STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

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F 161 SS=D	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 record review and staff interview, it was determined that the facility did not have an adequate amount of coverage in it's surety bond to cover the amount actually in the personal funds accounts. A surety bond is required as a protection of monies deposited in the personal needs account of residents who choose to have the facility hold their money. The findings included: On 10/19/05, the Administrator provided the surveyor with a copy of the facility's surety bond. The amount of the current bond provided $10,000 insurance. A review of the bank statements for the two personal needs accounts revealed that the ending balances on 9/30/05 totaled $11,792.97. The Director of Medical Records verified that their funds were all personal needs funds. The bond was inadequate to cover the residents' funds which were held by the facility.	F 161	Preparation and execution of the response and plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State's Operation Manual F161 It is the practice of this facility to have the appropriate amount of coverage to insure the amounts that are deposited with this facility. 1) The facility surety bond was increased to $15,000.00 (fifteen Thousand) on or about 11/15/2005 2) The administrator and the Business office Manager will assure that there is an adequate amount of coverage on its surety bond to cover the amount actually in the personal funds account. 3) The Business Office Coordinator has been instructed to inform the Administrator when there is a need to increase the surety bond and when there is a large amount in any one account. 4) The Administrator will monitor for compliance. Any concerns with corrective action will be discussed at least quarterly at the facility QA committee meeting **COMPLETION DATE: 11/15/2005**	
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daniel Rodgers MHA	Adm	12/6/05

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 164	Continued From page 1 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This Requirement is not met as evidenced by: Based on observation, resident interview and record review, the facility failed to ensure that one of ten sample residents (#5) was provided privacy and that confidential resident information was not	F 164	**F 164** It is the practice of this facility to employ qualified personnel that have the resident care, dignity, and treatment as a priority under the laws of the State and the Resident Right's act. 1) The CNA involved in the care for resident #5 is no longer employed by the facility. An all staff meeting was held on 10/21/2005 and all the issues were reviewed and the HIPPA compliance officer provided staff members with a copy of the "summary of Privacy Policies for Staff" and instructed staff on the meaning and requirements of personal privacy including that the staff must pull	

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F 164	Continued From page 2 discussed within hearing distance of other residents. The findings included: 1. Record review of sample resident #5's medical record revealed the resident had been admitted to the facility on 3/2/01 with diagnoses that included cardiovascular accident (stroke), renal failure, reactive psychosis and dementia. The resident's current quarterly Minimum Data Set (MDS) assessment dated 10/9/05 indicated the resident had long/short term memory loss and severely impaired decision making skills. The MDS also indicated the resident needed extensive to total assistance with bed mobility, transfers, dressing and toileting. a. Observation of the resident on 10/18/05 at 1:30 PM revealed CNA #1 was providing incontinence to the resident after lunch and laying the resident down for a nap. The CNA removed the resident's incontinent brief and his/her sweatpants and transferred the resident to the bed. Although the CNA placed a cover over the resident, he did not pull the privacy curtains around the resident or shut the door of the room after completing the personal care. b. On 10/18/05 at 4:25 PM an observation of the resident revealed that the resident had kicked the covers off and was laying on the bed with his/her lower extremities (including the perineum) exposed and observable from the hallway. Although staff members were observed to pass by the room in the hallway, no one entered the room to cover the resident, pull the privacy curtain or close the door. c. Another observation on 10/19/05 at 2:40 PM revealed sample resident #5 lying on his/her bed. The resident had no incontinent briefs or pants on	F 164	privacy curtains, close doors, assure residents are removed from public view and provide clothing or draping to prevent exposure of body parts during personal care and services including Resident #5. The plan of care for resident #5 has been changed to indicate the need to pull the privacy curtain when the resident is in bed. On 10/21/2005, the Director of Nurses and the HIPPA compliance officer informed CNA's and Nurses that talking outside of the resident's room regarding their care or any other issues is against resident rights and it poses a dignity issue. Staff was also informed that if they need to talk about issues that they need to find an area that is away from the residents 2) The IDT identified residents who have a tendency to expose themselves to assure care plan reflects current plan of care. All employees are orientated on the privacy practices and confidentiality during orientation and reviewed at least annually 3) On 10/21/2005 the staff was in serviced on the resident rights with emphasis on providing privacy during cares and the HIPPA privacy practice related to not discussing residents protected health information in the halls or public area. The HIM will present the "Privacy Policies for Staff Summary" education on an annual basis. The information discussed at the in services will be included as part of the orientation for new staff. For pool/agency, the information will be placed in the binder as part of their orientation to the facility.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 3 and was exposed from the waist down. The privacy curtain was not pulled around the bed and the door of the resident's room was open. 2. In an interview with a group of residents on 10/19/05 at 9.00 AM they indicated that they had heard staff members talking about confidential resident information in the hallways, especially at night.	F 164	4) The HIM or designee will ask the residents during the monthly resident council if they have heard staff discussing confidential resident information in front of other residents or visitors. The SSD will monitor for compliance by making random rounds in the hall to ensure that privacy is upheld. This will be monitored for compliance weekly for a month, and monthly thereafter. Results of the audits corrective action taken will be discussed with the Quality Assurance and Assessment committee at least quarterly. **COMPLETION DATE: 10/21/2005**	
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 record review and staff interview, it was determined that the facility failed to develop and implement all required abuse policies and procedures. The facility failed to ensure that: abuse policies and procedures were included in the orientation of staff. The findings included: FAILURE TO DEVELOP ADEQUATE ABUSE/NEGLECT POLICIES: 1. Copies of the facility abuse protocol were requested during the entrance conference on 10/18/05. Several policies were given to the survey team, titled as follows: o Abuse or Neglect (#303) o Abuse Prevention (#401) o Identification of Residents at Risk for Abuse	F 226		

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F 226	Continued From page 4 (#401-1) o Avoiding situations of Abuse (#401-2) o Investigation of Possible Verbal or Mental Abuse (#401-3) a. An interview on 10/19/05 at 2:00 PM with the social service director who provided orientation/training to staff regarding abuse and neglect revealed that she was using an old abuse policy for her orientation classes. Review of the materials she used showed no evidence that the above policies (#303, #401, #401-1, #401-2 and #401-3) were included in the orientation/training of staff. b. In an interview with the administrator on 10/19/05 at 2:30 PM, he was asked which set of policies were the current policies and he again confirmed that the above policies (#303, #401, #401-1, #401-2 and #401-3) were the current policies. None of these policies showed when the policies had been adopted by the facility or an effective date. c. After the exit conference on 10/20/05 the medical records manager faxed three policies/forms and indicated these were the policies used in the orientation on abuse. These polices/forms were the ones presented to the surveyor by the social service director. These polices/forms did not show when these policies had been adopted by the facility or an effective date. d. Review of the policies which the administrator had indicated were the current abuse policies revealed the following: 1. The current abuse policies failed to indicate that an employee would be precluded from	F 226		

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

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F 226	Continued From page 5 employment for having a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. ii. The current abuse polices did not indicated that employee screening would include verification with all appropriate licensing boards and registries including those out-of-state boards and registries. iii. The current abuse policies did not indicate that staff members who have reported suspected violations are protected from reprisal. iv. The current abuse polices did not indicate that positive investigation findings would be reported to all appropriate licensing boards and registries. v. The policies (#401-3) indicated reportable occurrences relating to abuse/neglect for the state of Colorado. The policy did not show reportable occurrences relating to abuse/neglect for the state of Wyoming where the facility is located. vi. The Director of Nursing indicated that although they evaluate a resident's needs before the resident was admitted to the facility, there was no form/process to assess the risk for resident-to-resident abuse and potential aggressive behaviors that could place other residents at risk. FAILURE TO IMPLEMENT ABUSE/NEGLECT POLICIES 2. Review of personnel files revealed the facility failed to implement their current policies	F 226		

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

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F 226	Continued From page 6 regarding abuse and neglect. The facility failed to ensure that all individuals (including pool agency staff) who provided personal care to the residents did not have a history of abuse/neglect before providing care to the residents. a. The current abuse policy (#401) indicated that all potential employees will be screened to avoid hiring those with a history of abuse or potential abuse. Policy (#401) titled "Abuse Prevention", indicated that background checks/licenses/certifications will be completed on all new hires at time of employment. b. Review of the contract between the facility and the staffing (pool) agency revealed when pool staff was assigned to the facility, the staffing agency was to fax copies of resume, skills checklist, individual contract, immunization record (for Hepatitis B, MMR(Measles, Mumps and Rubella)titer, TB Skin Test), and licensure/certification to the facility at the time of assignment. The contract did not specify how the staffing agency/facility would ensure that individuals from the staffing agency had no findings of abuse with the Wyoming Board of Nursing or Nurse Aide (NA) registry. The contract did have a stipulation that the agency and its employees agreed to comply with all of the facility's policies and procedures. c. Review of staffing schedules from 6/1/05 to 10/20/05 showed 21 pool/staff agency employees were used to cover both nursing and CNA shifts. d. In an interview with the facility administrator on 10/19/05 at 2:30 PM he indicated that the staffing agency was responsible for ensuring their staff had current licenses and CBI (Criminal Background Investigation) checks. He indicated	F 226		

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F 226	Continued From page 7 that when pool staff nurses/certified nurse aides (CNAs) are first assigned that the staffing agency was to send the results of the CBI check, copy of the individual's license and evidence of tuberculosis (TB) testing. This information was requested on CNA #1, #2 and #3 who were employed by the staffing agency. i. According to facility staffing schedules CNA #1 was first assigned to the facility on 7/14/05. No employee information was present in the facility until requested by the survey team on 10/19/05. The Administrator indicated he had contacted the staffing agency for the contractual information. The CBI check had been completed on 10/9/05 and faxed to the facility on 10/20/05. CNA #1's immunization record showed no evidence that a TB test had been conducted. Evidence of the CNA's Wyoming nurse aide certificate was not available in the facility until requested by the survey team. ii. According to facility staffing schedules CNA #2 was first assigned to the facility on 9/25/05. No employee information was present in the facility until requested by the survey team on 10/19/05. The Administrator indicated he had contacted the staffing agency for the contractual information. The CBI check had been completed on 10/6/05 and faxed to the facility on 10/20/05. CNA #2's immunization record showed no evidence that a TB test had been conducted. Evidence of the CNA's Wyoming nurse aide certificate was not available in the facility until requested by the survey team. Although the CNA had a Wyoming CNA certification there was no evidence that the facility or the staffing agency had called the Wyoming Board of Nursing to verify licensure status of this individual for possible findings of abuse with the Wyoming State Board of Nursing	F 226	**F 226** It is the practice of this facility to employ qualified personnel that have the resident care, dignity, and treatment as a priority and to allow the resident a homelike environment that is free of Abuse and Neglect under the laws of the State and the Resident Right's act. 1) According to the Policy and procedure of the facility, the papers regarding Abuse and Neglect that was faxed to the Federal Surveyors has been corrected and the new policies given to the new employees. The facility Policy and Procedures have been corrected to reflect:	

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

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F 226	Continued From page 8 or NA registry. iii. According to facility staffing schedules CNA #3 was first assigned to the facility on 9/28/05. No employee information was present in the facility until requested by the survey team on 10/19/05. The Administrator indicated he had contacted the staffing agency for the contractual information. The CBI check had been completed on 10/19/05 and faxed to the facility on 10/20/05. Evidence of the CNA's Wyoming nurse aide certificate was not available in the facility until requested by the survey team. Although the CNA had a Wyoming CNA certification there was no evidence that the facility or the staffing agency had called the Wyoming Board of Nursing to verify licensure status of this individual for possible findings of abuse with the Wyoming Board of Nursing or registry. 3. The current abuse policy (#401) indicated that staff would receive in-service training on abuse and neglect upon hire and annually. The facility failed to ensure that all individuals (including pool agency staff) who provided personal care to the residents, received initial training and orientation of abuse/neglect policies and procedures and a general orientation to the facility and the residents. a. Review of information on three staffing agency CNAs (#1, #2, and #3) revealed no documentation that they were oriented to the facility or to the facility's current abuse/neglect policies. b. In an interview with CNA #3 on 10/19/05 at 7:15 AM, she indicated she had received a limited orientation to the facility. She indicated she had not received an orientation regarding	F 226	-not hiring those who have had backgrounds of abuse etc. (including nursing board) -screenings include verification of active, license with licensing boards and registries including out of state. Staff will be in-serviced and sign the acknowledgement of avoiding abuse. A form has been devised for the Social Service Director to assess the resident at risk for resident-to-resident abuse. This will also track aggressive behaviors prior to admission. 2) The files of all current agency staff and facility staff have been reviewed to assure they have received training on the facility's abuse and neglect Policy and Procedure. All Agency staff will meet the facility's P/P requirements prior to accepting a shift. When any Agency staff is brought in, all required all information will be made available to this facility and it will be kept on record prior to Agency personnel accepting a shift on the floor. 3) On 10/21/05, the Director of Nurses, the HIM, Social Service Director, and the Administrator reviewed the Abuse policy and procedure and presented to the QA team at the next meeting for final approval. All staff and agency pool staff were re-in serviced on the abuse and neglect Policy and Procedure manual. The Administration will review the pre-admission assessment prior to admission and make a decision if the facility can	

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F 226	Continued From page 9 abuse/neglect or a copy of the facility's current abuse policy. c. In an interview with CNA #1 on 10/18/05 at 2:00 PM, he indicated he had received a limited orientation to the facility. He indicated he had not received an orientation regarding abuse/neglect or a copy of the facility's current abuse policy. When the surveyor interviewed CNA #1 regarding the care needed by resident #5 on 10/18/05 at 1:30 PM, he indicated he was not sure what care was needed. (See F164 for specifics regarding observations of exposure of resident #5).	F 226	meet the needs of the resident who exhibits aggressive behaviors. 4) The Administrator or designee will monitor compliance on a monthly basis and as needed thereafter. Results of the audits with corrective action taken will be discussed with the Quality Assurance and Assessment committee at least quarterly. **COMPLETION DATE: 12/07/2005**	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to serve and assist residents with meals in a manner that recognized and enhanced their dignity. This failure involved 1 sample resident (#6) and three supplemental residents (#11, #15, and #16). The findings included: 1. Observations of the evening meal service on 10/18/05 from 6:00 PM to 6:55 PM revealed a Certified Nurse Aide (CNA) was feeding residents while standing at their side. The CNA was assisting 3 residents (#11, #15, and #16) seated at a square table. The CNA went from resident to resident, giving the residents' bites of food without	F 241	**F 241** It is the practice of the facility to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. 1) On 10/21/2005, the Director of Nursing addressed in an all staff meeting that all residents are to be treated at all times with respect and dignity. The staff was informed that standing up and feeding was unacceptable and that the Aides need to sit down while feeding at all times. The staff was also informed that talking in this area needed to be directed to the resident and that the resident needed to be the main focus of the nursing Staff. Residents' #6, #11, and # 15 will be assisted in the dining room as indicated. Resident #16 is independent in ADL's and would have been feeding him/herself and would not have been receiving assistance.	

