POC accepted 2/22/05 Jennelle Cowden, OTR/L

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

PRINTED: 02/03/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING _____ B. WING _____	01/27/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1115 LANE 12 LOVELL, WY 82431

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F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the facility's policy for restraints, and medical record review, the facility failed to assure a physical restraint was utilized in the least restrictive manner for one (#70) of one sample resident. The findings were: Review of the 11/25/04 quarterly Minimum Data Set (MDS) assessment for resident #70 revealed the resident had fallen in the past 30 days and the past 31 to 180 days. This assessment also revealed the resident did not use physical restraints. Review of the 11/04 ADL (Activity of Daily Living)/Restorative Assessment revealed the resident could ambulate independently. Interview with registered nurse (RN) #10 on 1/26/05 at 3:15 PM revealed the resident had a history of falls. The interview revealed the resident was capable of ambulating independently and a "lap buddy" (a cushion attached to a wheelchair that may prevent a resident from standing) was used to prevent the resident from standing and walking independently because of the resident's fall history. Review of the facility's policy titled Restraints revealed restraints would be used only with a written order from a physician and would include the type of restraint to be used. The policy also documented restraints would be released every two hours for fifteen minutes, and all restraints would be removed while residents	F 221	FEB 14 2005	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dave Lloyd CEO | TITLE: CEO | (X6) DATE: 2/14/2005

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. POC accepted. Message left for Dave Lloyd, CEO on 2/22/05 @ 1605.

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F 221	Continued From page 1 were under supervision of nursing staff. The following concerns were identified: a. Observation of the resident on 1/24/05 from 5:45 PM until 6:30 PM during the evening meal revealed the resident was seated in a wheelchair with a lap buddy secured to the arms of the wheelchair. The observation revealed three certified nurse aides (CNA) were present in the room during the meal; however, the lap buddy was not removed. Observation of the resident on 1/25/05 from 8 AM to 8:30 AM during the breakfast meal revealed the resident was again seated in a wheelchair with a lap buddy secured to the armrests; four CNAs were present in the dining room. On 1/25/05 at 8:30 AM the resident was taken to the TV area by a CNA and transferred to a recliner and placed in a recumbent position. At 10:16 AM on 1/25/05 the CNA returned to the TV area and transferred the resident from the recliner to a wheelchair. The lap buddy was again secured to the wheelchair armrests. During the observation, the CNA stated the lap buddy was to keep the resident from standing and falling. b. Review of the January, 2005, physician's orders revealed no physician order had been written for the use of a lap buddy. Review of the resident's 12/03/04 care plan revealed no plan was in place that identified when the lap buddy would be used or when the lap buddy would be released. c. On 1/26/05 at 4:10 PM interview with RN #1 and the director of nursing (DON) revealed the lap buddy was not utilized as a positioning device, but was utilized to prevent the resident from standing and ambulating independently. The interview revealed there was no medical symptom for the use of the lap buddy, and no evaluation was done to assess for the least restrictive use of	F 221	The facility will ensure that residents will be free from restraints unless required to treat the resident's medical symptoms. a. Resident #70 will be evaluated by Occupational Therapy for the least restrictive environment. Resident #70 will have a doctor's order and care plan for the lap buddy. Resident #70 will have the lap buddy removed at intervals per facility policy. b. All residents will lap buddies will be reviewed for restraints. c. All residents will be reviewed monthly for physical and chemical restraints with the Interdisciplinary Team. d. The restraint Policy will be reviewed at the February mandatory nursing staff meeting. d. Compliance will be monitored and reported monthly by the Nurse Supervisor as part of the facility Quality Assurance Program.	3/15/05

