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F 161 SS=B	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and surety bond review, the facility failed to provide surety bond coverage for the total amount in resident trust accounts and ensure that residents with trust accounts were the beneficiaries. Fifteen residents had trust accounts. The facility census was 28. The findings were: Interview with the business manager on 9/9/05 at 9:25 AM revealed the resident trust account total was $8727.57. The manager stated 15 residents had trust accounts. Review of the surety bond (expiration date 2/1/06) revealed its coverage totaled $5000.00. In addition, the bond documented the facility as the beneficiary and not the residents with trust accounts.	F 161	F 161 The facility has purchased a surety bond in the amount of $10,000 to cover resident trust accounts. The beneficiary on the bond has been changed from the facility to the residents with trust accounts.	~~9/26/05~~ 10/31/05
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.	F 226		

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

Gary Otter | CED | 9-29-05

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

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F 226	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on personnel record review, staff interview and policy and procedure review, the facility failed to follow their approved procedure for pre-employment screening for five of five sample employees. The findings were: Review of the facility's policy and procedure "Abuse: Seven Key Points" dated 9/8/04, revealed a section titled "Screening." The procedure for this section documented the following: "Pre-employment screening will attempt to establish: If applicants have been convicted of abuse by a court of law. This will be accomplished through the Department of Family Service Registry ...Two reference checks will be conducted to establish applicant's appropriateness for the position. No application will be hired who fails to meet the above criteria." Review of five personnel records and interview with the human resources manager on 9/9/05 at 10:15 AM revealed the following problems with potential employees being screened according to facility policy: a. There was no evidence reference checks were conducted for any of the five sample employees who had hire dates of 6/3/05, 6/7/05, 8/1/05, 8/8/05 and 9/6/05. According to the human resources manager, the reference checks should be documented on the employee's application. b. The background check for four of the five employees was sent to the Department of Family Services on either the date of hire or the following day. The results of the background check for three of the five employees were not attained by the facility until 10 - 20 days following hire.	F 226	F 226 Facility policy for pre-employment screening will be following as evidenced by monthly compliance monitoring to be reviewed by DON. Files of all nursing department employees hired within last 120 days will be audited for DFS checks, 2 reference checks, and licensure verification by DON. Appropriate checks and verifications will be completed if not found in file.	10/31/05

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F 226	Continued From page 2 Interview with the human resource manager on 9/9/05 at 10:45 AM, and interview with the director of nursing on 9/9/05 at 11:00 AM, confirmed the two reference checks were not conducted for any of the five employees. Further interview with the human resources manager on 9/9/05 at 1:30 PM confirmed the procedure for pre-employment screening should be followed.	F 226		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the	F 272		

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F 272	Continued From page 3 resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to assess one (#27) of five sample residents who utilized a urinary catheter. The findings were: Observation of resident #27 on 9/7/05 at 9:15 AM revealed the resident utilized a urinary catheter. Review of the medical record failed to reveal an assessment for the use of the catheter. Documentation on the urinary resident assessment protocol module summary, dated 1/17/05, showed the resident's catheter was placed in October, 2004, after a hip fracture. Medical record review with the director of nursing (DON) on 9/7/05 at 12:41 PM revealed no other evidence related to the resident's need for the catheter or an assessment for its continued use. Interview with the DON on 9/8/05 at 8:11 AM revealed the catheter was removed and then reinserted during a hospitalization in July 2005 and the resident's need for the catheter was not assessed.	F 272	F 272 The necessity of need for Foley catheter on resident #27 was made by the physician and the catheter was removed on 9/12/05. Residents admitted with a Foley catheter or returning with a Foley catheter will be assessed by nursing and documentation made in the bladder assessment tool for MDS. This will be evidenced by monthly QI monitoring	~~10/1/05~~ 10/31/05
F 278 SS=E	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 4 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure accurate coding and/or dating of Minimum Data Set (MDS) assessments for three (#9, #25, and #27) of ten sample residents. In addition, one (#9) of ten assessments lack signatures of the person or persons responsible for the document's completion. The findings were:	F 278	F 278 Accurate coding and/or dating of MDS will be completed accurately during assessment reference period and signed by RN on sign by date. This will be evidenced by weekly QI monitoring by MDS coordinator and nursing unit coordinator. Resident #9's MDS from 4/14/05 has been corrected to show his significant change as well as being a 30-day Medicare assessment. MDSs of residents #9, #25, and #27 have been reviewed with all members of the MDS training team by 10/1/05.	10/7/05 10/31/05

