNA #2 on 8/26/08 at 3:15 PM revealed she had not checked or provided any services for the resident that day and stated the spouse takes care of the resident's toileting needs. Observation from 9:30 AM until 1:30 PM on 8/26/08 revealed the spouse was not in the facility until 1:30 PM. Interview with the spouse on 8/26/08 at 3:30 PM confirmed s/he was not in the facility until 1:30 PM. c. Observation on 8/26/08 from 11:33 AM to 12:20 PM revealed the resident's adult child was in the facility, however, interview with the adult child at 12:20 PM revealed s/he did not provide any toileting or care for the resident. The adult child stated s/he only sat with the resident during lunch then walked the resident to his/her room. 4. Review of the 8/5/08 quarterly MDS assessment revealed resident #10 used a wheelchair for locomotion, had multiple daily episodes of bowel and bladder incontinence and required extensive assistance with toileting and personal hygiene. Review of the 8/5/08 care plan revealed an approach for incontinence was scheduled voiding with check and change of the resident's incontinence briefs before meals, after meals, at bedtime and when ever necessary.	F 282		

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F 282	Continued From page 11 Observation on 8/2/08 from 2 PM to 6:15 PM (4 hours 15 minutes) revealed staff did not assist the resident to the bathroom or check and change his/ her brief. Interview with CNA#5 on 8/27/08 at 2:30 PM revealed her resident care assignment on 8/26/08 included providing care for this resident. The CNA also said staff did not follow the care plan interventions for toileting this resident was due to the lack of sufficient staff. 5. Review of the 8/14/08 quarterly MDS assessment revealed resident #13 used a wheelchair for locomotion, had frequent bowel and bladder incontinence and required extensive assistance with toileting and personal hygiene. Observation on 8/2/08 from 2:00 PM to 6:40 PM (4 hours and 40 minutes) revealed staff did not assist the resident to the bathroom or check and change his/ her brief. Interview with CNA#5 on 8/27/08 at 2:30 PM revealed her resident care assignment on 8/26/08 included providing care for the resident. The CNA also said staff did not follow the care plan interventions for toileting residents was due to the lack of sufficient staff.	F 282		
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	F314 Pressure Sores: Correction: Resident # 40 is now being assessed weekly and the area is showing signs of healing. Resident #112, is now being assessed weekly and the area is showing signs of healing. Identification: Residents currently residing in the facility are at potential risk. Systemic Changes: Full house skin sweep will be completed by the DON/designee. IDT will review all residents currently in the building, with skin breakdown, to ensure that interventions are appropriate to promote healing. Residents with breakdown will be screened by therapy for positioning a cushion	

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F 314	Continued From page 12 Based on observation, staff interview, and medical record review, the facility failed to provide ongoing assessment and monitoring to promote healing for pressure sores for two (#112, #40) of five sample residents with pressure sores. The lack of assessment and monitoring resulted in worsening and harm for resident #40. The findings were: 1. Review of the 6/19/08 MDS assessment and corresponding resident assessment protocol (RAP) summary for resident #40 revealed s/he was at risk for developing pressure sores because his/her skin was desensitized to pain and pressure, because s/he had an above the right knee amputation, was paraplegic, required extensive assistance of two for bed mobility and had a urinary catheter and colostomy. Further review revealed the resident currently had a stage II pressure sore. The following concerns were identified: a. Review of quarterly MDS assessments, dated 9/25/07, 12/07/07, and 3/5/08 revealed the resident consistently had had at least one stage II pressure sore since 9/25/07. Review of the 6/13/08 care plan revealed interventions included weekly measurement and staging of the wounds using the pressure ulcer healing assessment form. Review of the February to July 2008 physician order sheets revealed physician orders for staff to perform weekly skin assessments with documentation of the findings on the reverse side of the treatment administration record (TAR). However, review of the 2008 TARs, pressure ulcer healing assessment forms, and nursing assessment records revealed staff had not performed a complete skin and wound assessment for the resident since 2/11//08 (more than six months).	F 314	needs. Residents that are high risk as identified through the use of the Braden Scale, they will be reviewed by IDT and care plans will be updated. Regional Clinical Director will in service the IDT on the Skin Management System and weekly wound rounds. The DON/designee will in service the nursing staff and therapy on the Skin Management System, utilization of the 24 hour report process to notify IDT of new or worsening issues. Monitoring: The IDT will track the progress of residents through the weekly skin action meeting. During the weekly wound rounds the IDT will ensure that the interventions are in place and still appropriate. Department heads will review the 24 hour report and telephone orders at the AM stand up meeting to monitor for any new skin issues. DON/designee will review the TARs weekly to make sure that the weekly skin assessments are completed. IDT will present outcome of the weekly skin action meetings to the QA&A committee to identify any problems with this system. Date of Compliance: 10/12/08	