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F 241	Continued From page 10 cueing, without telling the resident what food they were being fed or without talking to each resident while they were being fed. The CNA was heard talking to another staff at the next table while continuing to feed these 3 residents. Resident #6 was also seated at this table but was able to eat by him/herself and was not cued by staff when the resident pushed himself/herself away from the table. This resident had been identified by staff as having a significant weight loss and needing encouragement to eat. The CNA did not offer seconds to this resident and continued to visit with coworkers. Interview with the dietary manager on 10/18/05 at 6:40 PM identified the four residents at this table as needing to be cued and assisted with meals. The facility failed to provide an environment to enhance each resident's dignity and respect during the meal service.	F 241	2) Also on 10/21/2005, the Nursing staff was informed that during dining times the staff should inform the residents of the food that they are feeding and what the resident is about to consume. 3) On 10/21/2005, the Director of Nurses in serviced the nurses on the appropriate way to assist the resident during meal times The information discussed at the in services will be included as part of the orientation for new staff. For pool/agency, the information will be placed in the binder as part of their orientation to the facility. 4) The Director of Nurses or designee will monitor compliance weekly for a month and monthly thereafter. Any trends will have corrective action taken and will be reported to the Quality Assurance and Assessment committee at least quarterly.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to maintain the facility in a sanitary and orderly manner. The findings included: 1. On 10/19/05, starting at 9:23 AM, the following observations were made: a) In room 29, the heater unit cover located along the wall under the window was partially off	F 253	**COMPLETION DATE: 11/11/2005** **F 253** It is the practice of the facility to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. 1) On or before 10/21/2005, the Director of Maintenance and the Housekeeping Supervisor developed a cleaning and repair schedule for all of the items listed as deficiencies. The list is as follows:	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 253	Continued From page 11 the hooks. b) In room 16, the heater unit cover located along the wall under the window was partially off the hooks. The bathroom had a strong urine odor smell. The tile floor in the resident's room had dirt and stains on it. c. During the initial environmental tour on 10/18/05 from 8:10 AM to 9:45 AM, the heater unit in the bathroom in room 2 was partially loose and hanging off the wall. d. Observation on 10/19/05 from 3:10 PM to 4:40 PM during the tour of the environment with maintenance staff and the Administrator, the heater covers were discussed. The maintenance staff reported that the covers of the wall heaters were frequently bumped and dislodged from their hooks. He reported staff was to replace covers on the hooks or tell maintenance if repair was needed. He also reported they had been looking for a replacement cover for the type of units they have but had not found a replacement thus far. 2. The bedside dresser in room 11 had a missing strip of veneer off the front of the dresser, creating a rough and uncleanable surface. 3. During observations on the initial tour of the facility on 10/18/05 at 8:30 AM with Nursing Staff, urine odors were present in the hallway by room 34. These odors persisted through the survey. Observation on 10/19/05 from 3:10 PM to 4:40 PM during the tour of the environment with maintenance staff and the Administrator revealed urine odors were present in the hallway by room 34 and in room 34.	F 253	a) Contacting carpet places for bids on the dining room floor b) Installed new key locks in the med cabinets c) Find, repair, and reeducate staff on placement of the heater covers. Staff educated on 11/22/05 d) Add the cleaning of the fans to the housekeeping duties on a weekly basis. Fans in rooms 36 and 34 were cleaned on 10/19/05 e) Replace the worn chair in room 34 and add a more intense cleaning schedule for the room. Room 16 was deep cleaned f) Replace all the dumpsters and lids. Completed on 10/19/05 g) Blinds will be replaced in the dining room by 11/30/05 h) Hand rail will be installed in the dining room by 11/30/05 Room 16 had been cleaned and a schedule is being formulated to remove the linoleum in the bathroom and replace it with tile and the bedside dresser in Room 11 has been replaced. NHA will review needs for repair of furniture in the residents' rooms on rounds. Corrective action will be taken as needed. 2) The Housekeeping and Maintenance director completed an inspection of the facility to identify any additional cleaning or Maintenance needed and corrective action taken as indicated. A notebook is kept at the nursing station for the maintenance person to check any repair	

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F 253	Continued From page 12 In an interview with the Housekeeping Supervisor on 10/20/05 at 8:30 AM she reported that urine odors had been an ongoing problem in room 34. Resident #18 who resided in room 34 had a personal chair which needed to be replaced. This replacement need had been reported back in January 2005 however the chair had not been replaced. In an interview with the corporate nurse consultant on 10/20/05 at 8:45 AM, the urine odors in room 34 were reported. The nurse consultant then proceeded to room 34 to check Resident #18's chair. Resident #18's recliner was positioned next to door to the room. The chair was a blue cloth recliner which had a stained seat and had a strong urine odor. The back rest of the chair was also misshapen, leaving gaps and unpadded areas where the resident would sit. The nurse consultant confirmed that urine odor was present and indicated she would talk to social services about getting this resident's chair replaced. 4. Observation noted fans in the facility which were in need of cleaning. a. There was a large fan sitting on the desk at the nurses station. The fan was turned on blowing over the nurses station as well as a hallway leading to the dining room. The fan had a build up of dust and debris and was in need of a thorough cleaning. b. Room 34 where two residents resided had a fan sitting on the resident's small dresser. The fan had a build up of dust and debris on the covering as well as the fan blades. c. Room 36 where one resident resided had a	F 253	needs found by all staff or housekeeping. He will initial and date when completed. For additional cleaning needs the housekeeping staff is notified of the room or area needing cleaning. The NHA will make daily rounds to check for cleaning and repair needs. The NHA will monitor the maintenance work orders at least weekly to assure repairs are completed timely. On weekends the manager-on-duty will make rounds to do follow-up on cleaning needs that need immediate attention. Charge nurses will do follow up as well. For times when housekeeping is not available, nursing staff has access to mops and other cleaning materials 3) By 11/04/2005, the Director of Maintenance and the Housekeeping Supervisor implemented this cleaning and repair schedule for all of the items listed as deficiencies. The Housekeeping staff was in serviced on the cleaning schedule and duties on 11/15/05. The information discussed at the in services will be included as part of the orientation for new staff. For pool/agency, the information will be placed in the binder as part of their orientation to the facility. 4) The Director of Maintenance and the Housekeeping Supervisor or designee will monitor compliance weekly for a month and monthly thereafter. Any trends with corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **COMPLETION DATE: 11/30/2005**	

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

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	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 253	Continued From page 13 fan sitting on the dresser. The fan was on and blowing in the direction of the resident. The fan had a build up of dust and debris on the covering as well as the blades and was in need of a thorough cleaning.	F 253		
F 272 SS=E	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 resident assessment protocols; and Documentation of participation in assessment.	F 272		

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

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F 272	Continued From page 14	F 272		

This Requirement is not met as evidenced by:
Based on record review, observation and staff interview, it was determined that the facility failed to accurately complete the Resident Assessment Instrument (RAI) as specified and required for four of ten sample residents (#3, #1, #4, and #5) and to assess the sleep patterns for the continued use of sedative/hypnotic medications for one of ten sample residents (#4) and one supplemental resident (#17) . The facility failed to document the intake of all nutritional supplements and snacks which were assessed and care planned for the residents and to consistently document the intake of the bedtime snack for all residents. The findings included:

RAP SUMMARY/USE OF RAI

1. Record review of sample resident #3's 1/13/05 RAP Summary form revealed that the location and dates of the specific assessment information used for the assessment of falls and nutritional status was not completed.

2. Record review of sample resident #1's 8/18/05 RAP Summary form evidenced a lack of dates for the specific assessment information used for the assessment of nutritional status and dehydration.

3. Record review of sample resident #5 s medical record revealed the resident had been admitted to the facility on 3/2/01 with diagnoses that included cardiovascular accident (stroke), renal failure reactive psychosis and dementia.

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

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F 272	Continued From page 15 The resident's current quarterly Minimum Data Set (MDS) assessment dated 10/9/05 indicated the resident had long/short term memory loss and severely impaired decision making skills. The MDS also indicated the resident needed extensive to total assistance with bed mobility, transfers, dressing and toileting. a) The Resident Assessment Summary (RAS) dated 10/9/05 indicated the resident had a change in mood but there was no description of what that change was. The 10/9/05 MDS indicated no indicators of depression of mood change (section E1). b) The resident's annual MDS dated 7/18/05 included the Resident Assessment Protocol (RAP) Summary. Review of the RAP summary revealed no dates of the specific assessment information for cognitive loss, nutritional status and psychotropic drug use. 4. Record review of sample resident #4's medical record revealed the resident had been readmitted to the facility on 12/11/03 with diagnoses that included spinal stenosis, duodenal ulcer, anemia, depression, hypertension, and affective psychosis. The resident's annual MDS dated 7/28/05 included the Resident Assessment Protocol (RAP) Summary. Review of the RAP summary revealed no dates of the specific assessment information for cognitive loss, mood and behavior, nutritional status and psychotropic drug use. DOCUMENTATION OF SUPPLEMENTS AND SNACKS 1. On 10/18/05 at 10:00 AM, in an interview with	F 272	F272 It is the practice of the facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 1) The interdisciplinary clinical team completed a comprehensive assessment for resident #1, #3, #4, and #5. The RAP summary has been completed for resident #1, #3, #4, and #5 to reflect the location and dates of the specific information. The location and dates used for the assessment of falls and nutritional status was completed for resident #3. The location and dates for the assessment of nutritional status and dehydration were completed for resident #1. The mood change for resident #5 has been re-evaluated. The location and dates for the assessment for cognitive loss, nutritional status, and psychotropic drug use were completed for resident #5. The location and dates for the assessment for cognitive loss, mood and behavior, nutritional status and psychotropic drug use were completed for resident #4.	

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F 272	Continued From page 16 the Certified Dietary Manager (CDM), she was requested to provide the surveyor with a list of residents who receive supplements and/or snacks. She stated that she could provide a list of the residents who were on supplements, but the actual items would be difficult to list as they are changed constantly. Nineteen of thirty-seven residents were listed on the CDM's list of residents on supplements/snacks (dated 10/18/05). Six of the nineteen residents were sample residents (#1, #3, #4, #5, #6, and #7) who lacked evidence that the intake of these snacks/supplements were being monitored and documented. The failure to document the intakes impacted the ability of the facility to determine the appropriateness or effectiveness of these nutritional interventions. 2. On 10/19/05, the October/2005 "HS (bedtime) Snack" charting forms (Section I, II, and III) were reviewed. For the dates when "A" or "X" (for accepted) were charted for the residents, no percentage of actual intake was noted. The following were dates when no HS snacks were documented: Section I: 10/4/05, 10/5/05, 10/6/05, 10/10/05, 10/12/05, and 10/18/05. On 10/14/05, two residents were charted to have received HS snacks; no refusals were charted on this date. Section II: 10/3/05, 10/4/05, 10/5/05, 10/6/05, 10/7/05, 10/8/05, 10/10/05, 10/11/05, 10/12/05, 10/14/05, 10/15/05, 10/16/05, 10/17/05, and 10/18/05. Section III: 10/3/05, 10/11/05, and 10/18/05. On 10/1/05, only one resident was noted to receive an HS snack and on 10/15/05, two residents were noted to receive HS snacks; no refusals were	F 272	On 11/22/05, the nursing staff has been instructed to document the supplement/snack intake for every resident requiring a specific supplement or snack to include resident #1, #3, #4, #5, #6, and #7. The dietary manager will reference the residents' average intake of supplements &/or snacks in the nutritional progress notes. On 11/22/05, the evening nursing staff was instructed to document the percentage of bedtime snack the residents consumed on the designated record. The staff has been instructed to document if the resident declines the HS snack. On 11/08/05, the registered dietician assessed the nutritional needs and food preferences for resident #8. Resident #8's nutritional risks/needs care plan has been reviewed/revised as indicated by the interdisciplinary clinical team to include the registered dietician. The peanut butter and jelly sandwich has been the finger food preference for resident #8 for a period of time. The staff routinely offers other alternates, but the resident has consistently refused. Finger foods will be offered to the resident before offering the peanut butter and jelly sandwich. The dietary manager will document the resident's preference of alternates and periodically review this with the resident.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 17 charted on these dates. 3. Review of the "ADL (Activities of Daily Living) Flow Record" form revealed no place for meal intake charting. 4. Review of the "Meal Intake Record" form evidenced that there were spaces to chart AM (morning), PM (afternoon), and HS snacks. There were no separate spaces for the charting the intake of supplements which were given with the meals. 5. On 10/20/05 at 7:43 AM, in an interview with the Director of Nursing (DON), she verified that nursing staff charted supplements given with the meals as part of the overall meal intake. She confirmed that she was aware that the HS snack documentation was inconsistently done. The failure to chart supplement and snack intake percentages limits the evaluation of the effectiveness of nutritional interventions for nutritionally at risk residents. 6. Record review for sample resident #8 revealed diagnoses that included dysphasia, gastric reflux, and, osteoarthritis. Observations of the evening meal on 10/18/05 and the noon meal on 10/19/05 revealed that the resident refused to eat the items on the menu. The resident was provided with a peanut butter sandwich at each of these meals. The resident was observed to consume the sandwich at each meal. No other substitutes were offered or provided to this resident at either meal. Review of the October, 2005 "Meal Intake Record" evidenced that staff charted that the	F 272	Resident #8 has been added to the supplement and snack list. The dietary manager has reviewed/revised the diet card as indicated for resident #8. A dentist on 10/21/05 examined Resident #8. A licensed nurse on 11/08/05 completed a comprehensive sleep assessment for resident #4. The reasons for the resident's insomnia were communicated to the resident's attending physician. The Restoril will be audited and the nursing staff will try alternatives prior to offering this medication and will be care planned and documentations. The clinical interdisciplinary team on 11/22/05 completed an assessment. Specific non-drug interventions to implement prior to administering a hypnotic are documented on the medication administration record. The resident's care plans and behavior monitoring record were reviewed/revised as indicated to reflect the resident's current plan of care. A licensed nurse completed a comprehensive sleep assessment on 11/18/05 for resident #17. The reasons for the resident's insomnia have been communicated with resident #17's attending physician. Insomnia was related to the introduction of caffeine and tobacco during the late PM hours. The resident's insomnia needs care plan and behavior-monitoring record were reviewed and revised as indicated to reflect the current plan of care for resident #17.	