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F 221	Continued From page 2 the lap buddy.	F 221		
F 273 SS=D	483.20(b)(2)(i) RESIDENT ASSESSMENT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to assure an admission assessment for one (#74) of 16 sample residents was completed within 14 days of admission. The findings were: Review of the medical record for resident #74 revealed the resident was admitted to the facility on 1/7/05. On the date of the medical record review on 1/25/05 the review revealed no admission Minimum Data (MDS) assessment was done. Interview with registered nurse #3 (RN) who was responsible for the resident's admission assessment revealed the assessment was not completed. The RN stated the assessment should have been completed by 1/21/05 but was not. The RN stated the following areas were not completed: Section B, Cognitive Patterns; Section E Mood and Behavior Patterns; and Section F Psychosocial Well-Being. The RN stated the aforementioned sections should have been completed by social services. Interview with the social services designee on 1/25/05 revealed	F 273	The facility will ensure that a comprehensive assessment of residents will be complete within fourteen days after admission. a. Resident #74 assessment has been completed. b. All residents will have their assessments completed within the required time frame. c. The MDS Coordinator will notify staff members responsible for certain sections to have their sections complete with the specific date for the last day for completion. d. The MDS Coordinator will monitor weekly as part of the facility Quality Assurance Program and report monthly.	3/15/05

2/13/05

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F 273	Continued From page 3 she was aware the MDS was due, but just overlooked completing the assessment.	F 273		
F 278 SS=D	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. 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 Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or 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, staff interview, and medical record review, the facility failed to assure the Minimum Data Set (MDS) assessments and dietary assessments were accurate for one (#6)	F 278	The facility will ensure that resident assessments accurately reflect the residents status.	3/13/05

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F 278	Continued From page 4	F 278		
	of three sample residents with swallowing problems. The findings were:			
	Review of the 10/29/04 annual Minimum Data Set (MDS) assessment showed resident #6 did not have swallowing problems. In addition, review of the 10/26/04 nutrition evaluation showed the resident's ability to swallow was "fair." The evaluation did not document a history of aspiration. However, the following examples of documentation in the medical record showed the resident had swallowing problems, including a history of aspiration:			
	a. The patient transfer form from the hospital on 10/26/01 documented the resident had a diagnosis of aspiration pneumonia, and was on aspiration precautions.		a. Resident #6 has been assessed and the MDS corrected.	
	b. A physician's note dated 8/27/03 documented "...patient is at chronic risk for aspiration and probably aspirates frequently as speech therapy has seen with really nothing that can be done except conservative feeding."		b. All residents will be reviewed on their scheduled assessment dates and reviewed for accuracy.	
	c. An interim history and physical dated 8/18/04 revealed "...the patient also continues to have significant difficulty with aspiration."		c. The Interdisciplinary Team will review assessments due weekly to ensure accuracy.	
	d. Physician's notes dated 9/1/04, 9/10/04, 9/14/04, 9/21/04, 9/29/04, 10/5/04, and 10/15/04 documented problems with aspiration.		d. The MDS Coordinator will monitor accuracy of the assessments and report monthly as part of the facility Quality Assurance Program.	
	e. A nursing note dated 2/13/04 showed the resident was suctioned, and stated "...does not swallow."			
	f. A nursing note dated 2/14/04 revealed the resident was suctioned. The note documented medications were held because the resident was not swallowing.			
	Observation during the breakfast meal on 1/25/05 at 8:20 AM, 8:21 AM, and 8:22 AM revealed CNA #9 cued the resident to swallow, because the			

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F 278	Continued From page 5 resident was pocketing food. At 8:24 AM, the CNA fed the resident a bite. The resident coughed, and a gurgling sound from the resident's throat was heard. During an interview on 1/26/05 at 2:45 PM, the registered dietitian (RD) stated the MDS was inaccurate. In addition, the RD stated the nutrition evaluation should have addressed the resident's swallowing problems.	F 278		
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: 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 s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to develop a comprehensive care plan for two (#6, #70) of thirteen sample residents. The findings	F 279	The facility will ensure that each resident will have a comprehensive care plan.	3/15/05
		a.	Residents #6 and #70 will have their care plans updated to reflect current care including therapy recommendations to meet their needs.	