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F 314	Continued From page 13 b. Observation of the resident's skin on 8/26/08 at 3:20 PM revealed the area near the resident's inner thigh was smaller and the other areas, except the right buttock pressure sore, remained as described on 2/11/08 with no improvement. Observation revealed the pressure sore on the right buttocks that was a stage II with no depth on 2/11/08, had deteriorated to a pressure sore with approximately 2 cm of tunneling. Further observation revealed the dressing that covered the pressure sore was saturated with serous drainage, and when licensed practical nurse (LPN) #1 removed the dressing, blood oozed from areas above and below the pressure sore (the areas were not noted in the 2/11/08 documentation). Interview with LPN #1 on 8/26/08 at 3:40 PM confirmed the 2/11/08 Braden Scale and corresponding nursing skin/wound assessment was the most current and last documented assessment of the resident's skin and wounds. 2. Review of the 7/31/08 MDS quarterly assessment and corresponding RAP summary for resident #112 revealed the resident was at risk for developing pressure sores because his/her skin was desensitized to pain and pressure, because s/he had an above the right knee amputation, was paraplegic, required extensive assistance of two for bed mobility and had a urinary catheter and colostomy. Further review revealed the resident currently had a stage II pressure sore. Review of 12/2/07 quarterly and 5/6/08 annual MDS assessments revealed the resident's current pressure sore had been present since December 2007. The following concerns were identified: a. Review of the 7/31/08 care plan revealed care plan interventions included measurement	F 314		

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F 314	Continued From page 14 and staging of the wound weekly using the pressure ulcer healing assessment form. Review of the February to July 2008 physician order sheets revealed physician's orders for staff to perform weekly skin assessments with documentation of the findings on the reverse side of the TAR. However, review of the 2008 TARs, pressure ulcer healing assessment forms and nursing assessment records revealed staff had not performed a complete skin and wound assessment for the resident since they completed the 1/29/08 weekly pressure ulcer record. b. Review of the 1/29/08 weekly pressure ulcer record revealed the resident had a 6 centimeter (cm)by 5 cm stage II pressure sore on the left buttock that had a boggy center, moderate amount of serosanguinous drainage, and red wound bed with surrounding dark red, white/ gray tissue. Observation on 8/26/08 at 1:25 PM revealed the pressure sore on the resident's left buttock was slightly smaller, but continued to have a baggy center and oozed a copious amount of serosanguinous drainage. Further observation revealed the pressure sore was a stage II pressure sore. The surrounding dark red tissue extended from the open pressure sore to approximately 4 cm over the resident's buttocks. c. Interview with LPN #1 on 8/26/08 at 1:25 PM revealed a complete skin assessment had not been done because the facility did not have a wound care nurse. The LPN stated the physician prescribed dressing changes once a day and when necessary. She further stated the wound required a dressing change once or twice each shift due to the large amount of drainage. 3. Interview with the DON and administrator on 8/26/08 at 5:05 PM revealed weekly skin assessments, documentation, monitoring and	F 314		