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F 272	Continued From page 18 resident ate 25 % of the evening meal and 100 % of the noon meal. Review of the resident's tray card revealed that the resident was to receive "regular - finger foods if not eating main entree." Additionally, the notations on the breakfast, lunch, and dinner sections of the tray card noted "Pb/jelly sand. (peanut butter and jelly sandwich) if not eating.' Review of the resident's 10/11/05 RD's Interdisciplinary Progress Notes (IPN) revealed that "Current wt is 155.7 #. 4.9 % wt decrease past 6 mo. however 1% wt increase past mo. .. Reg (regular) diet, finger food offered if poor po (oral) intake." Review of the resident's 10/12/05 Nutritional Assessment noted "moderate risk - @ risk weight decreased, diff (difficulty) chewing. Diff drinking from reg (regular) cups. R/T (related to) tremors." Review of the resident's October, 2005 Medication and Treatment records revealed that no supplements had been charted for the resident. Nineteen of thirty-seven residents were listed on the CDM's list of residents on supplements/snacks (dated 10/18/05). Resident #8 was not on the list as receiving supplements or snacks. Review of the facility's menus evidenced that there was a therapeutic finger food menu. The RD had approved this menu in 5/05. There was no evidence to indicate that the RD was aware of or had evaluated/assessed the substitution of the entire meal for one peanut	F 272	The MDS coordinator reviewed the most recent RAP summary of all residents to assure the location and dates of the specific assessment information were reflected. Corrective action will be taken as indicated. The dietary manager has reviewed the specific supplement and/or snack needs for each resident. The dietary manager has reviewed the intake records for the past month for each meal, supplements, and snacks. The supplement and/or snack needs for specific residents will be reviewed and revised as indicated. A variety of bedtime snacks will be available each evening. The dietary manager reviewed the weight status and meal intake of each resident. Prior to the survey and ongoing, any resident who has had a significant weight variance &/or specific nutritional problems/needs were assessed by the registered dietician. The resident's nutritional risks/needs care plans will be reviewed/revised by the interdisciplinary team as indicated. All residents who currently have orders for a hypnotic/sedative have been identified. A comprehensive sleep assessment has been completed as indicated. A determination of alternatives to be used as indicated has been identified by the interdisciplinary team. The specific non-drug interventions to be implemented prior to administering a hypnotic have been documented on the medication	

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

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F 272	Continued From page 19 butter sandwich. SLEEP ASSESSMENTS: Reference for Professional Standards of Practice in Sleep Assessment: Fundamentals of Nursing, Fourth Edition, Lippincott, Taylor, Lillis & LeMone, Chapter 39: A comprehensive sleep assessment should focus on usual sleep patterns and recent changes in that pattern including usual sleeping and waking times, number of hours of undisturbed sleep, quality of sleep and number/duration of naps. The assessment should also include the effect of the sleep pattern on everyday functioning such as energy level and the ability to perform activities of daily living. Other factors to consider in a comprehensive sleep assessment include the history of insomnia, the use of such sleep aids as means to relax before bedtime, bedtime rituals and the sleep environmental factors. Assessment of sleep disturbances and contributing factors should include the nature of the sleep disturbance, onset, causes (physical psychosocial and medicine-related) severity, symptoms and interventions attempted and the results of those interventions. Sleep produced by sedative-hypnotics is an unnatural sleep and daily use of a sedative-hypnotic has safety concerns especially with the elderly. Possible reasons for the insomnia such as depression, pain, noise, light, infections, caffeine, or other foods) should be ruled out and interventions designed to eliminate or reduce these causative factors. 1. Record review of sample resident #4's medical record revealed the resident had been readmitted to the facility on 12/11/03 with diagnoses that included spinal stenosis, duodenal	F 272	administration record. The resident's care plan and behavior monitoring record have been revised as indicated to reflect the current plan of care. 3) On 11/30/05, the MDS coordinator has in serviced the interdisciplinary team on the RAI process with emphasis on including the location and dates of the specific assessment information on the RAP summary and accuracy of the resident assessment summary and minimum data set. The team was instructed to make sure there was supporting documentation or description of any change such as mood or insomnia/sleeplessness in the resident's record. On 11/22/05, the Director of Nurses instructed the nurses to document the amount of supplement on the respective resident's medication administration record to include resident #1, #3, #4, #5, #6, #7, #8 and all residents receiving a supplement &/or snack. On 11/22/05, the Director of Nurses instructed the nursing staff on the bedtime snack policy and procedure with emphasis on documenting on the designated record the amount of bedtime snack each resident consumed. The staff was instructed to document if the resident declined the snack.	

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

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F 272	Continued From page 20 ulcer, anemia, depression, hypertension, and affective psychosis. a. Review of the resident's current physician orders revealed an order for Temazepam (Restoril, a hypnotic) 15mg at bedtime which was started on 4/26/05. On 9/15/05 the Restoril was changed to PRN (as needed). b. According to drug manufacturer's information Restoril may cause lethargy, drowsiness, daytime sedation, dizziness, irritability, memory impairment and gastrointestinal discomfort. c Review of medication administration records revealed the resident was taking this medication continuously from July 1 through 9/15/05. (see F329 for specifics relating the failure to monitor behaviors and side effects, to document adequate indications for drug use, and to ensure hypnotics were not given in excessive duration) d. Although the order indicated the Restoril was for "episodic mood disorder," this is a hypnotic or sleep aide and was always given at bedtime. There was no documentation of any bedtime "mood disorder". The nurses' documentation of the administration of the Restoril indicated it was actually given for insomnia or sleeplessness. e. The resident's current quarterly MDS assessment dated 10/9/05 indicated the resident did not have complaints of insomnia (Section E 1 k). A Significant change MDS dated 5/13/05 and one dated 7/14/05 indicated that the resident had no complaints of insomnia although the RAS and the RAP narrative reports indicated the resident was taking the sleeping pill nightly. f. Although the night shift nurse documented	F 272	The nurses have been instructed on the Unnecessary Drug regulatory requirements and the facility's policy and procedure for hypnotic/sedative use. Whenever a hypnotic/sedative is ordered for a resident who requests a medication for insomnia, the licensed nurse shall complete a comprehensive sleep assessment to determine the reason for the resident's insomnia and alternative measures. The nurses have been instructed to provide interventions designed to eliminate or reduce specific causative factors such as but not limited to administering pain medication if indicated, correct any environmental factors (noise, light, room temperature), or offer a snack or warm milk. The nurses were instructed of the facility's policy of not administering a hypnotic/sedative medication until non-drug interventions have been provided. The policy includes not administering a hypnotic/sedative before 2100 or after 0200. The information discussed at the in services will be included as part of the orientation for new staff. For pool/agency, the information will be placed in the binder as part of their orientation to the facility. The pharmacy consultant will do an in service for nursing staff on hypnotic/sedative side effects and response by 12/30/05. On a monthly basis, the pharmacy consultant will monitor the use of hypnotics/sedatives	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 272	Continued From page 21 episodic sleeplessness, review of the resident's medical record showed no evidence that a comprehensive sleep assessment had been conducted to identify his/her sleep pattern/sleep disturbance, history of and possible reasons for any insomnia such as night noise, pain, side effect of other medications or possible infections. The medical record revealed the resident had a history of back pain. g. The Director of Nursing indicated there was no documented comprehensive sleep assessment for resident #4. In an interview with the night nurse on 10/20/05 at 7:30 AM she indicated that she was not aware of any comprehensive sleep assessment form utilized in the facility. 2. Review of the medical record for supplemental resident #17 revealed the resident was admitted to the facility on 11/1/04 with diagnoses of spinal cord injury, hypertension, schizophrenia and osteoporosis. The resident was started on Temazepam (Restoril) 15mg at bedtime PRN (as needed) on 9/9/05 for insomnia. a. According to drug manufacturer's information Restoril may cause lethargy, drowsiness, daytime sedation, dizziness, irritability, memory impairment and gastrointestinal discomfort. The resident was also on Risperdal and Paroxetine for schizophrenia. b. A fax memo to the physician dated 9/8/05 indicated the resident was not sleeping but "denies that (his/her) caffeine intake has caused (his/her) sleeplessness". A Fax memo indicated the resident was drinking "several (6 pack +) ..... soda daily".	F 272	and will make recommendations as needed. The medical director will be given the monthly reports from the pharmacist on the hypnotic/sedative use and will review it and make recommendations. These recommendations will be part of the review at the Quality Assurance Committee meeting. 4) The interdisciplinary team will audit the accuracy and completion of the comprehensive assessments before they are sealed and transmitted to the State database. The MDS coordinator will monitor the completed comprehensive assessments weekly to assure the location and a date of the specific assessment information is included on the RAP summaries. The MDS coordinator will review the resident assessment summaries and the MDSs to assure there is a description and supporting documentation for any changes in the resident's mood state, behavioral or physical condition. The results of the audits with corrective action taken will be discussed at least quarterly at the facility quality assessment and assurance committee meeting. The night nurse will check the documentation of the consumption of bedtime snacks nightly. If the resident didn't accept a snack at bedtime, the staff will offer a snack if the resident is awake during the night. The dietary manager will monitor the HS snack documentation weekly for a month, and monthly thereafter. Any concerns will be reported to the Director of Nurses. Any concerns with corrective action will be discussed at	

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F 272	Continued From page 22 c. Review of the Medication Record for October 2005 showed the resident received this hypnotic from 10/3/05 through 10/18/05, sixteen days. Medication records show the Restoril was often given with two Tylenol for pain. See F329 for specifics regarding the failure to ensure resident #17 only received a hypnotic when other possible reasons for insomnia have been ruled out and failed to ensure daily use of the hypnotic was less than 10 continuous days unless an attempt at a gradual dose reduction was unsuccessful. d. Review of the resident's care plan did not reveal a care plan regarding the resident's insomnia which would include non-pharmacological nursing interventions, managing pain prior to administration of a hypnotic or monitoring of the resident's hours of sleep for effectiveness of interventions. (See F279 regarding the facility's failure to develop comprehensive care plans.) e. The resident's current quarterly MDS assessment dated 8/1/05 indicated the resident did not have complaints of insomnia (Section E 1 k). Behavior tracking forms for September 2005 did not show the resident was having complaints of insomnia. f. In an interview with the night nurse on 10/20/05 at 7:30 AM, she indicated that resident #17 drank a lot of soda pop. She also indicated that she was not aware of any comprehensive sleep assessment form utilized in the facility. g. Although the night shift nurse documented episodic sleeplessness, review of the resident's medical record showed no evidence that a comprehensive sleep assessment had been conducted to identify his/her sleep pattern/sleep	F 272	least quarterly at the facility's quality assessment and assurance committee meeting. The Director of Nurses or designee will monitor compliance with documenting the percentage consumed for each supplement at least weekly for a month, and monthly thereafter. Results of the audits with corrective action will be discussed at least quarterly at the facility's quality assessment and assurance committee meeting. The Director of Nurses or designee will monitor compliance in completing comprehensive sleep assessments, documentation requirements in providing non-drug interventions prior to administering hypnotics/sedatives and completing behavior tracking records at least weekly for a month, and monthly thereafter. The psychoactive medication/behavior management clinical team will monitor the use of hypnotics/sedatives and attempts to reduce or eliminate at least quarterly. On a monthly basis, the pharmacy consultant will monitor the use of hypnotics/sedatives and will make recommendations as needed. The medical director will be given the monthly reports from the pharmacist on the hypnotic/sedative use and will review it and make recommendations. These recommendations will be part of the review at the Quality Assurance Committee meeting. **Completion date: 12/15/05**	

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F 272	Continued From page 23 disturbance, history of and possible reasons for any insomnia such as night noise, pain, caffeine, medication side effect, or possible infections.	F 272		
F 278 SS=D	483.20(g) - (j) 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 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 record review, observations and staff	F 278		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 24 interview, it was determined that the facility failed to accurately assess four of ten sample residents (#3, #8, #4 and #5). These residents' Minimum Data Set (MDS) assessments did not contain accurate information for the residents at the time the assessments were completed. The findings included: 1. Record review for sample resident #3, admitted 6/8/04, revealed diagnoses that included fractured hip, chronic end stage airway obstruction, gastritis, and end stage Alzheimer's. Review of this resident's 9/15/05 quarterly MDS assessment revealed that the resident was coded as requiring extensive assistance with transfer, eating, toilet use, personal hygiene, and bathing. The resident was also assessed to usually be continent of bowel and occasionally incontinent of bladder. The resident was assessed to be involved in activities 1/3 to 2/3 of the time. On 10/19/05 at 10:13 AM, in an interview with a Certified Nurse Aide (CNA), she stated that the resident requires total care, including feeding, and is incontinent of bowel and bladder. Observations at the evening meal on 10/18/05 and at the noon meal on 10/19/05 revealed that the resident required total assistance with eating. On 10/19/05, observations of the resident being transferred and showered evidenced that he/she required total assistance. On 10/19/05 at 9:03 AM, in an interview with the Activities Director (AD), she indicated that the resident was not very active, but will come to a few activities. She verified that the resident gets family visits.	F 278		

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F 278	Continued From page 25 2. Record review for sample resident #8 revealed diagnoses that included dysphasia, gastric reflux, and, osteoarthritis. Record review of sample resident #6's annual MDS dated 10/13/05 revealed that the only dental item marked was daily cleaning of teeth/dentures and no nutritional problems were marked. Throughout the survey, observation of the resident revealed that the resident had some of his/her natural teeth. Observation of the evening meal on 10/18/05 and the noon meal on 10/19/05 revealed that the resident ate peanut butter sandwiches. Staff indicated at this time that the resident had food dislikes and did not eat many food items. On 10/19/05 at 7:40 AM, the nurse stated that the resident was not eating well because (he/she) had a sore tooth. Review of the Interdisciplinary Progress Notes (IPN) on 10/19/05 and 10/20/05 evidenced that the nurse had not documented that the resident had a tooth problem. The last nursing note was dated 9/16/05. There was an IPN by the RD, dated 10/11/05, but there was no mention of a tooth problem. Review of the resident's medical staff progress notes evidenced that the physician's assistant (PA) repeatedly listed dysphagia as a diagnosis. The resident had a diagnosis of dysphasia (difficulty speaking), not dysphagia (difficulty swallowing). Review of the resident's "RAP (Resident Assessment Protocol) Narrative Report", dated 10/13/05, evidenced that the resident had long and short term memory problems. Review of the resident's 10/13/05 annual MDS assessment	F 278	F-278 RESIDENT ASSESSMENT It is the practice of this facility to provide accurate assessment to reflect the resident's status. 1) MDS's will be reviewed by the ID Team to determine if the residents have been accurately assessed or if there are other observations that would contribute to the assessment. Resident # 3 has been reassessed with completion of new MDS, RAPS and review of the care plan for any changes in care plan needs. Resident #8 has been reassessed and an updated MDS completed. A dental	