2/28/05

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F 279	Continued From page 6 were: 1. Review of the following examples of documentation in the medical record showed resident #6 had swallowing problems, including a history of aspiration: a. The patient transfer form from the hospital on 10/26/01 documented the resident had a diagnosis of aspiration pneumonia, and was on aspiration precautions. b. A physician's note dated 8/27/03 documented "...patient is at chronic risk for aspiration and probably aspirates frequently as speech therapy has seen with really nothing that can be done except conservative feeding." c. An interim history and physical dated 8/18/04 revealed "...the patient also continues to have significant difficulty with aspiration." d. Physician's notes dated 9/1/04, 9/10/04, 9/14/04, 9/21/04, 9/29/04, 10/5/04, and 10/15/04 documented problems with aspiration. e. A nursing note dated 2/13/04 showed the resident was suctioned, and stated "...does not swallow." f. A nursing note dated 2/14/04 revealed the resident was suctioned. The note documented medications were held because the resident was not swallowing. Observation of the evening meal on 1/24/05 from 6:04 PM until 6:34 PM revealed resident #6 was seated in a geri-chair (wheeled recliner). The resident was not seated upright, but the back of the geri-chair was reclined to approximately 60 degrees (fully upright would be 90 degrees). The resident's neck was extended (approximately 30 degrees of neck extension), with the chin pointed up towards the ceiling. At 6:20 PM and 6:21 PM, the resident was pocketing food in his/her mouth,	F 279	b. Care Plans will be reviewed weekly through the Patient Care Committee and updated as needed to meet the resident's individualized needs. c. Staff education will be provided related to care planning at the February mandatory staff meeting. d. Random care plan review (2 per floor per month) will be assigned by the nurse supervisor and reported monthly as part of the facility QA program.	

JC 2/22/05

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F 279	Continued From page 7	F 279		

so the CNA cued the resident to swallow. The resident's neck was still extended. At 6:26 PM and 6:34 PM, a gurgling sound was heard coming from the back of the resident's throat.

Observation of the breakfast meal on 1/25/05 from 8:05 AM until 8:35 AM revealed the resident was seated in the geri-chair, with the back reclined to about 60 degrees. The resident's neck was extended, with the chin pointed up. At 8:20 AM, 8:21 AM, and 8:22 AM, CNA #9 cued the resident to swallow, because the resident was pocketing food. At 8:24 AM, the CNA fed the resident a bite. The resident coughed, and a gurgling sound from the resident's throat was heard. The CNA cued the resident to cough, but did not re-position the resident's head. When asked if the resident had swallowing problems, the CNA replied "I think so." At 8:27 AM, the CNA adjusted the back of the geri-chair to a more upright position (approximately 80 degrees), and cued the resident to cough. However, the resident's head was still extended.

During an interview on 1/25/05 at 9:02 AM, CNA #9 stated the resident often was "gurgly" during meals, and pocketed food. The CNA stated she was unaware of any specialized positioning instructions for the resident during meals to help with swallowing. On 1/25/05 at 9:46 AM, CNA #4 stated she was unaware of any special positioning instructions during meals for the resident.

Review of the current care plan, dated 11/10/04, revealed the resident's swallowing problem and history of aspiration was not included. The care plan did not address positioning during meals, or strategies for swallowing. On 1/26/05 at 2:45 PM, the registered dietitian (RD) confirmed the care plan did not address the swallowing problem. The RD stated

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F 279	Continued From page 8 sometime ago, she and a nurse discussed that swallowing was not addressed on the care plan. 2. Observation of resident #70 on 1/24/05 from 5:45 PM to 6:30 PM, and on 1/25/05 from 8 AM to 8:30 AM and on 1/25/05 at 10:10 AM revealed the resident was seated in a wheelchair with a lap buddy secured to the wheelchair armrests. A lap buddy is a soft cushion attached to a wheelchair that may prevent a resident from standing. Interview with RN #10 on 1/26/05 at 3:15 PM revealed the lap buddy was used to prevent this particular resident from standing and ambulating independently. Review of the resident's 12/3/04 care plan revealed no plan was in place that identified the reason the lap buddy was used or when the lap buddy should be released.	F 279		
F 309 SS=J	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of in-service documentation, the facility failed to assure one (#6) of one sample dependent resident with a history of aspiration and swallowing problems	F 309	The facility will ensure that residents are provided the necessary care and services to attain or maintain the highest well-being. a. Resident #6 has been assessed by speech therapy and occupational therapy and interventions care planned.	3/15/05