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F 314	Continued From page 15 ongoing evaluation had not been done because the facility was short of staff and the nurse who previously was the wound care nurse had to work as a charge nurse. Additionally, the DON said the facility did not have a system for determining whether the current pressure sore treatments and interventions, that were implemented by staff more than six months ago, were effective.	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that 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, record review and staff interview, staff failed to provide toileting assistance for two (#10, #13) of eight sample residents who required assistance. The findings were: 1. Review of the 8/5/08 quarterly Minimum Data Set (MDS) assessment revealed resident #10 used a wheelchair for locomotion, had multiple daily episodes of bowel and bladder incontinence and required extensive assistance with toileting and personal hygiene. Review of the 8/5/08 care plan revealed the following approaches for incontinence care: a. Scheduled voiding	F 315	F315 1. Correction: Resident #10 has been reviewed by the IDT and is receiving care as outlined on their care plan. Resident #13 has been reviewed by the IDT and is receiving care as outlined on their care plan. 2. Identification: Residents currently residing at the facility are at potential risk. 3. Systemic changes: Nursing staff will be in serviced, by the DON/designee, on the Urinary Management System, to include following the residents toileting, changing schedules as well as providing the assistance as needed as outlined on the care plan. NHA will assign Ambassador rounds to the department heads to monitor for Resident have not been changed or offered assistance. IDT will review Residents who are incontinent or in the need for assistance and update their care plans. Reference F353.	

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F 315	Continued From page 16 b. Check and change of the resident's disposable brief before meals, after meals, at bedtime and when ever necessary. Observation of the resident on 8/26/08 from 2 PM until 6:15 PM (4 hours and 15 minutes) revealed the resident remained in a wheelchair and without any staff assistance to the bathroom or to check and change the brief. At 6:15 PM, when certified nurse aide (CNA) #4 removed the brief which was noted to be saturated with feces and urine. In addition, the resident's buttocks was red and excoriated. Interview with CNA #4 revealed direct care staff had been instructed to assist the resident with toileting at least every two hours because the resident could not tell staff when he/she needed to urinate or defecate. Interview with CNA #5 on 8/27/08 at 2:30 PM revealed her resident care assignment on 8/26/08 (the date of observation) included providing care for this particular resident. The CNA also stated she knew the resident was to be toileted every two hours, but she was not able to provide the toileting assistance on 8/26/08 as needed due to the lack of sufficient staff. 2. Review of the 8/14/08 quarterly MDS assessment revealed resident #13 used a wheelchair for locomotion, had frequent bowel and bladder incontinence and required extensive assistance with toileting and personal hygiene. Observation of the resident on 8/26/08 from 2 PM until 6:40 PM (4 hours and 40 minutes) revealed the resident remained in a wheelchair throughout that time period, and staff did not assist the resident to the bathroom or attempt to check and change the resident's brief. At 6:40 PM, CNA #4 removed the resident's urine saturated brief before assisting the resident to the bathroom. Interview with CNA #4 on 8/26/08 at 6:40 AM	F 315	4. Monitoring: Residents are reviewed by the IDT on admission, quarterly, annually and with change of condition through the action team meeting process, care plans are updated at that time. IDT will monitor for changes in Resident's needs through review of the 24-hour report process at the morning stand up meeting. New admissions will be reviewed to ensure that they are care planned appropriately for their toileting needs. Outcomes of the reviews will be brought before the QA&A committee to monitor for system compliance. 5. Date of Compliance: October 12, 2008	

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F 315	Continued From page 17	F 315		

revealed the resident had fewer episodes of incontinence when staff provided toileting assistance every two to three hours. Interview with CNA #5 on 8/27/08 at 2:30 PM revealed her resident care assignment on 8/26/08 included providing care for this resident. The CNA also said she knew this resident was to be toileted every two hours, but she had not been able to provide the toileting assistance on 8/26/08 as needed due to the lack of sufficient staff.