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F 278	Continued From page 26 revealed that the resident was coded as having no short term memory problems and as having long term memory problems. 3. Record review of sample resident #5's medical record revealed the resident had been admitted to the facility on 3/2/01 with diagnoses that included cardiovascular accident (stroke), renal failure, reactive psychosis and dementia. The resident's current quarterly Minimum Data Set (MDS) assessment dated 10/9/05 indicated the resident had long/short term memory loss and severely impaired decision making skills. The MDS also indicated the resident needed extensive to total assistance with bed mobility, transfers, dressing and toileting. a. The MDS had section C4 (Making self understood) with a "0" indicating the resident could make self understood. Observations and interviews with staff indicated the resident's speech was often difficult to understand and the resident was often very confused. The Resident Assessment Summary (RAS) dated 10/9/05 indicated the resident was only sometimes understood. b. The RAS also indicated the resident had a change in mood but there was no description of what that change was. The 10/9/05 MDS indicated no indicators of depression of mood change (section E1). 4. Record review of sample resident #4's medical record revealed the resident had been readmitted to the facility on 12/11/03 with diagnoses that included spinal stenosis, duodenal ulcer, anemia, depression, hypertension, and affective psychosis. Review of the resident's current physician orders revealed an order for	F 278	assessment is being completed to assess dental needs. The physician's assistant will be made aware of the different diagnosis for the resident, dysphasia rather than dysphagia. Resident # 5 has been reassessed for making self-understood, mood, and general function with an updated MDS completed. RAP's will be reviewed and completed to correspond with the assessment findings for the MDS. Resident # 4 has had a sleep assessment completed to determine alternatives to use of the hypnotic. All residents using hypnotics will have a sleep assessment completed. In the future, other residents will have a sleep assessment completed if there is a problem with insomnia to assist in determining other means of aiding them to sleep. 2) The IDT have identified residents whose assessments do not accurately reflect resident status and will collaborate to assure that MDS reflect the resident as accurate as the resident currently presents. 3) On 11/30/05, the IDT were in serviced on the care plan process with emphasis on revising the care plan and reflecting the resident's current status. 4) The Director of Nurses and ADON or designee will monitor compliance weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion Date is: 11/30/2005**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 278	Continued From page 27 Temazepam (Restori., a hypnotic) 15mg at bedtime which was started on 4/26/05. On 9/15/05 the Restoril was changed to PRN (as needed). The resident's current quarterly MDS assessment dated 10/9/05 indicated the resident did not have complaints of insomnia (Section E 1 k). A Significant change MDS dated 5/13/05 and one dated 7/14/05 indicated that the resident had no complaints of insomnia although the RAS and the RAP narrative reports indicated the resident was taking the sleeping pill nightly.	F 278		
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 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).	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 279	Continued From page 28	F 279		

This Requirement is not met as evidenced by:
Based on record review, it was determined that the facility failed to develop comprehensive care plans for one of ten sample residents (#5) and one supplemental resident (#17). The findings included:

1. Record review of sample resident #5's medical record revealed the resident had been admitted to the facility on 3/2/01 with diagnoses that included cardiovascular accident (stroke), renal failure, reactive psychosis and dementia. The resident's current quarterly Minimum Data Set (MDS) assessment dated 10/9/05 indicated the resident had long/short term memory loss and severely impaired decision making skills. The MDS also indicated the resident needed extensive to total assistance with bed mobility, transfers, dressing and toileting.

There was no care plan related to measures to take to prevent this confused, cognitive impaired resident from self-exposures when the staff had removed his/her garments during the resident's naptime (See F164 for specifics relating to exposures).

2. Review of the medical record for supplemental resident #17 revealed the resident was admitted to the facility on 11/1/04 with

F-279

COMPREHENSIVE CARE PLANS

It is the practice of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

1) Care Plans for Resident # 5 and #17 have been reviewed and corrections made in the care plans. Attention will be given to areas in the Care Plan that need approaches to meet the needs of the resident.
Attention will be given to resident # 5 needs related to confusion and privacy to

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 279	Continued From page 29 diagnoses of spinal cord injury, hypertension, schizophrenia and osteoporosis. The resident was started on Temazepam (Restoril) 15mg at bedtime PRN (as needed) on 9/9/05 for insomnia. According to drug manufacturer's information Restoril may cause lethargy, drowsiness, daytime sedation, dizziness, irritability, memory impairment and gastrointestinal discomfort. The resident was also on Risperdal and Paroxetine for schizophrenia. a. Although the night shift nurse documented episodic sleeplessness, review of the resident's medical record showed no evidence that a comprehensive sleep assessment had been conducted to identify his/her sleep pattern/sleep disturbance, history of and possible reasons for any insomnia such as night noise, pain, caffeine, medication side effect, or possible infections. (Cross Reference F272: the facility failed to assess the sleep patterns for the continued use of sedative/hypnotic medications). b. See F329 for specifics regarding the failure to ensure resident #17 only received a hypnotic when other possible reasons for insomnia have been ruled out and failed to ensure daily use of the hypnotic was less than 10 continuous days unless an attempt at a gradual dose reduction was unsuccessful. c. Review of the resident's care plan did not reveal a care plan regarding the resident's insomnia which would include non-pharmacological nursing interventions, managing pain prior to administration of a hypnotic or monitoring of the resident's hours of sleep for effectiveness of interventions.	F 279	prevent exposure. A sleep assessment will be completed to determine non-hypnotic means of relieving insomnia and care plan such approaches. Resident # 17 has had a sleep assessment completed and the care plan will reflect alternative means of aiding the resident to sleep such as determining if pain management is needed. 2) Medications are reviewed with the care plan process to identify any care planning needed. Nursing staff is informed of any approaches changed or added. As appropriate, approaches will be added to the CNA's assignment sheets. An audit will be completed to ensure that the MDS, RAPS and Care Plan reflect the resident's needs and that the approaches meet the needs. The audit tool will be reviewed at Quality Assurance Committee Meetings. If an area needs revision, a committee action plan and follow up will be done. The results of the action plan will be reviewed at the next committee meeting to ensure compliance. 3) On 11/30/05, the IDT were in serviced on the care plan process with emphasis on revising the care plan when the residents need change. 4) The DON and MDS nurse or designee will monitor compliance weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion date is: 11/30/2005**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 280	Continued From page 30	F 280		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to review and revise the care plans of five of ten sample residents (#3, #2, #6, #4, and #5) as their individual needs changed. The findings included: 1. Record review for sample resident #3 revealed diagnoses that included fractured hip, chronic end	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1216 CANYON HILLS ROAD THERMOPOLIS, WY 82443

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F 280	Continued From page 31 stage airway obstruction, gastritis, and end stage Alzheimer's. Review of the resident's 9/15/05 quarterly Minimum Data (MDS) assessment evidenced that the resident required extensive assistance for bed mobility, transfer, eating, toilet use, personal hygiene, and bathing and total care with locomotion on and off the unit and dressing. a. Review of the resident's care plan for activities revealed an approach of "introduce to peers with similar interests and encourage interaction/involvement." Observations on 10/18/05 and 10/19/05 revealed that the resident did not attend activities and interacted only with a family member. On 10/19/05 at 9:03 AM, in an interview with the Activities Director (AD), she verified that the resident was not very active in the facility's activity programs. She stated that the family visits the resident often and the resident receives one to one visits. b. Review of the resident's care plan for at risk for infection (9/28/04) revealed an approach to "monitor incision daily and PRN (as needed)." The site for monitoring was the left hip (from 9/04 hip fracture). The target date was 12/05. c. Review of the resident's care plan for history of hip pain from fractured hip (9/04) evidenced an approach of "assist with mobility as needed." The resident was observed to require total assistance with mobility. On 10/19/05 at 10:13 AM, in an interview, the Certified Nurse Aide (CNA) verified that the resident was dependent on staff for mobility. d. Review of the resident's care plan for potential	F 280		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 280	Continued From page 32 for falls revealed approaches to "keep environment free of clutter/obstruction", "keep frequently used items within ____ (resident's name) reach," and "monitor condition of shoes, have repaired/replaced as needed." The resident was dependent on the staff for mobility and eating and drinking. The resident did not ambulate. 2. Record review for sample resident #2 revealed the resident was admitted to the facility on 9/28/99. The resident's diagnoses included: MVA (motor vehicle accident) with traumatic brain injury, severe spasticity, joint contractures and aphasia. a. Review of physician progress notes included: 7/13/05 which identified the resident as being in a "persistent vegetative state", 10/18/05 "Resident unable to communicate with nursing staff. ....A lot of flexion contractures on the wrist and contractures of the lower extremities..." b. Review of the physical therapy screen dated 7/7/05 identified the resident as having full loss of voluntary function with partial loss of PROM (passive range of motion) neck, arms, hands and feet. c. Review of the MDS (minimum data set) dated 9/26/05 identified the resident as having two stage I (one) and one stage II (two) pressure sores and being totaly dependent on staff for all cares. d. Review of the "Care Plan Conference Summary" sheet dated 7/7/05 had a note written in the "Summary of Care Plan conference	F 280		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 33 Discussion" section stated, '[Resident] has sores on [his/her] feet and [his/ her] [parent] would like to know why [he/she] has these sores." The area on the back of the sheet under section marked "Risks/Consequences" stated, "Sores on feet R/T [related to] rolling [resident name] in bed." There was no documentation of actions or interventions taken to prevent further sores or injury to the resident's feet in the plan of care. 3. Resident #8's medical record review revealed the resident was admitted to the facility 3/10/04 with diagnosis including; dementia with behaviors, hypertension, atherosclerotic heart disease, osteoarthritis, renal and ureteral disease and insomnia. a. Review of the MDS date 6/17/05 identified the resident as having a significant change in condition. The areas identified as decline included: cognitive skills from modified independence to moderately impaired, transfer from needing supervision to extensive assistance, Change in ADL (activities of daily living) function marked as (2) deteriorated, weight loss, falls and increase in pain. A note on the review summary with the assessment stated, "significant decline since recent Fx (fracture)." b. Review of the resident's plan of care dated 6/29/05 (onset) with target date 12/05. This was after the resident had a fall which resulted in a fractured clavicle. It listed problem for falls R/T (related to) use of psychoactive medications and continuous wandering. [Resident] takes antidepressants daily and antianxiety PRN. The goal was -will remain free of fall every day. The typed approaches included: 1) keep environment free of clutter/obstructions everyday,	F 280		

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F 280	Continued From page 34 2) keep frequently used items within [resident's] reach, 3) anticipate [resident's] needs daily, 5) medicate as ordered notify physician of any change in behavior / mental status, 6) monitor condition of shoes, have repaired/replaced as needed, 8) encourage to take rest periods, 9) Keep room free from clutter". There were additions written in with some of the resident's falls listed which included falls dated; 6/28/05, 7/5/05, 7/18/05, 7/20/05, 8/2/05 and 8/12/05. The written in approaches were motion monitor, bed alarm, PT (physical therapy) to screen after falls, scheduled toileting q (every) 2-4 hours round the clock, boat mattress and self releasing seat belt. These additional approaches were not dated to show timeliness of these interventions or changes in approaches when interventions were not effective. The resident continued to have falls. The facility failed to ensure the care plan is evaluated and revised as to meet this resident's needs. (Cross refer to F324 regarding the facility's failure to ensure adequate supervision to prevent accidents.) 4. Record review of sample resident #5's medical record revealed the resident had been admitted to the facility on 3/2/01 with diagnoses that included cardiovascular accident (stroke), renal failure, reactive psychosis and dementia. The resident's current quarterly Minimum Data Set (MDS) assessment dated 10/8/05 indicated the resident had long/short term memory loss and severely impaired decision making skills. The MDS also indicated the resident needed	F 280	F-280 COMPRESHENSIVE CARE PLAN It is the practice of this facility to have the resident participate in their plan of care and treatment or change in care and treatment unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State and periodically reviewed and revised by a team of qualified persons after each assessment.	

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F 280	Continued From page 35 extensive to total assistance with bed mobility, transfers, dressing and toileting. a. Review of the resident's care plan revealed the care plan consisted of 42 pages of problems/goals and approaches to use with the resident. Many problems had repetitive approaches. b. The resident had a care plan for pain in his/her toes. The care plan did not indicate the administration of any analgesics for pain relief although the resident was receiving Ultram twice a day for pain. The care plan did not reflect how this cognitively impaired resident routinely exhibited his/her pain (i.e. grimacing irritability screaming out etc.). c. The resident's care plan (#12) indicated the resident was at risk for wandering although the approaches as well as the current MDS indicated he/she was unable to stand or move the wheelchair without assistance for staff. One of the approaches indicated that staff were to allow the resident to wander freely in the facility and to verify his/her location at least PRN (as needed) d. The resident's care plan (#14) indicated the resident had impaired verbal communication. Approaches listed "become familiar with words used by (resident) and what those words mean to (resident. Share info with other staff" and "become familiar with non-verbal cues, gestures and body language used by (resident. Share info with other staff". The care plan did not list the words or non-verbal communication used by the resident to share with new/pool staff caring for the resident. e. Review of the medical record revealed that	F 280	1-Care Plans are being reviewed for individualized approaches that meet the resident's individual needs. Approaches will be dated. Resident # 3 the care plan has been individualized and activities will have approaches that will meet the resident's level of function. . A review of activity program for appropriate care plan interventions to meet resident's needs has been completed. Identified issues will have approaches to meet current needs such as mobility. All Care plans are reviewed and revised as indicated to reflect current plan of care. Resident # 2 has had the care plan adjusted and interventions in place to prevent sores from occurring on his toes. His total care plan was also reviewed revised as indicated to reflect current plan of care Resident #6's care plan is update to reflect approaches that are current to meet the resident's needs to prevent falls. The additional approaches added to the care plan will be dated as well as other approaches in the care plan. Resident # 5's care plan will be reviewed with related problems combined to reduce the number of problems with the same approaches. A problem has been identified to managing her pain and approaches to identify the need for medication. Review of her care plan included means of communication and methods of communication. Approaches for wheelchair safety have been addressed.	