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F 309	Continued From page 9 received feeding assistance in a safe manner. During two of two meals observed, facility staff did not assure the resident was positioned in a safe manner to compensate for swallowing difficulties, which resulted in immediate jeopardy. In addition, the facility failed to accurately assess or care plan the resident's swallowing problem. The findings were: Observation of the evening meal on 1/24/05 from 6:04 PM until 6:34 PM revealed resident #6 was seated in a geri-chair (wheeled recliner). The resident was not seated upright, but the back of the geri-chair was reclined to approximately 60 degrees (fully upright would be 90 degrees). The resident's neck was extended (approximately 30 degrees of neck extension), with the chin pointed up towards the ceiling. The resident received a pureed diet, with pudding thick liquids, and was dependent on staff for feeding. While feeding the resident, certified nurse aide (CNA) #13 made no attempts to re-position the resident, or place the head in a neutral or slight flexed position. At 6:20 PM and 6:21 PM, the resident was pocketing food in his/her mouth, so the CNA cued the resident to swallow. The resident's neck was still extended. At 6:26 PM and 6:34 PM, a gurgling sound was heard coming from the back of the resident's throat. Observation of the breakfast meal on 1/25/05 from 8:05 AM until 8:35 AM revealed CNA #9 fed the resident the meal. The resident was seated in the geri-chair, with the back reclined to about 60 degrees. The resident's neck was extended, with the chin pointed up. At 8:20 AM, 8:21 AM, and 8:22 AM the CNA cued the resident to swallow, because the resident was pocketing food. The CNA made no attempt to place the resident's	F 309	b. The dietician will observe resident eating in dining rooms, one dining room per week and report to nurse supervisor any problems. c. Mandatory staff education and training regarding positioning during meals and dysphagia. Staff will report on temperature problem reports to the nurse supervisor when residents are experiencing swallowing difficulties or aspiration concerns. d. Temperature problem reports will be reviewed during the weekely IDT meeting and Dietician Report will be reviewed weekly during the IDC meeting as part of the facility QA program and reported monthly by the MDS coordinator.	

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F 309	Continued From page 10	F 309		

head in a neutral or slight flexed position. At 8:24 AM, the CNA fed the resident a bite. The resident coughed, and a gurgling sound from the resident's throat was heard. The CNA cued the resident to cough, but did not re-position the resident's head. When asked if the resident had swallowing problems, the CNA replied, "I think so." At 8:27 AM, the CNA adjusted the back of the geri-chair to a more upright position (approximately 80 degrees), and cued the resident to cough. However, the resident's head was still extended. At 8:50 AM, registered nurse (RN) #5 gave the resident his/her medications in the thickened juice, using a spoon. The RN made no attempt to re-position the resident's head in a more neutral position. The RN fed the resident some bites of food, with the resident's neck in extension.

During an interview on 1/25/05 at 9:02 AM, CNA #9 stated the resident often was "gurgly" during meals, and pocketed food. The CNA stated she was unaware of any specialized positioning instructions for the resident during meals to help with swallowing.

On 1/25/05 at 9:32 AM (after the breakfast meal), CNA #4 assisted the resident to bed. A gurgling sound from the back of the resident's throat was heard. The CNA commented that it sounded like the resident was getting a cold. On 1/25/05 at 9:46 AM, CNA #4 stated she was unaware of any special positioning instructions during meals for the resident.