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F 278	Continued From page 5 1. Medical record review of the MDS assessments for resident #9 revealed he/she had a significant change in condition after a hospitalization in March 2005. Yet the review failed to reveal a significant change assessment. The review did reveal a full resident assessment instrument (RAI) dated 4/14/05 (in section R2b), but was not signed (section R2a). The assessment was coded as a Medicare 30 day assessment. Further review revealed section "V" was dated, but not signed. In addition, section AA9d documented assessment section 'H' was completed on 4/16/05, which was 2 days after the unsigned completion date of the entire assessment (dated 4/14/05). Interview with the director of nursing (DON) on 9/8/05 at 8:13 AM revealed the 4/14/05 assessment should have included coding for a significant change assessment. The DON stated the the R2b date was the date of the completion of the assessment and that the AA9 section dates should all reflect assessment dates on 4/14/05 or prior to that date. In addition, the DON stated signature sections such as R2a and section V should be signed. 2. Review of the quarterly MDS dated 7/11/05 for resident #27 revealed section H1b coded the resident as totally incontinent of bladder. Review of section H3 revealed the resident used "none of the above" which included interventions such as a toileting plan, retraining program, catheters and ostomy. Observation of the resident on 9/7/05 at 9:15 AM revealed the resident used a urinary catheter. Review of the 1/17/05 urinary resident assessment protocol module summary showed the resident's catheter was in place October 2004. Interview with the DON on 9/8/05 at 2:59 PM revealed the 7/11/05 MDS was coded	F 278		

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F 278	Continued From page 6 incorrectly since the resident had the catheter. Another concern found during the record review was section AA9e. It revealed the assessment for section H was completed on 7/12/05. Review of the assessment completion date, section R2b, revealed it was dated 7/11/05. Interview with the DON on 9/8/05 at 8:13 AM revealed the assessment completion date (section R2b) should occur after all individual section assessments (section AA9) have been completed. 3. Review of the quarterly MDS assessment for resident #25 revealed one individual assessment section (section AA9) was dated after the assessment completion date (section R2b) of 7/10/05. Section AA9e revealed a completion date for section H of 7/12/05 which is two days after the entire assessment completion date. Interview with the DON on 9/8/05 at 8:13 AM revealed the assessment completion date (section R2b) should occur after all individual section assessments (section AA9) have been completed.	F 278		
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 observation, staff interview, and policy review, the facility failed to ensure medications were passed within professional guidelines. One of two medication pass observations revealed	F 281		

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F 281	Continued From page 7 staff handled the medications with bare hands. The findings were: Observation of the medication pass on 9/7/05 at 8:00 AM revealed licensed practical nurse (LPN) #3 removed an Imdur (a cardiac vasodilator) 60 mg tablet from its bottle, broke the tablet in two with her bare hands, and then placed the tablet half in the medication cup. The LPN used her bare hand to put the other half back into the bottle. The last medication dispensed was atenolol (a blood pressure medication). The LPN used her bare hands to remove two tablets from the bottle. One tablet was added to the medication cup, and one was placed in a medication cutting device, arranged in the device with a bare hand, and then cut in two pieces. One piece was placed in the medication cup with a bare hand, and one piece was poured back into the medication bottle. The LPN then delivered the medications to resident #4. The observation revealed a box of gloves on the medication cart and available for use. Interview with the director of nursing (DON) on 9/7/05 at 12:41 PM revealed the staff were expected to use the medication cutting device or gloved hands when they handled medications. Review of the facility policy titled "Medication Administration" with a review date of February, 2004, revealed staff were instructed to pour the required number of tables/capsules into the bottle cap and transfer them to the medication cup. The policy documented, "Do not touch medicines with you fingers."	F 281	F 281 All nurses will utilize gloves and pill splitter if indicated when splitting pills. This will be evidenced by inservice education by DON at staff meeting and compliance rounds documented and reported monthly by DON.	~~10/1/05~~ 10/31/05
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility	F 282		