3. Review of the 9/25/07 initial and the 3/7/08 and 5/28/08 quarterly MDS assessments for resident #2 revealed s/he was incontinent daily with some control present. Review of this resident's care plan for incontinence revealed the resident required toileting before and after meals, at bedtime, and as needed. The following concerns were identified:

a. Continuous observation on 8/26/08 from 9:30 AM until 1:30 PM (4 hours) revealed the resident was not toileted or checked for incontinence. Interview with CNA #1 on 8/26/08 at 3:15 PM verified she had not checked or provided any services for the resident since she got the resident up and dressed that morning. The CNA further stated the facility was short staffed, and it was difficult for the CNAs to accomplish all of their assigned tasks.

b. Interview with CNA #2 on 8/26/08 at 3:15 PM revealed she had not checked or provided any services for the resident that day and stated the spouse took care of the resident's toileting needs. However, observation from 9:30 AM until 1:30 PM on 8/26/08 revealed the spouse was not in the facility until 1:30 PM. Interview with the spouse on 8/26/08 at 3:30 PM confirmed s/he had not been in the facility prior 1:30 PM.

c. Observation on 8/26/08 from 11:33 AM to

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F 315	Continued From page 18 12:20 PM revealed the resident's adult child was in the facility; however, interview with the adult child at 12:20 PM revealed s/he did not provide any toileting or other incontinence-related care for the resident. The adult child stated s/he sat with the resident during lunch and then walked the resident to his/her room.	F 315		
F 353 SS=F	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 nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and medical record review, the facility failed to ensure an adequate number of staff to provide the necessary care and services for a	F 353	F353 Nursing Services: sufficient staff 1. Correction: The facility will provide nursing staff in sufficient numbers to meet the needs of the residents. The facility will evaluate the current level of nursing staff to ensure resident needs are met. See POC: F314, F315, F244, F441. 1. Identification: Residents currently residing in the facility are at potential risk. 2. Systemic changes. NHA/DON and/or designee will evaluate the staffing sheet daily to ensure sufficient staff are present to meet the needs of the residents. The NHA, DON or designee has assigned a charge nurse on each shift. 3. Monitoring: NHA will provide a report to the QA&A who will review the staffing patterns until the committee determines that the facility has maintained compliance with this regulatory requirement. 5. Date of compliance: October 12, 2008	

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F 353	Continued From page 19 census of 114 residents; specifically for five (#2, #10, #13, #40, #112) of 21 sample residents The findings were: 1. Refer to F 314 regarding lack of services for resident #40 related to pressure ulcer care. This lack of services resulted in an avoidable deterioration of a pressure ulcer on the resident's right buttock. Evidence showed the lack of routine monitoring and assessments were related to lack of staff. 2. Refer to F 314 regarding a lack of services and failure to follow physician's orders to monitor a pressure ulcer for resident #112. 3. Refer to F 315 regarding the lack of services for incontinence care for resident #10. The lack of services was noted to be related to the lack of adequate staffing. 4. Refer to F 315 regarding the lack of adequate services for incontinence care for resident #13. This lack of services was noted to be related to the lack of adequate staff. 5. Refer to F 315 regarding the lack of adequate services for incontinence for resident #2. This lack of services was noted to be related to the lack of adequate staff. 6. Refer to F 244 regarding resident council concerns about long waits for meals in the dining room. According to the citation, this was directly related to lack of staff. 7. Refer to F 441 regarding the lack of an infection control coordinator to ensure an effective infection control program was in place.	F 353		