On 1/25/05 at 10:43 AM, at the request of the surveyor, licensed practical nurse (LPN) #8 conducted a respiratory assessment of the resident. The LPN stated the resident had

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F 309	Continued From page 11 diminished lung sounds in the lower lobes bilaterally with some crackles in the mid lobes. Review of the respiratory assessment documented in the nurse's notes on 1/25/05 showed the bases of the lungs with decreased breath sounds and the mid lobes with slight to moderate wheezing, and the right upper lobe with wheezing. Review of the medical record revealed the following documentation of swallowing problems, and/or aspiration: a. The patient transfer form from the hospital on 10/26/01 documented the resident had a diagnosis of aspiration pneumonia, and was on aspiration precautions. b. A physician's note dated 4/10/02 revealed the resident had "...probable aspiration....swallowing evaluation next time able to get one." c. A physician's note dated 9/24/03 indicated the resident had hypoxia, "...seems to be probably secondary to the aspiration..." d. A physician's note dated 8/27/03 documented "...patient is at chronic risk for aspiration and probably aspirates frequently as speech therapy has seen with really nothing that can be done except conservative feeding." e. An interim history and physical dated 8/18/04 revealed "...the patient also continues to have significant difficulty with aspiration." f. Physician's notes dated 9/1/04, 9/10/04, 9/14/04, 9/21/04, 9/29/04, 10/5/04, and 10/15/04 documented problems with aspiration. g. A nursing note dated 2/13/04 showed the resident was suctioned, and stated "...does not swallow." h. A nursing note dated 2/14/04 revealed the resident was suctioned. The note documented	F 309		

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

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FORM APPROVED
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	535030	A. BUILDING ______ B. WING ______	01/27/2005

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F 309	Continued From page 12 medications were held because the resident was not swallowing. i. A nursing note documented on 9/28/04 the resident was coughing up phlegm, and rattling could be heard of the base of the throat. Review of the 10/29/04 annual Minimum Data Set (MDS) assessment showed it inaccurately documented the resident did not have swallowing problems. In addition, review of the 10/26/04 nutrition evaluation showed the resident's ability to swallow was "fair." The evaluation did not document the resident's history of aspiration. The evaluation listed care plan concerns as chewing deficit, lactose intolerance, and compromised protein status. The resident's swallowing problem was not identified as a care plan concern. During an interview on 1/26/05 at 2:45 PM, the registered dietitian (RD) stated the MDS was inaccurate. In addition, the RD stated the nutrition evaluation should have addressed the swallowing problems. Review of the current care plan, dated 11/10/04, revealed the resident's swallowing problem and history of aspiration was not included. The care plan did not address positioning during meals, or strategies for swallowing. On 1/26/05 at 2:45 PM, the RD confirmed the care plan did not address the swallowing problem. The RD stated sometime ago, she and a nurse discussed that a swallowing evaluation was not in the chart, and swallowing was not addressed on the care plan. Review of the medical record revealed no occupational therapy evaluation for positioning during meals, nor a speech therapy evaluation for swallowing. On 1/25/05 at 1:15 PM, the director of nursing (DON) provided occupational therapy evaluations from 8/6/98 and 12/1/99 from the purged file. The DON stated there was not a more recent occupational therapy evaluation	F 309		

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F 309	Continued From page 13 addressing positioning during meals. At that same time, the DON supplied speech therapy screenings for dysphagia dated 5/29/98 and 7/24/98. The 7/24/98 evaluation indicated the body position should be 90 degrees of hip flexion, and 45 degrees of neck flexion. During interviews on 1/25/05 at 10:52 AM and 1/26/05 at 3:45 PM, the DON stated she was unable to find a more recent speech therapy evaluation for swallowing. The DON stated if a speech therapy evaluation had been done, she was unaware of what the recommendations were. Interview on 1/25/05 at 10:35 AM with the staff development coordinator (SDC) revealed there had not been an in-service on positioning during meals or swallowing problems for at least six months. On 1/25/05 at 1:16 PM, the DON provided documentation of the last in-service conducted by the speech therapist on dysphagia, which was on 1/3/03. Interview with the DON on 1/25/05 at 9:20 AM revealed residents with swallowing difficulties should be positioned as upright as possible, with the head positioned at least at neutral. On 1/26/05 at 3:45 PM, the DON stated the facility did not have policies and procedures on positioning during meals or swallowing precautions. According to the 2004 Nursing Assistant, A Nursing Process Approach by Hegner, Acello and Caldwell (9th edition, p 416), the patient should be positioned as upright as possible. The head should face forward, with the neck flexed forward slightly. Special feeding techniques and positioning improve swallowing and prevent aspiration. The care plan should provide information related to positioning and feeding techniques such as tucking the chin to aid in swallowing. In addition, according to Nursing Interventions and Clinical Skills by Elkin, Perry,	F 309		