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F 282	Continued From page 8 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, medical record review, and staff interview, the facility failed to provide a tab monitor (an audible safety alarm) according to plans of care for two (#6 and #7) of two sample residents who were assessed as being at risk for falls. The findings were: Review of the 3/13/05 annual Minimum Data Set (MDS) assessment for resident #6 showed s/he fell within the last 30 days. Review of the care plan for this resident revealed the resident was to have a " tab alarm at all times. " Observations on 9/6/05 at 4:08 PM, and on 9/8/05 at 10:35 AM, revealed the resident was sleeping on his/her bed; however a tab monitor was not in use. Interview with LPN #2 on 9/8/05 at 10:35 AM confirmed a tab monitor should have been utilized. Review of the 6/2/05 quarterly MDS assessment for resident #7 showed the s/he fell within the last 31 - 180 days. Review of the care plan for this resident revealed. "Bed alarm on bed to alert staff to exiting bed. " Observation on 9/8/05 at 10:35 AM showed the resident was sleeping on his/her bed; however, an alarm was not in use. Interview at that time with LPN #2 confirmed the tab monitor should have been utilized.	F 282	F 282 Tab alarms were checked and added for resident #6, and #7 Tab alarms will be placed on all residents as directed in individual plan of care. This will be evidenced by education at staff meeting and 1-2 times weekly compliance rounds by nurses and CNAs and reported monthly.	10/1/05 10/31/05
F 315	483.25(d) URINARY INCONTINENCE	F 315		

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F 315 SS=D	Continued From page 9 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 one (#27) of five sample residents who utilized a urinary catheter, required its use. The findings were: Observation of resident #27 on 9/7/05 at 9:15 AM revealed the resident utilized a urinary catheter. Review of the medical record which included physician orders, assessments, and diagnoses, failed to reveal a medical reason or rationale for the resident's need for a urinary catheter. Documentation on the resident urinary assessment protocol module summary, dated 1/17/05, showed the resident's catheter was inserted in October, 2004, after a hip fracture. No other evidence was found related to the resident's need for the catheter. Review of the medical	F 315	F 315 Indwelling catheter on resident #27 has been removed. The facility will ensure that any resident entering the facility without an indwelling catheter will have a complete bladder assessment performed by nursing and every effort made to restore normal urinary function and prevent urinary tract infections. When on indwelling catheter is inserted the appropriate diagnosis for the catheter will be obtained from the physician and documentation entered on the bladder assessment form. All indwelling catheters will be tracked weekly by MDS team.	~~10/1/05~~ 10/31/05

Accepted & Reviewed w/ Connie Clous, DON on 10/17/05 @ 10:15am
E Changes on pgs. 9, 13

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F 315	Continued From page 10 record with the director of nursing (DON) on 9/7/05 at 12:41 PM failed to reveal documentation related to the use of the catheter or an assessment. Interview with the DON on 9/8/05 at 8:11 AM revealed she had reviewed the resident's hospital record. She stated the catheter had been removed and then reinserted during a hospitalization in July, 2005. The DON stated that at the time, the resident had required the catheter during adjustment of his/her diuretic medications, but currently the resident might not need the catheter.	F 315		
F 318 SS=E	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, restorative documentation, resident interview, and staff interview, the facility failed to consistently provide restorative services for four sample (#5, #9, #14, #25) and five (#1, #2, #8, #16, #18) non-sample residents who required restorative services five days a week. The findings were: Interview with the restorative certified nurse aide (RCNA) on 9/8/05 at 10:40 AM revealed she was the only CNA currently trained to assist residents with restorative exercises. Observation of resident #25 on 9/8/05 at	F 318		