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F 353	Continued From page 20 8. Interview with the administrator and DON on 8/28/08 at 9:34 AM verified there was a staffing shortage in the facility. They stated they currently had six vacancies for licensed nurse positions and nine to eleven vacancies for certified nurse aide positions.	F 353		
F 362 SS=F	483.35(b) DIETARY SERVICES - SUFFICIENT STAFF The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure there was a sufficient number of dietary staff to perform the cleaning tasks to maintain sanitary conditions in the main kitchen and in the secure unit kitchenette. The findings were: Interview with the dietary manager and the registered dietitian on 8/26/08 at 3:55 PM revealed the dietary department was short staffed and was trying to recruit several positions. Further interview with the dietary manager on 8/27/08 at 11:10 AM revealed for the past two to three months, they had vacancies in the following positions: three full-time employees in the kitchen, one cook, and two dietary aides/dishwashers. She stated these vacancies were posted at the local job service but, as far as she was aware, no additional recruitment efforts were in process. Due to the lack of staff in the kitchen, the dietary manager stated the cleaning was not being	F 362	F362: 1. Correction: The facility will provide dietary staff in sufficient numbers to meet the needs of the residents. The facility will evaluate the current level of dietary staffing to ensure that the resident's needs are met. Ref: F371 2. Identification: Residents currently residing in the facility are at potential risk. 3. Systemic changes: NHA/Dietary Manager and/or designee will evaluate the staffing to ensure that there is sufficient staff to meet the resident's needs as well as to maintain sanitary conditions in the main kitchen and in the secure unit kitchenette. The Dietary Manager will in service cleaning schedule to the dietary staff. Monthly sanitation rounds in the dietary, will be assigned to the department heads by the NHA 4. Monitoring: Results of these rounds will be brought before the QA&A committee, as well as the staffing patterns, until the committee determines that the facility has maintained compliance with this regulatory requirement. 5. Date of Compliance: October 12, 2008.	

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F 362	Continued From page 21 accomplished as scheduled. Refer to federal citation F371 for details related to a lack of cleanliness and sanitation.	F 362	F364 1. Correction: The facility is following the recipes as written. 2. Identification: Residents currently residing in the facility are at potential risk. 3. Systemic changes: Dietary manager will attend monthly food committee meeting with the Residents. Dietary cooks have been in serviced on preparing foods according to recipes. NHA and RD will do at least a weekly test tray, to monitor palatability, flavor, appearance and temperature. NHA will schedule facility Ambassador rounds; these will include randomly asking the residents how their meal tasted. 4. Monitoring: Results/Ideas from the monthly food committee meeting will be brought before the NHA for review. Department heads will review the results of the Ambassador rounds at the AM stand up meeting. Dietary manager will follow up on issues identified and provide a monthly report to the QA&A meeting to ensure compliance is maintained. 5. Date of compliance: October 12, 2008	
F 364 SS=F	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, test tray evaluation, resident interview and review of the food committee monthly minutes, the facility failed to ensure foods were of acceptable quality and palatability. The findings were: Review of the food committee meeting minutes from June 2008 showed the residents were concerned with the quality of food, and stated the food was too dry. Review of the minutes revealed there was no evidence actions to improve the quality of food were taken. Evaluation of a test tray on 8/26/08 at 1:25 PM revealed the macaroni and cheese served was dried out and tasted very bland. Interview with the dietary manager at that time revealed it was prepared fresh that day. However, she also stated the macaroni and cheese appeared dry. Further interview with the dietary manager on 8/28/08 at 9:10 AM revealed there was no process in place to ensure the food was palatable.	F 364		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or	F 371		

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F 371	Continued From page 22 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of cleaning lists, the facility failed to ensure equipment and surfaces in two of two kitchens were cleaned and that staff used proper hand washing techniques. In addition, the facility failed to ensure foods were properly dated and labeled, and that spoiled food was not available for use. The resident census was 112. The findings were: 1. Observation of the main kitchen on 8/26/08 at 3:20 PM revealed the following areas of the kitchen were not cleaned: a. The ice machine had a whitish brown buildup on the edge of the inside piece where the ice dropped down. Interview with the dietary manager and the preparation cook on 8/25/08 at 2:35 PM revealed they were uncertain when the machine was last cleaned and sanitized. According to the manufacturer's instructions posted on the inside of the ice machine lid, the machine should be cleaned and sanitized twice a year. b. Observation on 8/26/08 at 3:50 PM revealed there were two insulated units used to hold hot and cold foods while foods were being transferred to the secure unit kitchen. At 3:50 PM one of the containers was noted to have a strong odor of rancid food, and a moist yellow substance	F 371	F371 Sanitary Conditions 1. Correction: The Ice machine has been cleaned and sanitized. The insulated hot/cold units have been deep cleaned and are wiped down daily. The bottom shelves on the preparation tables have been cleaned. The ceiling vents have been taken down and cleaned. The hood vent on the range has been cleaned. The coffee pots in the kitchenette have been cleaned. The steam table covers have been cleaned. Shelving has been cleaned. An In service has been given to servers #1&#2 regarding hand washing and sanitation. The undated and outdated food has been removed and thrown away. 2. Identification: Residents currently residing in the facility are at potential risk.	