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F 309	Continued From page 14 and Potter (2004, p. 192-193), the client should be positioned upright in bed or chair with head slightly flexed forward; this position reduces the risk of aspiration. Maintaining an upright position to enhance the effects of gravity is important. On 1/25/05 at 11:20 AM, the DON was notified of the immediate jeopardy (the administrator was unavailable at that time). On 1/25/05 at 1:43 PM, the administrator was notified of the immediate jeopardy. On 1/27/05 at 10:45 AM, the immediate jeopardy was removed on-site by the following actions by the facility: an assessment by a respiratory therapist was conducted, a chest x-ray was done (results: no acute cardiopulmonary abnormalities), an occupational therapy evaluation for positioning during meals was completed, the care plan was updated, a speech therapy evaluation was ordered, and staff were instructed on the updated care plan during report for each shift. In addition, observation during two subsequent meals revealed the resident was positioned appropriately.	F 309		
F 332 SS=D	483.25(m)(1) QUALITY OF CARE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and medical record review, the facility failed to assure a medication error rate of less than five percent was accomplished during observations of the medication pass. Four nonsignificant errors occurred during observation of 50 medications which resulted in an 8% error	F 332	The facility will ensure that the medication error rate is 5% or less. a. Residents #18 and #24 have received the correct medications as ordered.	3/15/05

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F 332	Continued From page 15 rate. The findings were: 1. On 1/25/05 at 6 AM observation of licensed practical nurse (LPN) #8 revealed she prepared and administered medications for resident #18 that included vitamin C 500 milligrams (mg) one tablet, and ibuprofen 200 mg. As the LPN prepared the resident's medication, the resident stated to the LPN that the night nurse did not give a scheduled 6 AM dose of ibuprofen. Interview with the resident during the observation revealed he/she always received ibuprofen for pain at 6 AM, but the night nurse did not administer the medication. Interview with the LPN during the observation confirmed the night nurse failed to administer the scheduled dose of ibuprofen at 6 AM. Review of the medication administration record with the LPN revealed the scheduled 6 AM dose of ibuprofen was not signed as administered; therefore, the dose was administered two hours late to the resident. Review of the January 2005 physician's orders confirmed the resident should have been administered ibuprofen 200 mg at 6 AM daily. The physician's orders also revealed the resident should receive vitamin C 500 mg, two tablets daily; however, the LPN administered one tablet instead of two. 2. Observation of LPN #9 on 1/26/05 at 7:50 AM revealed the she prepared and administered medications for resident #24 that included Tylenol 325 mg two tablets. During the observation the LPN stated she was notified in morning report that the resident was complaining of discomfort so she planned on administering Tylenol with the morning medications. Review of the January 2005 physician's orders revealed Tylenol 500 mg was ordered as needed for pain, not Tylenol 325	F 332	b. LPN's #8 and #9 have been remediated. c. Mandatory Nurse Inservice by the Contract Pharmacist will be held to educate nurses on proper medication dispensing. d. Performance will be monitored by the Pharmacist monthly as part of the Facility Quality Assurance Program.	