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F 280	Continued From page 36 resident #5 was taken to the emergency room on 10/12/05 after getting his/her left middle finger caught between the spokes of the wheelchair, amputating the tip of the finger. Review of the resident's care plan revealed that this amputation was listed but there was no approaches regarding wheelchair safety to prevent reoccurrence of this incident with this confused resident. 5. Record review of sample resident #4's medical record revealed the resident had been readmitted to the facility on 12/11/03 with diagnoses that included spinal stenosis, duodenal ulcer, anemia, depression, hypertension, and affective psychosis. a. Although the night shift nurse documented episodic sleeplessness, review of the resident's medical record showed no evidence that a comprehensive sleep assessment had been conducted to identify his/her sleep pattern/sleep disturbance, history of and possible reasons for any insomnia such as night noise, pain or possible infections. (See F272 for resident specifics regarding lack of a comprehensive sleep assessment). b. Although the resident had a care plan related to the use of a sedative the plan did not include approaches to ensure the resident did not take the hypnotic drug for more than 10 continuous days unless an attempt at a gradual dose reduction is unsuccessful. c. Review of the resident's care plan revealed the care plan consisted of 34 pages of problems/goals and approaches to use with the resident. Many problems had repetitive approaches.	F 280	Resident # 4 has had a sleep assessment completed and approaches to aid in sleep. Nurses have been in serviced on sleep aids other than hypnotic medication and the limitation on the frequency and side effects of giving hypnotics. The need for other means of achieving sleep will be care planned and identified on the MAR or Interdisciplinary Progress Note before a sleeper is used. Approaches in the care plan are being reviewed to find related problems to combine to improve approaches and use of care plan. All resident's and/or responsible parties are invited to attend care planning. Nursing staff have been in serviced on notifying families, including resident #2's, regarding any changes in condition which includes skin conditions. Resident #2's legal representative consistently participates in the resident's care conference 2) All resident care plans will be reviewed to assure revisions have been made as indicated. 3) On 11/30/05, the IDT were in serviced on the care plan process with emphasis on revising the care plan when the residents need change. 4) The Director of Nurses, ADON and MDS nurse will monitor compliance weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion date is 11/30/2005**	

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

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F 309 SS=D	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 physica , mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: Based on observation, record review, and resident/ staff interview, it was determined that the facility failed to provide care in a manner which helped four of ten sample residents (#4, #5, #7, and #9) reach their highest practicable level of physical, mental, and/or psychosocial functioning. The findings included: 1. Review of the medical record for sample resident #7 revealed the resident was admitted to the facility in November 1984. The resident's current diagnoses included pruritus, dysphasia, osteoporosis, seizure disorder and organic brain syndrome. The resident had a urine culture on 4/9/05 which showed contamination of E coli. According to The Merck Manual, 16th edition, Escherichia coli (E. coli) is the most common cause of UTIs (urinary tract infections) in adults. These bacteria are normally present in the colon and may enter the urethral opening from the skin around the anus and genitals. Poor perineal care can contribute to UTIs. a. The resident had a care plan for risk for infections secondary to a history of UTIs. There were no approaches related to preventive measures for UTIs.	F 309		

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F 309	Continued From page 38 b. In an observation on 10/18/05 at 4:10 PM of CNA #4 during personal cares for resident #7, the CNA indicated the resident had dried smears of stool on his/her perineum and buttocks. The CNA stated "they didn't clean (the resident) up very well". Observation of the resident and the care provided by the CNAs showed the pad under the resident was saturated with urine and blood stains from the open areas on his/her buttocks. The CNA used several wipes to clean the resident's perineum. When asked if the resident had just had a bowel movement the CNA stated "no this is dried on from before". 2. Record review of sample resident #5's medical record revealed the resident had been admitted to the facility on 3/2/01 with diagnoses that included cardiovascular accident (stroke), renal failure, reactive psychosis and dementia. The resident's current quarterly Minimum Data Set (MDS) assessment dated 10/9/05 indicated the resident had long/short term memory loss and severely impaired decision making skills. The MDS also indicated the resident needed extensive to total assistance with bed mobility, transfers, dressing and toileting. a. The resident has several care plan approaches (#7, #8, and #16) which indicated he/she ate better when fed with small plastic spoons and small plastic cups. Observations of staff members feeding the resident during survey revealed that the staff did not use plastic spoons and cups as outlined in the resident's care plan. b. Observation of the resident on 10/18/05 at 1:30 PM revealed CNA #1 was providing pericare to the resident after lunch and laying the resident down for a nap. The CNA removed the resident's incontinent brief and his/her sweatpants and	F 309		

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

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F 309	Continued From page 39 transferred him/her to the bed. CNA used two wipes to wipe the resident's front genital area and rectal area. The CNA wiped with the cloth several times to clean the resident's genital area. Although the resident was frequently incontinent and at high risk for skin breakdown, the CNA did not apply any protective creams after providing pericare. The resident's care plan (#3) indicated the resident was to be encouraged to lay on his/her side when in bed and a barrier cream was to be applied after each incontinent episode. Observation of the CNA #1's performance of incontinent care for resident #5 did not show that the resident was assisted to position him/herself in a side-lying position or that the CNA applied the barrier cream as directed in the care plan. c. Review of the resident's care plan revealed the resident had had several skin tears since 7/29/05 and the resident was to have gerigloves on to protect his/her skin. Observation on 10/18/05 from 12:30 PM to 7:00 PM revealed these gloves had not been applied. d. Review of the Chemical/Physical Restraint Appropriate Review Form for 10/10/05 indicated the resident was to have a mat on the floor for safety and the resident's fall risk. On 10/18/05 at 4:25 PM an observation of the resident revealed the resident was lying on the bed. There was no protective pad on the floor by the resident's bed. 3. Record review of sample resident #4's medical record revealed the resident had been readmitted to the facility on 12/11/03 with diagnoses that included spinal stenosis, duodenal ulcer, anemia, depression, hypertension, and affective psychosis. a. The resident's annual MDS dated 7/28/05	F 309	F – 309 QUALITY OF CARE It is the practice of this facility to provide the resident with 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. 1 - Nursing staff has been in serviced on providing pericare with an appropriate technique. Competencies on pericare were done with CNA's to show proficiency or need for additional training and measures to prevent UTI's was added to resident #7's risk for infection Care Plan. Resident #5's care plan for use of plastic spoons and cups has been reviewed with the staff and they have been using plastic	

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F 309	Continued From page 40 included the Resident Assessment Protocol (RAP) Summary. Review of the RAP summary indicated that the resident was at risk for skin breakdown and pressure ulcers related to incontinence and decreased mobility. b. The resident's care plan (16) related to the risk for skin breakdown indicated the resident had an anti-pressure device on his/her bed and directed staff to keep bed linens wrinkle free. There was no approach listed for an anti-pressure device in the resident's wheelchair where he/she sat several hours daily. c. Observation of the resident's wheelchair on 10/18/05 at 9:00 AM indicated that he/she did have a pressure-relieving cushion in the wheelchair. The cushion had deep wrinkles in the plastic cover and was covered with a towel. The resident indicated to the surveyor that the cushion was not really comfortable and the towel helped some. d. Observation of the resident's cushion on 10/19/05 at noon revealed the cushion was deeply wrinkled and covered with a bath towel. e. According to "Pressure Ulcer Treatment", U.S. Department of Health and Human Services, Clinical Practice Guideline, Number 15, the resident should have an individually prescribed seat cushion which will relieve or reduce pressure on bony prominences. Support surface and positioning needs should be assessed and reviewed regularly and determined by results of skin inspection, patient comfort, ability, and general state. Covering these support services with bed linens, towels or incontinent pads decreases their effectiveness for pressure relief.	F 309	equipment as per care plan for each meal. Staff is being made aware of all care plan issues in the care of the resident regarding incontinent care and protections and positioning. Resident # 5 Extra geri-gloves have been ordered and are available at the nurses' station and in supply. The mat will be on the floor next to the bed when the resident #5 is in bed. Resident # 4 Care plan for anti-pressure device for the bed pressure relief cushion in wheelchair has been care planned. The cushion in the wheelchair is appropriate per manufacturers specification. The resident should not be sitting directly on the cushion and may have a thin cover over the cushion. Resident # 9's UTI had cleared and there has not been a reoccurrence since. On 11/30/2005, the nurses were in serviced on follow up documentation when resident is experiencing a change in condition. 2) All residents with recent changes in condition, documentation have been reviewed to assure documentation is completed. Wheelchair cushions have been reviewed for appropriateness Care Plans are updated as necessary. All resident's and/or responsible parties are invited to attend care planning. Nursing staff have been in serviced on notifying families, including resident #2's, regarding any changes in condition which includes skin conditions. Resident #2's legal representative consistently participates in the resident's care conference	

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F 309	Continued From page 41 4. Resident #9 medical record review revealed the resident was admitted to the facility on 6/14/05 with diagnosis including: osteoporosis, hypertension, macular degeneration, joint pain pelvis and depression. Review of the MDS dated 8/9/05 identified the resident's cognitive skills for decision making as modified independence, with falls in the past 30 days and 31 -180 days, moderate pain daily, recent UTI (urinary tract infection) and not being on a restorative nursing program. Review of the "Interdisciplinary Progress Notes" dated 8/10/05 identified the resident was seen by the physician and had a new order to increase current antidepressant. The entry on 8/11/05 at 11:00 AM stated, "Res. c/o (complained of) N/V (nausea and vomiting) and diarrhea, mod (moderate) emesis 1 cc Phenergan IM given as ordered, will cont. to monitor." The next documentation was 8/29/05 18 days later. The facility failed to provide timely follow up for this resident who had a change in condition. There was no follow up to assess if the increase in medication had caused adverse side effects or other causes for nausea, vomiting and diarrhea.	F 309	3) On 11/30/05, nurses were in serviced on the care plan process and document requirements for the COC. The information discussed at the in services will be included as part of the orientation for new staff. For pool/agency, the information will be placed in the binder as part of their orientation to the facility. 4) The DON or designee will monitor compliance weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion date is 11/15/05**	
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This Requirement is not met as evidenced by: Based on observation, resident/staff interviews and record review, it was determined that the	F 311		

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

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F 311	Continued From page 42 facility failed to provide adequate meal assistance to three of ten sample residents (#8, #6 and #7) and four supplemental residents (#13, #11, #15, and #16). These residents were facility-assessed and/or observed to be able to feed him/herself all or part of his/her meals, but required supervision, cueing, and/or physical assistance to eat and/or to be positioned at the table. The findings included: 1. Record review for sample resident #8 revealed diagnoses that included dysphasia, gastric reflux, and osteoarthritis. Review of the resident's 10/13/05 annual Minimum Data Set (MDS) assessment revealed that the resident required only setup help with eating. a. On 10/18/05 from 5:30 PM to 6:35 PM, observations of the resident during the evening meal revealed the following: When the resident's meal was served at approximately 5:45 PM, he/she indicated to staff that he/she did not want the food. The CNA said that she would check back with him/her to see if he/she wanted something else to eat. The resident was observed to be eating only the banana and orange. At 6:04 PM, the surveyor requested that a CNA check with the resident since the resident was not eating and no staff member had returned to see if the resident wanted something different to eat. The CNA brought the resident a peanut butter sandwich. She placed the plate with the sandwich on it to the left of the resident's other plate (off the Dycem). The resident appeared to have difficulty reaching	F 311		

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	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 311	Continued From page 43 the sandwich, but consumed it when he/she got ahold of it. The resident's juice and water were placed above the Dycem and plates of food, so the resident was unable to reach them. At approximately 6:25 PM, when the resident finished eating the sandwich, the surveyor went to get the nurse to show her that the resident's drinks were out of reach. While the surveyor was waiting to talk to the nurse, the resident requested assistance from another surveyor. The second surveyor reported to staff that the resident had asked for assistance. The staff member commented, "Oh does [resident] need his/her drink in reach?" Staff then placed drink glasses within the resident's reach. The resident was observed to drink the entire glass of juice immediately. b. On 10/19/05 from 12:00 noon to 12:45 PM, observation of the resident during the noon meal revealed that the resident refused to eat the menued items. The resident was provided with a peanut butter sandwich, which he/she consumed without drinking any liquids. The liquids were placed above the Dycem, out of the resident's reach. No staff members were present at the table or returned to the table to offer assistance to the resident. The facility failed to provide this resident with substitutes and/or assistance in a timely manner. The resident was observed to consume the sandwich at each meal. No other substitutes were offered or provided to this resident at either meal. Review of the October, 2005 "Meal Intake Record" evidenced that staff charted that the resident ate 25 % of the evening meal and 100 % of the noon meal.	F 311	F – 311 ACTIVITIES OF DAILY LIVING It is the practice of this facility to give residents the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. 1) Resident #8 - When the resident does not want the regular meal offered and requests a peanut butter and jelly sandwich, the resident will be served the peanut butter and jelly sandwich along with the alternate for that meal. The sandwich will be considered a portion of the meal with the alternate and the percentage considered from the total amount served as the alternate. The resident was reviewed by the RD and found the weight to have stabilized. The resident is also receiving a multivitamin.	