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F 371	Continued From page 23 on the bottom and sides of the container. The other unit contained standing water. Left over food debris was noted on the interior surface. Interview on 8/26/08 at 3:50 PM with the dietary manager revealed the containers were to be cleaned after each meal. c. On the bottom shelves of two preparation tables, there were dried on splatters and particles of food. d. Four ceiling vents, all located above food preparation areas, were heavily soiled with black grease and dust. e. The hood vents located above the range were visibly soiled with grease and dust. Interview with the dietary manager at 3:55 PM on 8/26/08 revealed she was unsure the last time the vents were cleaned. 2. Observation in the secure unit kitchen on 8/26/08 at 9:55 AM revealed three coffee pots in use that were soiled with a thick greasy build-up on the outside of the pots. In addition, the steamtable covers were soiled around the handles. There was also a skillet stored on greasy soiled shelving. 3. Review of the daily cleaning schedules for August 2008 showed the assigned tasks were not being done. Interview with the dietary manager on 8/27/08 at 11:10 AM confirmed she was aware the cleaning tasks were not being done daily. 4. Observation revealed the following concerns with handwashing: a. Observation during meal service on 8/25/08 at 5:25 PM in the main kitchen revealed server #1 answered the telephone and failed to perform any handwashing prior to returning to serving residents' meals.	F 371	3. Systemic changes: Dietary Manager will in service staff on the cleaning schedule, hand washing and sanitation in the dietary department. Monthly sanitation rounds will be assigned to the department heads by the NHA. NHA will meet with the Registered Dietitian and instruct him/her to include a weekly review of the dietary to include the checking of food in the refrigerators, as well as a check of the kitchenette on the secured unit. RD will report to the NHA monthly with the results of these rounds. 4. Monitoring: NHA will monitor the results of the monthly sanitation rounds and RD reviews and bring them before the QA&A committee to ensure compliance is maintained. 5. Date of compliance: October 12, 2008	

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F 371	Continued From page 24 b. Observation on 8/25/08 at 5:30 PM revealed server #1 answered the telephone with ungloved hands. After completing the telephone call, the server went into the dirty dishroom. Server #1 then returned to the kitchen, removed his cap, ran his hands through his hair, replaced the cap on his head. The server then picked up a scoop, touching the serving portion of the scoop, and proceeded to dish up food for serving to the residents. Server #1 did not wash his hands at any time during this observation. c. Observation on 8/26/08 at 12:20 PM in the main kitchen revealed server #2 answered the telephone, handled the reach-in refrigerator door, and, without any handwashing, continued to serve residents' meals According to the U.S. Public Health Service FDA 2005 Food Code, 2-301.14: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms ...immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS... (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms ... (I) After engaging in other activities that contaminate the hands. 5. Observation during the kitchen tour on 8/25/08 at 2:30 PM revealed a pan of leftover food product in the walk-in refrigerator. The container was not dated or labeled. At that time, the dietary manager and registered dietitian (RD) could not identify the product and did not know how long it had been there. The RD instructed that the food item be thrown away. However, observation on 8/26/08 at 3:20 PM revealed the same pan of food remained in the walk-in refrigerator. The pan was now labeled and dated. During an interview	F 371		