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F 318	Continued From page 11 10:54 revealed the resident had severe contractures of the legs. At the time of the observation, the RCNA was present and assisting the resident with range of motion (ROM) exercises. Interview with the RCNA revealed the resident required the ROM five times a week. The RCNA stated the goal of the exercises were to keep the muscles loose and prevent further contractures. The interview revealed the RCNA had taken time off, resident #25 had missed three days of exercise, and no other staff had assumed the restorative duties. Interview with the resident at that time confirmed no one had done the ROM exercises. A second interview with the RCNA was done on 9/9/05 at 8:41 AM. At that time, a review of the restorative documentation for all residents with restorative services was done. The interview and review revealed residents #1, #2, #5, #8, #9, #14, #16, and #18 all required restorative services five days a week. The RCNA confirmed all these residents and resident #25 had missed three days of services. Interview with the director of nursing on 9/9/05 at 11:05 AM revealed none of the current staff were cross-trained to provide restorative services when the RCNA was off, ill, or reassigned to work another area.	F 318	F 318 All residents with ordered Restorative Therapy will consistently receive Restorative Therapy. This includes residents #1, #2, #5, #8, #9, #14, #16, #18, and #25. This will be evidenced by monthly QI monitoring and job posting for relief. Restorative Therapy Aide and documentation of orientation/training.	10/15/05 10/31/05
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		

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F 363	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the planned menus and diet cards, the facility failed to follow the menu for one of one resident (#22), who received a 2-gram sodium restricted diet, and for five of five residents (#5, #8, #9, #16 and #17) with calorie-controlled diets. In addition, the facility failed to plan a 1600 Calorie menu for resident #9. The resident census was 28. The findings were: Observation of the resident diet cards, the planned menus, and food items served during lunch meal service on 9/8/05 from 12:15 PM - 12:25 PM revealed the following concerns: a. The diet card for resident #22 showed s/he received a 2-gram sodium restricted diet. The planned menu for the 2-gram sodium diet documented the resident should receive low-sodium fried potatoes and green beans. Observation of the resident's meal revealed s/he was served the pre-seasoned fried potatoes and the "green bean bake." b. The diet card for residents #5, #8, #9, #16, and #19 showed the residents were to receive specific calorie-controlled diets. The planned menus for these diets (1500, 1800, and 2000 Calories) documented a fruit cup for dessert. Observation of the meals provided to these residents revealed diet pudding was served for dessert. c. There was no planned menu for resident #9, whose diet card indicated the resident was to receive a 1600 Calorie diet. Interview with the dietary manager on 9/9/05 at 9:15 AM confirmed the planned menus for the	F 363	Diets for residents #22, #5, #8, #9, #16 + #19 were updated and are followed. F 363 All residents' diets will be followed and monitored to assure compliance. The Registered Dietician (RD) will complete and approve the extended menus for all of the diet prescriptions in the facility including the 1600 Calorie diet. These will be posted and used by the staff for guidance in meal preparation. The Dietary Manager (DM) and RD will in-service the dietary staff on the use of the extended menus for diet compliance. This will be monitored by the DM and RD. The RD will initiate a bi-weekly QI to assure formal compliance of the residents' diet prescription by the dietary staff during the meal service.	~~10/13/05~~ 10/31/05

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	535029	A. BUILDING _____ B. WING _____	09/09/2005

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F 363	Continued From page 13 2-gram sodium diet and the calorie-controlled diets should be followed. The dietary manager further commented that a 1600 Calorie menu was not planned for resident #9.	F 363		
F 371 SS=F	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to assure the chlorine in the dish machine was being dispensed at an adequate concentration for proper sanitation. In addition, ice for consumption was not stored in a sanitary manner. The findings were: Observation on 9/8/05 at 9:55 PM revealed cook #1 was washing racks of dishes in the dish machine. The surveyor requested the cook to test the concentration of sanitizer. The cook tested the concentration with a chlorine test strip; however, the white strip did not change color, indicating chlorine was not present for sanitation purposes. Interview with the dietary manager at that time revealed she had been " priming" the tube that connected the chlorine sanitizer to the dish machine, and routinely checking the chlorine concentration, because the sanitizer was not working properly earlier that morning, or the previous afternoon. Interview on 9/8/05 at 1:15 PM with the representative from the company that maintains the dish machine revealed the required concentration of chlorine for proper sanitation is	F 371	F 371 The facility will store, prepare, distribute, and serve food under sanitary conditions. The Registered Dietician (RD) and Dietary Manager (DM) will in-service the dietary staff on monitoring dish machine sanitizer concentration and the appropriate corrective actions to take. The RD and DM will develop a new monitoring log for the sanitizer concentration of the dish machine. Dietary staff will check and record the sanitizer concentration three times a day to assure that appropriate concentration is met. A QI will be initiated by the DM for monitoring. The RD and DM will in-service the dietary staff on proper storage techniques. Dietary staff will review the current policy and procedure on food storage, which states food will be stored at least 6" from the floor. No food will be stored on the floor. The DM will monitor this weekly to assure compliance.	~~10/13/05~~ 10/31/05