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F 311	Continued From page 44 c. Review of the resident's care plan evidenced that the resident was to be encouraged to drink fluids. The staff failed to place the resident's juice in reach. The resident did not drink the water at either meal. Staff did not offer the resident any additional fluids during the two meal observations. 2. On 10/18/05 from 5:30 PM to 6:35 PM, observation of supplemental resident #13 during the evening meal revealed the following: The resident appeared to have fallen asleep while waiting for his/her meal to be served. At 5:59 PM, the resident was served his/her food. The resident was observed to be seated at a table with his/her chin only slightly above the edge of the table. While the resident was eating, he/she kept his/her arm on the armrest of the chair. The resident was observed to get a very small amount of food on the end of the fork and then to bring it to his/her mouth without lifting his/her elbow off the chair armrest. At 6:25 PM, a CNA approached the resident and asked the resident if he/she was done eating. The resident had been eating continually, but had consumed only approximately 10% of the meal. The CNA did not cue, encourage, or assist the resident to eat. The CNA ambulated the resident out of the dining room. Review of the facility's "Weight Variance Summary" evidenced that the resident was experiencing a gradual weight loss (2.1% in 30 days, 7.4 % in 90 days, 6.4 % in 180 days). 3. Observations of the evening meal service on 10/18/05 from 6:00 PM to 6:55 PM revealed a	F 311	Resident #13 it will be stressed with staff in an in-service regarding the importance to cue a resident if the resident has not eaten the greater portion of a meal. The resident requests and receives snacks frequently. Resident # 7 will be encouraged to eat all of the alternate meal if not eating regular diet. Resident #16 is independent in eating. 2) All residents who receive assistance with meal service will be identified and care plan updated if necessary. 3) Staff is being in serviced by the DON regarding placement of food items in front of the resident so they are in reach. The staff is being instructed when they notice a resident may have drunk all of one fluid and not another, to ask the resident if they would like something else to drink or if the resident is not able to verbalize their desire, to offer additional fluid of preference. Staff will focus on the resident they are assisting with dining and, other than as care planned, will sit at eye level with the resident. Staff will be in serviced by the DON and CDM on how to measure meal intake. The CDM will in-service the dietary staff to be certain adequate food is provided with an alternate. In addition, there is an assigned department manager who will observe the dining room at each meal during the week and one manager will supervise one meal on the weekend. This manager will look for residents who need special assistance and as appropriate for the manager's	

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

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F 311	Continued From page 45 Certified Nurse Aide (CNA #3) was feeding residents while standing at their side. The CNA was assisting 3 residents (#11, #15, and #16) seated at a square table. Resident #6 was also seated at this table but was able to eat by him/herself. The CNA (#3) did not cue the resident when resident pushed self away from the table before finishing the meal. This resident had been identified by staff as having a significant weight loss and needing encouragement to eat. The CNA did not offer seconds to this resident and continued to visit with coworkers. Interview with the dietary manager on 10/18/05 at 6:40 PM identified the four residents at this table as needing to be cued and assisted with meals. 4. Review of the medical record for sample resident #7 revealed the resident was admitted to the facility in November 1984. The resident's current diagnoses included pruritis, dysphasia, osteoporosis, seizure disorder and organic brain syndrome. a. Although the resident's current quarterly MDS assessment dated 9/26/05 indicated the resident was independent with eating (G 1 h), the resident had a care plan for risk for weight loss. Approaches listed included directives for the staff to encourage intake at meals. The care plan (#19) for "requires limited to extensive assist with ADLs (activities of daily living)" included approaches to provide assist for eating all meals. The resident also had a care plan for risk for choking and aspiration. This care plan indicated staff was to encourage small bites and monitor for signs and symptoms of aspiration. b. Observation of the evening meal on 10/18/05 revealed sample resident #7 was provided with a	F 311	position, encourage and assist the resident or request a nursing staff member to assist the resident to complete the meal. If the resident refuses the meal offered, the manager will request an alternate to be offered or another choice for the resident. If the resident continues to refuse to eat what is offered, it will be noted on the intake sheet and anyone who has had a poor intake will be offered a snack later when the resident maybe more willing to accept the offered food. The charge nurse will be made aware whenever a resident refuses to eat or has minimal intake. If a pattern of refusal is found on the intake sheet, the resident will be reviewed by the Skin, Weight, Hydration Committee as to a need for a supplement to be offered or additional nutrients added to the foods of the resident's preference. The resident's physician and legal representative will be notified and follow-up action will be taken as needed. The resident's care plan will be revised to reflect the current plan of care. 4) The DON, ADON and CDM will monitor at least 3 meals weekly to see that foods are offered according to the menu and that assistance is provided to the resident in an appropriate manner. This will be monitored for compliance weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion Date is: 11/22/05**	

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F 311	Continued From page 46 regular diet. The resident was observed to gaze around the dining room but only take a few bites of food. No staff was observed to approach the resident and encourage or cue him/her to eat the meal. The resident ate less than 25 % of the meal.	F 311		
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 record review, observation and staff interview, it was determined that the facility failed to provide care planned treatment and services to increase or maintain range of motion (ROM) for six of ten sample residents (#1, #2, #4, #5, #7 and #8). The findings included: 1. On 10/19/05 at 8:42 AM, in an interview with the restorative aide (RA), she indicated that the facility has three levels of rehabilitation. She revealed that these levels are therapy, restorative nursing by an RA, and maintenance provided by the nurse aides (NAs). The RA stated that there are 18 residents receiving restorative care. This RA revealed that the residents are scheduled to receive restorative three to six times a week. She said that she could get all of the residents done, but was not providing services daily to each of the 18 residents. The RA was requested to provide a list	F 318		

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F 318	Continued From page 47 of residents who received restorative nursing. The RA verified that she is currently the only staff member providing restorative services. She stated that she is scheduled to work Wednesday through Sunday from 6:00 AM to 10:00 AM or 11:00 AM. She indicated that she has been the only RA providing restorative since she started working as an RA about four or five months ago. She confirmed that the previous RA also worked alone. Note: The RA verified that there is not a restorative dining program. Since the residents eat breakfast at 7:30 AM, no restorative services are provided for approximately an hour. This resulted in the RA having three to four hours a day, five days a week, to provide restorative services to the residents. The RA revealed that she has a restorative book to chart in. She said that the maintenance program is charted by the CNAs (Certified Nurse Aides) on the CNA flow sheets. 2. Record review revealed that sample resident #1 had diagnoses which included fractured hip, fractured pubis, fractured acetabulum, diabetes, difficulty in walking, convulsions, and osteoporosis. Review of the resident's 8/18/05 significant change Minimum Data Set (MDS) assessment revealed that the resident required limited assistance with bed mobility, transfer, locomotion off the unit, dressing, toilet use, personal hygiene, and bathing and extensive assistance with walking in and out of his/her room. Record review evidenced that the resident was referred from physical therapy to restorative on	F 318		

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F 318	Continued From page 48 8/31/05. The goal was independent ambulation with front wheel walker for all mobility needs three to six times a week. An additional restorative referral, dated 10/7/05, added a goal of pain-free with all ADLs (activities of daily living) and included sit to stand, pelvic tilt, and single knee to chest exercises three to six times a week. Review of the list of residents receiving restorative services and/or maintenance services revealed that the resident was care planned to receive restorative services provided by the RA and maintenance services by the CNAs. Review of the resident's "Restorative Nursing Daily Documentation' forms for 10/05 revealed the following Goals: Independent ambulation with front wheeled walker for all mobility needs - ambulate 40 to 60 feet to tolerance and up to 150 feet two to three times a day and independent ambulation with front wheeled walker; pain free with all ADLs in low back (started on 10/7/05). Services were documented as provided three to four times a week. Review of the resident's "Maintenance Restorative Nursing Documentation" forms for 10/05 revealed the following: Goals: Ambulate to and from meals from room with front wheeled walker (three meals a day); help prevent limitation of ROM and AMB (ambulation) - ambulate from whirlpool to chartroom (once on days and once on evenings); and ambulate to and from bathroom (days, evening, and noc).	F 318		

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F 318	Continued From page 49 Services were documented as provided as follows: Ambulate to meals: None charted 10/1 through 10/9/05 and 10/16/05 (except ambulate from dinner). Ambulate whirlpool to chartroom: None charted on days on 10/1/05, 10/2/05, 10/4 through 10/9/05, and 10/16/05; None charted on evenings 10/1 through 10/3/05 and 10/7 through 10/19/05. Ambulate to bathroom: None charted on days on 10/1/05, 10/2/05, and 10/6 through 10/9/05; none charted on evenings 10/1 through 10/3/05, 10/6 through 10/9/05, and 10/12 through 10/14/05; and none charted on noc (nights) 10/1 through 10/3/05, 10/5 through 10/14/05, 10/16/05, 10/18/05, and 10/19/05. On 10/20/05 at 7:43 AM, in an interview with the Director of Nursing (DON), she stated that the maintenance care (as provided by the CNAs) is to be done daily. She verified that the documentation was not being done to show that the CNAs were providing these services. 3. Record review for sample resident #8 revealed diagnoses that included dysphasia, gastric reflux, and, osteoarthritis. Review of the resident's 10/13/05 annual MDS assessment revealed that the resident required limited assistance with personal hygiene and extensive assistance with transfer, toilet use, and bathing. The resident was coded as independent with bed mobility, locomotion on and off the unit, and eating. Review of the list of residents receiving restorative services and/or maintenance services revealed that the resident was care planned to	F 318		

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F 318	Continued From page 50 receive maintenance services by the CNAs. The goal of the maintenance services was "help prevent limitation in ROM" with the approaches listed as "when dressing B (bilateral) shoulder flexion x 3 rep(repetitions) and knee to chest B (bilateral) legs x 3 rep." Review of the resident's "Maintenance Restorative Nursing Documentation" forms evidenced the following: 3/05: none charted for seven of 31 days. 4/05: none charted for nine of 30 days. 6/05: no form provided to surveyor. 7/05: none charted for 20 of 31 days. 8/05: none charted for 25 of 31 days. 9/05: none charted for 17 of 30 days. 10/05: none charted for 9 of 19 days. On 10/20/05 at 7:43 AM, in an interview with the DON, she stated that the maintenance care (as provided by the CNAs) is to be done daily. She verified that the documentation was not being done to show that the CNAs were providing these services. 4. Record review for sample resident #2 revealed the resident was admitted to the facility on 9/28/99. The resident's diagnoses included: MVA (motor vehicle accident) with traumatic brain injury, severe spasticity, joint contractures and aphasia. a. Review of physician progress notes included: 7/13/05 which identified the resident in a "persistent vegetative state", 10/16/05 "Resident unable to communicate with nursing staff. ....A lot of flexion contractures on	F 318		

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F 318	Continued From page 51 the wrist and contractures of the lower extremities..." b. Review of the physical therapy screen dated 1/7/05 identified the resident as having full loss of voluntary function with partial loss of PROM (passive range of motion) neck, arms, hands and feet. c. Review of the MDS (minimum data set) dated 9/26/05 identified the resident as being totally dependent on staff for all cares. d. Review of the resident's "Maintenance Restorative Nursing Documentation" forms for 9/05 revealed the following: "Restorative Nursing Goal -help prevent limitation of ROM; 1) ROM neck and arms, 2) ROM Feet (NOC)(nights] 3) Cones in hands NOC." An added note which was dated 9/1/05 stated, "Dc'd foot ROM until trained by RNA". There were three entries as care provided for ROM for neck and no documentation for ROM for feet or use of cones in the resident's hand contractures. The level three "Maintenance Restorative Nursing" program which was reportedly provided daily was not documented as being provided for this high risk resident. Review of the "Maintenance Restorative Nursing Documentation" sheet for August 2005, July 2005, June 2005 and May 2005 also showed that the program was not being provided as planned to meet this resident s needs. e. Observation on 10/18/05 at 5:20 PM two Staff	F 318		

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F 318	Continued From page 52 (CNAs) entered the resident's room to provide cares. The two staff supported the resident's torso during the turns but due to the resident's severe contractures and rigidity the resident's legs and feet were not protected or properly supported when turning. Staff reported, "[resident] is a difficult 2 person turn and 3 people is better but it's hard to get three staff to turn all the time..." The resident did not have positioning pillows or hand cones in place. f. Observation on 10/19/05 at 11:20 AM two Staff entered the resident's room to provide peri care. Staff reported, The positioning pillows, dog bone shaped pillows, were supposed to be used between knees, bend of arm contractures and by the feet when in bed. It's supposed to keep skin from rubbing together ". Staff reported that the resident's hand cones were missing and night shift reported follow up was needed to find the hand splints. Rolled wash clothes were placed in the resident's hands. The positioning pillows had not been used the previous day. 5. Record review of sample resident #5's medical record revealed the resident had been admitted to the facility on 3/2/01 with diagnoses that included cardiovascular accident (stroke), renal failure, reactive psychosis and dementia. The resident's current quarterly Minimum Data Set (MDS) assessment dated 10/9/05 indicated the resident had long/short term memory loss and severely impaired decision making skills. The MDS also indicated the resident needed extensive to total assistance with bed mobility, transfers, dressing and toileting. a. Review of the Restorative Referral dated 1/12/05 indicated the resident was to have a restorative treatment program 3-5 times per	F 318	F-318 RANGE OF MOTION It is the practice of this facility to ensure that the comprehensive assessment of 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. Refer to Wyoming Health Department Survey F353.	

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F 318	Continued From page 53 week. There is no documentation to show that the provision of exercises at the lower range of 3 times a week was based on patient need verses staffing availability. b. In an interview with the Director of Nursing on 10/20/05 at 7:45 AM, she indicated that the resident received restorative services 5 times a week only when restorative staff was available. c. Review of the Maintenance Restorative Nursing Documentation for August 2005 showed the resident went from 8/7/05 to 8/13/05, 8/13 /05 to 8/19/05 and 8/21/05 to 8/27/05 without any documentation of range of motion (ROM) exercises. This documentation shows a range of only 1 to 2 times a week. d. Review of the September 2005 Maintenance Restorative Nursing Documentation showed the resident received ROM exercises only one time from 9/7/05 to 9/17/05. The 9/05 Maintenance Restorative Nursing Documentation for ambulation indicated no assistance from 9/2/05 to 9/13/05. e. Review of the September 2005 Maintenance Restorative Nursing Documentation showed the resident received ROM exercises only one time from 9/7/05 to 9/17/05. The 9/05 Maintenance Restorative Nursing Documentation for ambulation indicated no assistance from 9/2/05 to 9/13/05. 6. Record review of sample resident #4's medical record revealed the resident had been readmitted to the facility on 12/11/03 with diagnoses that included spinal stenosis, duodenal ulcer, anemia, depression, hypertension, and affective psychosis.	F 318	1-A licensed nurse now directly oversees the restorative program. She and the physical therapist will be instructing the restorative aides on the process and expectation of the Level 2 program on 11/30/05. The licensed nurse and physical therapist do in servicing with the CNA staff on the functions of the Level 3 program. She will also be doing some of the restorative functions while demonstrating to the staff. Evaluation of the residents needs for the different levels of restorative will be done. The nurse will also audit "Restorative Nursing Daily Documentation" for completeness and that the program plans is being followed. Resident #1 only ambulates with her walker independently in her room, for bathing or to bathroom and though documentation did not reflect this ambulation the resident was performing this function with the CNA's. The CNA's have been in-serviced on documentation. This is also included on the daily assignment sheets. Resident # 8's Range of Motion is being provided and staff has been and again will be in-serviced on doing documentation. Resident # 2 night nurse and staff have been trained on doing ROM and placement of hand cones. Hand cones are available and are being placed in resident's hands. Pillow will be used for positioning as care planned. Resident # 5 Therapy referral has provided specific perimeters for frequency. Staff has been in-serviced on the appropriate documentation. She is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318	Continued From page 54 a. Two physician telephone orders dated 8/3/05 indicated that physical therapy and occupational therapy services were discontinued and the resident was placed on a restorative program 3-6 times a week. There is no documentation to show that the provision of exercises at the lower range of 3 times a week verses the more frequent range of 6 times a week was based on patient need verses staffing availability. b. Review of the Maintenance Restorative Nursing Documentation for August 2005 revealed the resident received ambulation from the RA staff eight times in entire month of August (8/1/05, 8/6/05, 8/7/05, 8/13/05, 8/14/05, 8/27/05, 8/28/05 and 8/31/05). The restorative documentation shows that knee braces were applied on 8/1/05, 8/6/05, 8/7/05, 8/13/05, 8/14/05, 8/19/05, 8/21/05, 8/27/05, and 8/31/05). The form indicated the knee brace was to be on days. 7. Review of the medical record for sample resident #7 revealed the resident was admitted to the facility in November 1984. The resident's current diagnoses included pruritis, dysphasia, osteoporosis, seizure disorder and organic brain syndrome. a. A physician telephone order dated 9/16/05 indicated that physical therapy (PT) services were discontinued and the resident was placed on a restorative program 3-6 times a week. There was no documentation to show that the provision of exercises at the lower range of 3 times a week verses the more frequent range of 6 times a week was based on patient need verses staffing availability.	F 318	ambulated to and from the bathroom on the Restorative Maintenance program. Resident # 4 has had a specific time set in referral from therapy for frequency of restorative Resident is to ambulate to and from meals and to have knee braces on when ambulating. Resident is not able to ambulate without braces. Staff was in serviced on 11/30/05 regarding documentation requirements Resident # 7 Therapy has provided specific frequency of ROM by Maintenance Restorative Staff. Nursing staff has been in serviced on doing the documentation as indicated. 2) The restorative programs currently ordered have been reviewed to assure programs have been done as instructed and documentation completed. 3) Nursing staff was in-serviced on the restorative programs documentation requirements by the MDS coordinator and designated RN. 4) This will be monitored by the restorative nurse and the Director of Nurses weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion Date is: 11/22/05**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 318	Continued From page 55 b. Review of the Maintenance Restorative Nursing Documentation for September 2005 revealed the resident only received ROM exercises from the restorative staff twice (on 9/23/05 and 9/25/05) during the first week after the PT services were discontinued.	F 318		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This Requirement is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to ensure that the environment was as free of accident hazards as possible. The findings included: 1. On 10/18/05 at 9:29 AM, during the initial tour of the kitchen with the Certified Dietary Manager (CDM) present, it was observed that the unlocked storage area under the handwashing sink contained bleach (gallon bottle), Whistle degreaser (spray bottle), oven cleaner (two spray cans), Greasestrip Plus, WD-40, Stainless Steel cleaner (three cans), and Windshield Wash (one gallon). The handwashing sink was located next to the door which opened into the hallway through which the residents entered the dining room. This door was observed to be open when staff were not present in the kitchen area. On 10/19/05 at 7:23 AM, observation revealed that the chemicals were still in the unlocked cupboard under the sink.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 323	Continued From page 56	F 323		