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F 371	Continued From page 25 with the dietary manager on 8/26/08 at 3:20 PM, she state she was unsure why this product was not thrown away as instructed. In addition, on 8/25/08 at 3:20 PM observation in a reach-in refrigerator revealed a large container with shredded lettuce. The date marked on the lid containing the lettuce was 8/13/08 (12 days prior to the observation). Most of the shredded lettuce was brown and spoiled. Interview with the dietary manager on 8/27/08 at 11:10 AM revealed the cook and prep cook were supposed to look for outdated items each day and discard anything more than three days from the date it was labeled.	F 371		
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: Based on staff interview and medical record review, the facility failed to ensure the physician acted on a pharmacy recommendation in a timely manner for one (#2) of 21 sample residents. The findings were: Review of the medical record for resident #2 revealed on 4/10/08 the pharmacist recommended changing the order for guaifenesin	F 428	F428 Drug Regimen Review 1. Correction The pharmacy recommendation on Resident #2 has been followed up on. 2. Identification: Residents currently residing in the facility are at potential risk. 3. Systemic changes: The NHA/DON will meet with the pharmacy consultant in regards to providing the DON with a copy of all the recommendations that he/she has made from the monthly review. The Pharmacy consultant will give monthly recommendations to the DON/designee, who will fax them to the physician. If no response has been received than a call will be placed to the physician. If their still is no response, then the recommendation will be sent to the Medical Director for follow-up. 4. Monitoring: DON/designee will report on the follow up to the pharmacy recommendations at the monthly QA&A committee. The Medical Director will follow up with the physicians who do not respond timely. 5. Date of compliance: October 12,2008	

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F 428	Continued From page 26 (expectorant) 600 milligrams (mg) from 1 to 2 tablets twice daily to just one tablet twice daily. According to the 2005 Edition PDR Nurse's Drug Handbook, page 571, side effects of this medication include nausea, vomiting, gastrointestinal upset, dizziness, headache, and rash. Review further revealed the recommendation was originally faxed to the physician on 4/15/08, then again on 5/20/08, with no response from the physician. Review of the 6/13/08 pharmacy recommendation to the physician revealed it was for the same request. Further review of the 6/13/08 recommendation revealed the physician responded to that fax and the order was decreased 61 days after the first recommendation was made (4/10/08 to 6/10/0). Interview with the director of nursing on 8/28/08 at 1:40 PM revealed they did not always get timely responses from physicians for these types of recommendations.	F 428		
F 441 SS=F	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 staff interview and review of infection control documents, the facility failed to have in	F 441	F441 Infection Control 1. Correction The facility has hired a Staff Development Coordinator, who will also serve as the facilities Infection Control Nurse. 2. Identification: The residents currently residing in the facility are at potential risk. 3. Systemic changes: The DON and SDC will be in serviced on the infection control program, including monitoring of infections for trending, logging, mapping and providing in servicing in the response to noted trends. DON/designee will in service the nurses to report new infections via the 24-hour report. The SDC will set up a month-to-month binder to keep the infection control	

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F 441	Continued From page 27 place an effective infection control program. The census was 116. The findings were: Interview with the director of nursing (DON) on 8/28/08 at 10:37 AM revealed there was no infection control coordinator currently, and there had not been one since 6/19/08. She stated the two Minimum Data Set (MDS) coordinators attended morning meetings Monday through Friday and if any residents were on antibiotics, one of the coordinators placed an infection control care plan in the chart. Interview with the two MDS coordinators on 8/28/08 at 10:37 AM confirmed that process. They further stated there was no infection control log, "no" tracking records, no monitoring for clusters, and no surveillance. All three staff stated the care plan was the only infection control intervention provided. When asked, the DON and both MDS coordinators stated there was no current infection control program. Upon further interview, the two MDS coordinators and the DON stated there was no employee health program or monitoring for communicable diseases.	F 441	paperwork in. DON/SDC will go back to the beginning of September to log and map the current infections and it will be updated on a Monday through Friday basis. 4. Monitoring: The SDC/DON will monitor for new infections through review of the telephone orders and the 24-hour report process at the AM stand up meeting. The SDC will report on the tracking and trending at the AM stand up meeting. NHA will review the binder weekly to ensure that it is kept up to date; results of the monthly oversight will be brought before the QA&A committee to ensure compliance. 5. Date of compliance: October 12, 2008 F502	
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory tests were conducted as ordered by the physician for one (#79) of 21 sample residents. The findings were:	F 502	1. Correction The lab order on Resident #72 was not completed due to the resident not being on the medication that would warrant this test being done. Resident #72 is having labs done as ordered. 2. Identification: Residents currently residing in the facility are at potential risk. 3. Systemic changes The DON/designee will complete a audit of all labs ordered in the last 3 months to ensure that they have been completed. Nurses will be in	