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F 371	Continued From page 14 50 parts per million. Observation in the walk-in freezer on 9/6/05 at 2:00 PM showed eight plastic bags of ice on the floor. Interview with the dietary manager and cook #4 on 9/6/05 at 2:10 PM revealed the ice " came in on Sunday " and was for drinking water. The interview further revealed the bagged ice was being stored in the freezer because the ice machine was "broken." Review of the facility's policy for food storage, reviewed on 6/18/04, revealed "Food shall be stored six inches off the floor to facilitate cleaning and prevent contamination from splashing." Interview with the dietary manager on 9/9/05 at 9:15 AM confirmed this policy also applied to the bags of ice. According to the 2001 Food Code, US Public Health Service: 3-305.11, Food Storage: Food shall be protected from contamination by storing the food in a clean dry location; where it is not exposed to splash, dust, or other contamination; and at least 6 inches off of the floor.	F 371		
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.	F 441		

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on staff interview, and review of the infection control program, the facility failed to assure the collected surveillance data was routinely analyzed in a timely and systematic manner, and subsequent cautionary measures were documented. In addition, the facility failed to assure policy and procedures for infection control surveillance were updated and available for review. The findings were: Interview with the infection control officer, and review of the infection control surveillance documents on 9/8/05 at 2:50 PM, revealed a staff nurse filled out a form for each resident identified as having signs and/or symptoms of an infection. The staff nurse was responsible for tracking the treatment, the results of cultures, as well as any follow-up actions. On a monthly basis, the staff nurse summarized the data into the following four categories: 1) Types of infections confirmed by cultures/x-ray; 2) Types of unconfirmed infections; 3) Total number of nosocomial (facility acquired) infections; and, 4) Total number of infections. This data was then given to the infection control officer. The following concerns were noted: a. Interview with the infection control officer on 9/8/05 at 3:00 PM revealed there was no systematic method in place to assist with the analysis of the collected surveillance data. b. Interview on 9/8/05 at 5:25 PM with RN #1, who compiled the surveillance data, confirmed there was no method to review and evaluate the collected infection control surveillance data. The RN further commented, "I don't know how we can track them [infections] without it."	F 441	F 441 The facility will develop a current Infection Control surveillance program. It will include policy and procedure for data to be analyzed in a timely manner and review by the Infection Control Physician. There will be a systematic method in place to assist with the analysis of collected data and a method to document cautionary measures taken to prevent the spread of infection.	~~10/31/05~~ 10/31/05

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F 441	Continued From page 16 c. Interview with the director of nursing (DON) on 9/9/05 at 9:15 AM revealed there was no system in place to routinely analyze the surveillance data, nor a method to document cautionary measures taken to prevent the spread of infection. The DON said, "The loop to tie it all together is not there." d. Further interview with the DON on 9/8/05 at 11:15 AM revealed the infection control coordinator usually takes a leave of absence for "a couple" of months each year. The DON said she was the "back-up" when the infection control officer was gone in January and February 2005; however, she did not have time to review and analyze the collected surveillance data for those two months. e. Interview with the DON on 9/9/05 at 11:15 AM revealed the infection control officer was not in the facility and the DON could not find the policies and procedures for infection control surveillance. The DON further commented the documents were removed from the facility's policy and procedure manuals to be updated and, "were never replaced." Thus, the policies and procedures were not available for staff, or survey team, review.	F 441		