2. On 10/19/05 at 9:30 AM, observation of the cupboards situated above the counter top at the nurses' station evidenced that the cupboards contained stock medications, intravenous (IV) supplies, needles, and blood draw supplies. The cupboards were locked with magnetic latches that unlocked when another special magnet was placed over the latch. The magnet used to open the cupboards was kept on the refrigerator located below the counter at the nurses' station. This system of storage allowed easy access by anyone.

Additionally, at the nurses' station there was a bottle of nail polish remover in a carrying tray. This tray was placed on the counter.

SIDE RAILS

Reference for Professional Standards of Practice for bed rail-related entrapment deaths/injuries: Bed rail-related entrapment deaths and injuries can occur in the elderly population, who are often at risk due to limited mobility, psychoactive or sedative medications, confusion, sedation, restlessness, lack of muscle control, size and physical deformities. Death by asphyxiation or injuries to the resident's extremities can occur when the resident becomes caught between the mattress and the bed rail; the headboard and the bed rail; or getting his or her head/extremity stuck in the bed rail. Both split and full rails have the potential to cause fall-related injuries as well as entrapment. Additionally fall-related injuries or injuries to extremities can occur when confused/disoriented residents climb over the top of side rails or get an arm or leg entrapped. Placement of air pressure mattresses (either overlay air mattresses placed on top of a regular

F-323
ACCIDENTS

It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 323	Continued From page 57 mattress or beds with built-in air mattresses) alters the space between the mattress and the rail when the mattress compresses as the resident shifts his/her weight on the bed. See FDA Safety Alert: Entrapment Hazards with Hospital Bed Side Rails August 23, 1995 and Joint Commission on Accreditation of Healthcare Organization: Sentinel Event Alert, Issue 27, September 6, 2002. 1. Observation on initial tour of the facility on 10/18/05 at 8:30 AM with Nursing Staff, residents were identified as using side rails for positioning devices. These residents included: a. Resident #17 was resting in bed with a 1/2 (half) side rail up to the open side of the bed. The type of side rail in use was noted to have inherent gaps in the rail itself. Staff confirmed the resident used the rail to assist him/herself in and out of bed. b. Resident #9 had half side rails on the bed which staff reported the resident used to assist with repositioning. c. Resident #1 had a u-shaped half rail on the open side of the bed which staff reported the resident used for positioning. 2. Observation on 10/19/05 from 3:10 PM to 4:40 PM during tour of the environment with maintenance staff and the Administrator the above side rails were checked and reviewed. There were three different types of side rails being used as assistive devices. Resident #17's side rail was checked and measured. There were three inherent gaps within the side rail itself. The two end gaps which measured approximately 8 inches wide and 8 inches in length and a center	F 323	1 - Chemicals will be locked under hand sink in kitchen, and in service of dietary staff to keep chemicals locked. Lock will be installed on cabinet. Certified dietary manager will monitor this. This will be completed by 11/14/05 Nail polish remover and other unsafe materials has been removed from the nurses' station and stored in a secured area. The key for blood draw supplies has been placed on the nurses' key ring. SIDE RAILS Side rails have been removed from all beds where there is no order for use. New grab bars have been ordered, received and replaced on the beds were the facility determined need for replacement. Resident #17 was re-evaluated by the therapist and a trapeze was placed on the bed and the side rails removed. 1-b-Resident #9 was assessed for safety with the side rail and the space between rails and between the rails and mattress were found to be under 5 inches so the resident to be unable to get wedged between the rail or mattress. Resident # 1 was assessed for safety with the side rail and the space between rails would not allow the residents head to fit between the rails. Resident #17 the rails were replaced with a trapeze after determined by the physical therapist. Resident # 8 requested side rails for his bed, to provide added protection bolsters are placed along the rails when the resident is in bed. Resident #19 rails have been removed.	

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	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 323	Continued From page 58 gap 8 inches wide and approximately 12 inches down to the mattress and 17 and a 1/2 inches down to the bed frame. These openings were large enough to pose risks for potential resident entrapment. a. The Administrator reported that a restraint review form is completed when using restraints and assistive devices including side rails. However the form does not assess the safety of the devices being used or assessment of the bed and mattress with the devices used. He reported that the side rails and other assistive devices would be looked at in regards to resident safety. b. The Maintenance staff reported that resident #17 had the only side rail of that type. c. Review of the 'Chemical/Physical Restraint Appropriate Review Form" for Residents #17, #9, and #1 did not address assessment for safety with the devices currently in use. 3. Observations of residents' beds on 10/20/05 at 10:30 AM revealed the following residents had side rails attached to their beds: Sample resident #8 had two full side rails Supplemental resident #19 had two half rails Supplemental resident #20 had two U-shaped half rails Supplemental resident #21 had two half rails Supplemental resident #22 had two U-shaped half rails Supplemental resident #23 had two U-shaped half rails Sample resident #6 had two U-shaped half rails There was no individualized evaluation of the	F 323	Resident # 20's rails are in place for Positioning. Resident # 21 has a trapeze and one half rail for positioning. Resident #22 has discharged. Resident # 23 no longer has rails. Resident # 6 the rails have been locked in place, the resident has a boat mattress and the resident has a high/low bed. 2) All side rails in use have been identified and corrective action taken as indicated 3) The safety committee has been in-serviced on 11/15/05 with regards to the requirements of the assessment and documentation for any side rail. The entire facility staff will be in serviced on December 7, 2005 on the need to be aware of the hazards posed by unsafe side rails. A Measure to Prevent Accident in service has been done to address hazards that might be found such as nail polish remover, chemical storage, disposal of needles and the MSDS sheets for chemicals reviewed as well as policy on storage of chemicals and disposal of needles. Safety awareness to include measures to prevent accidents will be included in the general orientation of new and temporary staff. 4) This is to be monitored by the DON and NHA for compliance weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. Completion date is: 12/07/05	

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F 323	Continued From page 59 safety of these rails for the respective residents who were using them i.e. measurement of gaps to ensure no entrapment risk.	F 323		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to supervise and provide adequate assistance to four of ten sample residents (#2, #6, #7, and #5) in order to prvent accidents. The findings included: 1. Record review for sample resident #2 revealed the resident was admitted to the facility on 9/28/99. The resident's diagnoses included: MVA (motor vehicle accident) with traumatic brain injury, severe spasticity, joint contractures and aphasia. a. Review of physician progress notes included: 7/13/05 which identified the resident to be in a "persistent vegetative state", 10/18/05 "Resident unable to communicate with nursing staff. ....A lot of flexion contractures on the wrist and contractures of the lower extremities..." b. Review of the physical therapy screen dated 1/7/05 identified the resident as having full loss of voluntary function with partial loss of PROM	F 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 324	Continued From page 60 (passive range of motion) neck, arms, hands and feet. c. Review of the MDS (minimum data set) dated 9/26/05 identified the resident as having two stage I (one) and one stage II (two) pressure sores and being totally dependent on staff for all cares. d. Review of the "Care Plan Conference Summary" sheet dated 7/7/05 evidenced a note written in the "Summary of Care Plan conference Discussion" section stated, "[Resident] has sores on [his/her] feet and [his/ her] [parent] would like to know why [he/she] has these sores." The area on the back of the sheet under section marked "Risks/Consequences" stated, "Sores on feet R/T [related to] rolling [resident name] in bed." There was no documentation of actions or interventions taken to prevent further sores or injury to the resident's feet. e. Review of a "Fax cover sheet" to the physician dated 7/22/05 stated, "[resident] bilateral feet scabs, monitor, lotion, healing." f. Observation on 10/18/05 at 1:25 PM staff entered the resident room to do cares. A three person, total lift was done to transfer the resident from the wheelchair to the bed. The resident's socks were removed which revealed two small scabs on the top of the right foot and a scab over the top of the left foot. Staff (CNA) reported the scabs on the resident's feet were from the bed. The staff stated, "I know they were looking at how to pad the bed but we haven't seen anything yet". Note: The resident was on a Clintron (fluidized therapy bed). The bed has a elongated oval ridge frame which holds air fluidized beads used to accelerate healing of wounds and skin disorders.	F 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 324	Continued From page 61	F 324		

g. Observation on 10/18/05 at 5:20 PM two Staff (CNAs) entered the resident's room to provide cares. The resident was in bed and had been incontinent of urine and feces. Staff rolled the resident from side to side multiple times in an attempt to provide peri care and change the brief and sheet under the resident. While the resident was being turned the resident's feet were observed to hit against the top edge of the bed. During a turn to the resident's left side a scab was bumped off the resident's left foot with blood observed on the wound and on the sheets. The two staff supported the resident's torso during the turn but due to the resident's severe contractures and rigidity the resident's legs and feet were not protected or properly supported when turning. Staff reported, "[resident] is a difficult two person turn and three people is better but it's hard to get three staff to turn all the time. I'll tell the nurse about his/her foot."

h. Observation on 10/19/05 at 11:20 AM two Staff entered the resident's room to provide peri care. The resident was turned from side to side with the resident's feet hitting the hard edge of the specialized bed. Staff reported positioning pillows, "dog bone shaped pillow", were supposed to be used between knees, between the bend of the arms and by the feet. However the positioning pillows were not in use and had not been used the previous day.

i. Review of the monthly "Incident/Accident" reports from June 2005 to October 2005 with the last entry being on 10/11/05 revealed no documentation of incidents for this resident.

There was no documentation provided at the time of survey to show the facility had addressed the