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F 332	Continued From page 16 mg two tablets. In addition, the physicians's orders revealed the resident was also prescribed a vitamin B tablet daily. Observation of the medication pass revealed the LPN did not administer a vitamin B tablet to the resident. Interview with the LPN on 1/26/05 at 8:43 AM revealed she gave Tylenol 325 mg two tablets, but should have administered Tylenol 500 mg instead.	F 332		
F 425 SS=D	483.60 PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in s483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and resident interview, the facility failed to assure physician prescribed medications were available for administration for one (#33) of one non-sample resident who utilized an inhaler. The findings were: Review of the 7/1/04 annual Minimum Data Set (MDS) assessment for resident #33 revealed the resident had diagnoses including chronic obstructive pulmonary disease (respiratory disorder), and was cognitively intact. Review of the January, 2005, physician's orders revealed the resident was prescribed Combivent (respiratory inhaler) two puffs four times a day. Interview with the resident on 1/25/04 at 10:50	F 425	The facility will ensure physician prescribed medications are available for administration. a. Resident #33 has the appropriate medication. b. The LPN has been remediated on how to secure medications from an alternate source. c. A mandatory Inservice meeting will be held for all nursing staff concerning medication from an alternate source.	3/15/05

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F 425	Continued From page 17 AM revealed the Combivent was not administered since 1/23/05 because the inhaler was empty. On 1/25/05 at 11 AM interview with licensed practical nurse (LPN) #8 revealed the resident was not administered Combivent since 1/23/05 (two days) because the resident was out of the medication The LPN also stated the medication was not reordered until 1/24/05. During the interview, a review of the the medication re-order log with the LPN confirmed the medication was not re-ordered until 1/24/05. The interview with the LPN revealed no attempt was made to secure the medication from an alternate source. According to the 2001 Medication Guide for the Long-Term Care Nurse, all medications ordered for administration to the resident should be available on the medicine cart, and each medication should be reordered before it runs out.	F 425 d:	Performance will be monitored monthly by the nurse supervisor as part of the facility Quality Assurance Program.	
F 431 SS=D	483.60(d) PHARMACY SERVICES Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility's policy for Labeling of Medications, the facility failed to assure medications stored in one of two medication refrigerators were labeled. The findings were:	F 431	The facility will ensure all drugs used in the facilty are appropriately labeled.	3/15/05
		a.	The medication not labeled properly has been returned to Pharmacy.	

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F 431	Continued From page 18 Observation of the second floor medication refrigerator on 1/24/05 at 5:45 PM revealed the refrigerator contained six unlabeled syringes. The unlabeled syringes were inside a plastic bag that was labeled Ativan (anti-anxiety) 0.5 milligrams /0.25 milliliters. Interview with licensed practical nurse (LPN) #8 on 1/24/05 at 6:10 PM revealed the unlabeled syringes were supplied to the facility by the hospital pharmacist; however, the LPN stated she was unsure what the unlabeled syringes contained even though the plastic bag was labeled. Interview with the pharmacy technician on 1/26/05 at 2:35 PM revealed the unlabeled syringes in the plastic bag should also be labeled with the type of medication contained in the syringe. The pharmacy technician stated if the syringes were to be separated from the plastic bag, nursing staff would not know what the syringes contained. Interview with the director of nursing (DON) on 1/26/05 at 5:15 PM revealed the medication was drawn up by the pharmacist from a multidose vial. The DON stated the syringes should at a minimum have a label that identifies the type of medication as well as an expiration date. According to the facility's policy number 6.5.2.22 "Labeling of Medications," repacked medication for inpatients shall be labeled with the resident's name, room number, name of the medication, medication strength, expiration date, lot number, manufacturer, and pharmacist's initials. In addition, the American Society of Hospital Pharmacists (ASPH): Minimum Standard for Pharmacies recommends whenever possible, medications shall be available for use in single-unit packages and in a ready-to-administer form; and manipulations of medications before administration such as withdrawal of doses from	F 431	b. Nursing staff will be instructed to check medications for proper labeling. c. Pharmacy will be instructed that all medications will be labeled appropiately at all times. d. Performance will be monitored monthly by the Nursing Supervisor and reported as part of the facility Quality Assurance Program.	

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F 431	Continued From page 19 multidose containers and re-labeling of containers should be minimized. The ASPH standards also recommend the routine inspection of medication storage areas to ensure the absence of outdated, unusable, or mislabeled products.	F 431		