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F 502	Continued From page 28 Review of the physician's orders for resident #79 revealed an order dated 5/5/08 for a prothrombin time, INR, complete blood count, and a comprehensive metabolic panel. Review of the entire medical record revealed no evidence the tests were done. Interview with the director of nursing on 8/28/08 at 12 noon confirmed the tests were not done.	F 502	serviced by the DON/designee on logging all labs that have been ordered, and marked off when they the results have been reported to the physician to ensure compliance. 4. Monitoring The DON/designee will review the 24 hour report as well as the telephone orders at the AM stand up meeting for new lab orders and follow up that they have been placed on the log. The DON/designee will review the lab logs at the AM stand up meeting weekly to ensure compliance. A report will be generated from this review, and brought before to QA&A X3 months then quarterly thereafter. 5. Date of Compliance: October 12, 2008	
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		

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F 520	Continued From page 29 Based on staff interview, resident interview, medical record review, and review of facility documents, the facility failed to ensure the quality assurance performance improvement (QAPI) program was effective in identifying and resolving problems in the facility. The findings were: 1. Review of the previous survey findings dated 7/12/07 revealed the facility was cited for not following professional standards (F281). Review of the OSCAR 3 report revealed the facility also was cited for not following professional standards in 2004. Refer to federal citation F281 for details related to concerns about not following professional standards during the 8/28/08 survey. 2. Review of the previous survey findings dated 7/12/07 revealed the facility was cited for not following the care plan (F282). Review of the OSCAR 3 report revealed the facility was also cited for not following the care plan in 2004 and 2006. Refer to federal citation F282 for details related to concerns about about not following the care plan during the 8/28/08 survey. 3. Review of the previous survey findings dated 7/12/07 revealed the facility was cited for not providing incontinence care (F315) in a timely fashion. Review of the OSCAR 3 report revealed the facility also was cited for not providing timely incontinence care in 2005. Review of the 7/12/07 plan of correction revealed random daily audits would be conducted to assess timely toileting of residents that needed assistance. Further review revealed the audit results would be presented to the Quality Assurance committee for recommendations and action as needed for continued compliance for three months. Refer to federal citation F315 for details related to	F 520	F520 Quality Assessment and Assurance: 1. Correction: The Regional Clinical Director will in service the Department heads on the Policy OP20107.00 QA&A committee, calendar, meeting agenda and plan. This also includes a focus on utilization of information to identify areas of concern and development of an action plan to resolve these issues. 2. Residents currently residing in the facility are at potential risk. 3. Systemic Changes: The NHA will follow the QA&A agenda at the monthly meeting, and oversee the development and implementation of the action plans of the areas of concern. 4. Monitoring: The Regional Vice President and Regional Clinical Director will review the QA&A meeting minutes during their monthly visits. Action plans will be emailed to the Regional Clinical Director monthly x3, if progress has been noted, then action plans will be reviewed during monthly visits. 4. Date of Compliance: October 12, 2008	

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F 520	Continued From page 30 concerns regarding incontinence care during the 8/28/08 survey. 4. Review of the previous survey findings dated 7/12/07 revealed the facility was cited for lack of compliance in the storage, preparation, distribution and serving of food under sanitary conditions. Review of the OSCAR 3 report revealed the facility was also cited regarding this concern in 2004 and 2006. Refer to federal citation F371 for details related to concerns regarding incontinence care during the 8/28/08 survey. 5. Interview with the administrator and director of nursing on 8/28/08 at 9:34 AM revealed the results of the previous survey were always monitored as part of the QAPI program.	F 520		