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F 324	Continued From page 62 resident's ongoing issues of injuries and scabs on the feet. The family brought concerns to the facility in the care plan meeting on 7/7/05. The note written in the "Summary of Care Plan conference Discussion" stated, [Resident] has sores on [his/her] feet and [his/ her] [parent] would like to know why [he/she] has these sores." The same type of injury was observed 10/18/05 during survey. This showed ongoing issues for the past 3 months without evidence of interventions or implementation of interventions to prevent further resident injury. 2. Resident #6 medical record review revealed the resident was admitted to the facility 3/10/04 with diagnosis including; dementia with behaviors, hypertension, atherosclerotic heart disease, osteoarthritis, renal and ureteral disease and insomnia. a. Review of the MDS dated 8/17/05 identified the resident as having a significant change in condition. The areas identified as decline included: cognitive skills from modified independence to moderately impaired, transfer from needing supervision to extensive assistance, Change in ADL (activities of daily living) function marked as (2) deteriorated, weight loss, falls and increase in pain. A note on the review summary with the assessment stated, "significant decline since recent Fx (fracture) clavicle related to fall". b. Review of "Radiology Reports" showed repeated falls which included: 5/12/05 "Fall this AM left shoulder pain. No acute fracture or dislocation of the left shoulder are noted, Moderate to marked osteoarthritis, left shoulder."	F 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 324	Continued From page 63 6/02/05 1)"Fall 5/27/05, left shoulder pain. There are severe degenerative changes of the left shoulder with superior subluxation of the humeral head consistent with a chronic supraspinatus tendon tear. A fracture has developed through the distal shaft head of the clavicle." 2) Hip pain "There is a left total hip prothesis with no alteration in position or alignment...Mild degenerative changes of the right hip remain stable..." 7/18/05 "left shoulder pain s/p (status post) fall this AM. There is an oblique fracture through the lateral shaft of the clavicle without displacement or angulation... Shoulder impingement syndrome. Severe degenerative joint disease glenohumeral joint..." 7/20/05 "Hip pain s/p new fall this AM...stable left hip prostnesis with no evidence of complication..." c. Review of notes on "Chemical & Physical Restraint Program Note" identified the resident having recurring falls. The note included: 5/25/05 "Post fall on 5/25/05 at 0400 (4:00 AM). Resident was found on floor lying on left side. Urine on the floor. Apparently slipped in urine. Assessment shows no sign of injury. reassessment 0450 (4:50 AM) showed bump on (his / her) head..." 5/5/05 "post fall on 5/31/05 at 0420 (4:20 AM). Resident bed alarm going off by the time staff reached (him / her) was found sitting on the floor on buttocks in the hallway. Denies pain..." 6/13/05 "post fall on 6/11/05 at 14:15 (2:15 PM) found sitting on th e floor in bathroom with urine on the floor. Started on new meds 6/9/05	F 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 324	Continued From page 64 Risperdal was [sign for increased], Xanax 0.25 mg TID (three times a day) and Vicodin 1 (one) PRN (as needed)..." 6/13/05 "Chem review; remains on Celexa 20 mg and Namenda 10 mg BID (twice a day), started on Restoril q (every) HS (bedtime) PRN on 5/24/05 and Do'd 5/27/05. Started on Risperdal 0.5 mg Q HS on 5/27/05 which has changed to Risperdal 1 mg at HS and Risperdal 0.5 mg in AM and Xanax 0.25 mg TID. Xanax order was changed to PRN on 6/13/05 due to resident lethargy..." 6/20/05 "post fall at 0500 (5:00 AM). Stood up and tried to walk fell to the floor landing on L (left) side. No c/o (complaint of) pain ROM (range of motion) WNL (within normal limits) L arm remains in sling and figure 8 brace..." d. Review of the "Interdisciplinary Resident Screen and Referral" sheets identified recurring falls which included: 6/29/05 "recent fall-Pt (patient) had urine on (him/her) when fell. Recommend q (every) 2 hour toileting [sign for secondary] falls involve pt. being wet often..." 8/2/05 "recent fall- Pt. found in bathroom on floor at 3:30 AM- motion monitor not attached. Last fall also involved toileting and occurred at 4 AM... Suggest toileting pt. at 3 AM in morning -w/c (wheelchair) seat alarm and motion monitor." There was no evidence of the resident being put on a toileting schedule to address his/her needs with repeated falls involving the resident being wet or trying to toilet self. There was documentation of reassessing the resident to see if the resident had removed the alarm, if motion	F 324	F-324 ACCIDENTS Alternatively, due to the requirements of Federal Law and without prejudice to the facility's request for informal review as to the validity of this deficiency, the facility submits the following plan of correction. 1) Resident #2 positioning needs were reassessed by the physical therapist on	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 324	Continued From page 65 monitor was an effective approach for this resident or if staff failed to attach the alarm. e. Review of the resident's plan of care which was dated 6/29/05 (onset) with target date 12/05. This was after the resident had a fall which resulted in a fractured clavicle. It listed a problem for falls R/T (related to) use of psychoactive medications and continuous wandering. [Resident] takes antidepressants daily and antianxiety PRN. The goal was -will remain free of fall every day. The approaches included: "1) keep environment free of clutter/obstructions everyday, 2) keep frequently used items within [resident's] reach, 3) anticipate [resident's] needs daily, 5) medicate as ordered notify physician of any change in behavior / mental status, 6) monitor condition of shoes, have repaired/replaced as needed, 8) encourage to take rest periods, 9) Keep room free from clutter". The care plan then had some of the resident's falls added under the problem for falls dated 6/28/05, 7/5/05, 7/18/05, 7/20/05, 8/2/05 and 8/12/05. The written in approaches were motion monitor, bed alarm, PT (physical therapy) to screen after falls 10) scheduled toileting q (every) 2-4 hours round the clock, boat mattress and self releasing seat belt. These additional approaches were not dated to show timeliness of these interventions or changes in approaches when interventions were not effective. However an "Interdisciplinary Progress Note" showed the motion alarm was not applied until 7/25/05 and the boat mattress on 7/29/05 after the resident fractured his/her clavicle. f. The resident was observed during survey on	F 324	11/20/05. The nursing staff was instructed on the repositioning techniques, application of protective boots, and positioning devices to use when resident #2 is turned from side to side in bed. The resident's care plan was reviewed/revised as indicated to reflect the current plan of care with the residents' legal representative. The nurses were instructed to complete an incident report in the event the resident sustains any signs of injury. The CNA's assignment sheets indicate the information for positioning of resident# 2. New nursing employees and temporary agency staff will be oriented to resident #2's special positioning needs as well as any other resident's special positioning and transfer needs during orientation The clinical safety team reviewed resident #6's history of falls and current interventions. The resident 's fall risk care plan was reviewed/revised as indicated to reflect the current plan of care. Resident # 6 has been assessed for timely toileting needs and placed on his schedule. The nursing staff has been instructed on the resident's toileting schedule and needs. New nursing staff and temporary agency staff will be oriented to resident #6's toileting schedule as well as other residents' specific toileting needs. Resident # 6 toileting times are placed on the CNA's assignment sheet and is stated that there should be toileting every 2 hours during the day and check and change on rounds NOC The CNA's were instructed on the proper transfer techniques for resident #5 and #7.	

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F 324	Continued From page 66 10/18/05 at 12:40 PM seated in a wheelchair in the hallway by room with chair alarm on and the seat belt not attached. g. Review of the "Incident/Accident Monthly Tracking Log" for the past 6 months from May 2005 to October 2005 revealed resident #6 had recurrent incidents. The incidents included the following: May 2005 3 falls, 5/12/05- 11:00 AM "location other-fall w/o (without) inj (injury)", 5/25/05- 4:00 AM "location res rm (resident room) -fall w/o inj", 5/31/05-4:20 AM "location hall-fall w/o inj", The fall log does not identify the fall which resulted in the left clavicle fracture. June 2005 3 falls, 6/11/05-14:15 (2:15 PM) "location - bath room - skin tear ", 6/16/05- 05:00 (AM) "location - hall -fall w/o inj", 6/28/05- 08:30 (AM) "location res rm fall w/o inj", July 2005 4 falls and one other incident identified, 7/5/05-09:45 (AM) "location T.V. room-fall w/o inj", 7/18/05-06:15 (AM) "location T.V. room-fall w (with) inj", 7/20/05-11:25 (AM)- "location T.V. room-fall w (with) inj, sent for x-rays", 7/24/05-04:00 (AM) "location res rm fall w/o inj", 7/30/05-03:30 (AM) "location bath room- other (abrasion). August 2005 1 fall, 8/11/05- 09:50 (AM) "location - hall -fall w/o inj", September 2005 1 fall,	F 324	The CNA assignment records were reviewed to assure the transfer needs for the resident #5 and #7 are current. Resident #5 and #7's ADL deficit care plans were reviewed to assure the assistance required for transfers are current. 2) The clinical safety team has identified all residents who require specific positioning devices when they are repositioned in bed. The care plans were reviewed/revised if indicated to reflect the current plan of care. Prior to the survey and ongoing, all residents are assessed for their risks for falls upon admission, with significant change of condition, at least quarterly. An audit was conducted by the clinical safety team to identify all residents who have had a fall or injury during the past quarter. Their care plans were reviewed/amended if indicated to reflect the current plan of care to prevent falls and or injury. The transfer needs for all residents have been reviewed to assure the specific needs are reflected on the care plan and the CNA assignment sheets. 3) The clinical safety team has reviewed the facilities fall prevention and management guidelines. On 11/01/05, the staff was in serviced on the fall prevention and management guidelines. On 11/15/05, the nursing staff was in serviced on the plan of care when repositioning residents #2. Beginning 11/01/05, the CNA's completed competencies on transfer techniques and repositioning a dependent resident that is severely contracted.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 324	Continued From page 57 9/8/05- 07:30 (AM) "location res rm (resident room)-fall w/o inj", October 2005 had one incident list as resident to resident event. This tracking log did not show the actions or interventions taken in an attempt to prevent incidents from reoccurring with 9 falls logged after the resident fell and had a fracture. Interview with the Administrator on 10/19/05 at 8:30 AM reported that falls had been an issue and a falls committee was started the end of July. The committee was looking at resident which have repeated falls. The interventions and actions for those residents were reviewed through the QA (quality assurance) committee. No information was provided at the time of survey to show how the fall committee was addressing resident #6 having repeated falls with injury. TRANSFER TECHNIQUES 1. In an observation on 10/18/05 at 4:10 PM of CNA #4 during a transfer of resident #7 from the chair to the bed the CNA told the resident to "give me a hug" and directed the resident to place her/his arms around the CNA's neck during the transfer. Transferring a resident in this manner place both the resident and the staff member at risk for injury. 2. In an observation on 10/18/05 at 1:30 PM CNA #1 during a transfer of resident #5 from the chair to the bed the CNA told the resident to "give me a hug" and directed the resident to place her/his arms around the CNA's neck during the transfer. Transferring a resident in this manner place both the resident and the staff member at risk for injury.	F 324	The physical therapist has done in-services with nursing staff and CNA's on transfer techniques and plans to do an all staff in service on 12/22/05. For special resident needs, staff is trained with that resident on the transfer techniques to be used, including resident #5 and resident #7. As part of the new staff orientation, the physical therapist reviews transfer techniques. Pool/agency staff will be shown by the facility staff member they are teamed with the transfer techniques to meet the individual resident needs. The CNA's assignment sheets will reflect each resident's transfer technique needs. A list of residents requiring a mechanical lift is reflected on the C.N.A assignment record as well as posted at the nurse's station. The clinical safety committee will review the status and investigate the cause of all falls and injuries within 48 hours after the incident/accident. The resident's care plan will be reviewed and revised to reflect the current plan of care. 4) The Director of Nurses or designee will monitor compliance utilizing a fall/injury-monitoring tool, which includes all steps of the post fall or injury procedure. Trends will be analyzed and corrective action will be discussed at the monthly safety committee and at least quarterly at the facility's quality assessment and assurance committee meeting. **Completion Date is: 11/30/05**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 324	Continued From page 68 Reference for Professional Standards of Practice in lifting/transfer techniques: Fundamentals of Nursing, Concepts, Process, and Practice, Potter and Perry, Mosby, 1997, Chapter 37 "Mobility and Immobility": the nurse is at risk for injury to lumbar muscles when lifting, transferring or positioning the immobilized resident. The procedure for transferring residents from the bed to a chair does not include requesting the resident to place his/her arms around the nurse or to "hug" the nurse as this can contribute to neck/back injuries.	F 324		
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This Requirement is not met as evidenced by: Based on medical record review and staff interview it was determined that the facility failed to timely assess and provide interventions to maintain acceptable parameters of nutritional status for 1 of 10 sample residents (# 1). The findings included: Record review for sample resident #1 revealed diagnoses that included diabetes, fracture hip, angina, convulsions, spina, stenosis, and coronary artery disease. Review of the resident's 8/30/05 Registered Dietitian (RD)'s Interdisciplinary Progress Notes (IPN) evidenced that "Current wt. (weight) is 138	F 325		

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

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F 325	Continued From page 69 # (pounds). 11.0 % weight decrease past mo. (month) Significant wt change....RD recommends NCS (No Concentrated Sweets) meal fortification. Offer routine snacks." Review of the resident's 10/11/05 RD's IPN revealed that the resident's "current wt. is 139 #; IBWR (Ideal Body Weight Range) is 109 - 133 #. 12 % wt loss past 3 mo. (months) of 158 #. Significant wt loss. RD recommends sugar free healthshake PRN (as needed) to slow significant wt loss. Continue NCS diet." Review of the resident's 10/13/05 Wt Mtg (meeting) IPN notes evidenced "14 lb (pound) wt down in 90 days R/T (related to) probable weight error and possible decrease in appetite." Review of the resident's tray card evidenced that the resident was receiving a NCS diet with no added salt and nectar-thick liquids. No supplements were listed on the card. Review of the resident's October, 2005 Medication and Treatment records revealed that no supplements had been charted for the resident. Review of the resident's weekly weight summary (August, September, and October) revealed the following weights (in pounds): Previous weight: 158 August - 1st week: 157 August - 2nd week: 140 (with '39 crossed through) August - 3rd week: 136 August - 4 th week: 138 September - 1st week: 144 (x 2) September - 2nd week: 134	F 325	F-325 NUTRITION It is the practice of this facility to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. The facility has acquired a new scale for more accurate weights. The skin, weight, and hydration committee will review everyone with a weight loss of 5% in a month, 7.5% in a quarter or 10% in 6 month to be certain that supplements are offered to the residents with weight loss or to use other supplements to stabilize weights.	

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F 325	Continued From page 70 September - 3rd week: 140 crossed through September - 4 th week: none October - 1 st week: 140 October - 2 nd week: 139 October - 3 rd week: 141. On 10/20/05 at 7:32 AM, in an interview with the Director of Nursing (DON) and the nurse consultant, the DON stated that if resident's weight varies more than five pounds from the previous weight, the resident is re-weighed. She stated that there was a problem with the scale about six weeks ago. Based on the DON's comments, a review of the weekly weight summary for August, September, and October for 22 of the facility's residents revealed that only two residents (including resident #1) had documented weight loss of greater than five pounds from the 1 st to the 2 nd week of August. All of the 22 residents' weights were crossed through for the 3 rd week of September and no weights were recorded for the 4 th week of September. The facility failed to ensure that this resident who had significant weight loss was accurately assessed in order to plan and implement nutritional interventions. There was no documentation to indicate that the RD's recommendations were implemented. Snacks/supplements were not recorded for this resident.	F 325	1- Resident # 1 is within her ideal body weight and the plan is to maintain that weight. Resident will be weighed weekly to assure weight remains stable. Snacks are being recorded and any supplements given. Goal is to maintain weight. RD will evaluate any resident with a significant weight variance. 2) DM has reviewed the weight statutes of all the residents. The team evaluates all residents who have a weight variance weekly and corrective action is taken if needed 3) Training on the weight management guidelines will be done on 11/22/05 with nursing staff. 4) This is to be monitored by the CDM and RD or designee weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion Date is: 11/30/05**	
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		

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

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F 329	Continued From page 71 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to accurately monitor behaviors and side effects, to document adequate indications for drug use, and to ensure hypnotics were not given in excessive duration for one of ten sample residents (#4) and one supplemental resident (#17). The findings included: 1. Record review of sample resident #4's medical record revealed the resident had been readmitted to the facility on 12/11/03 with diagnoses that included spinal stenosis, duodenal ulcer, anemia, depression, hypertension, and affective psychosis. a. Review of the resident's current physician orders revealed an order for Temazepam (Restoril, a hypnotic) 15mg at bedtime which was started on 4/26/05. On 9/15/05 the Restoril was changed to PRN (as needed). b. According to drug manufacturer's information Restoril may cause lethargy, drowsiness, daytime sedation, dizziness, irritability, memory impairment and gastrointestinal discomfort. c. Review of Medication Administration Records (MARs) revealed the resident was taking this medication continuously from 7/7/05 through	F 329		

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

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F 329	Continued From page 72 9/15/05. d. Although the night shift nurse documented episodic sleeplessness, review of the resident's medical record showed no evidence that a comprehensive sleep assessment had been conducted to identify his/her sleep pattern/sleep disturbance, history of and possible reasons for any insomnia such as night noise, pain or possible infections. (See F272 for resident specifics regarding lack of a comprehensive sleep assessment). e. The care plan for use of the hypnotic (#8) indicated the hours of the resident's sleep were to be monitored. Review of the Behavior Tracking Forms for September 2005 through October 2005 does not show that the hours of sleep were consistently monitored. September 2005 behavior sheet has no hours of sleep documented on 9/4/05, 9/5/05, from 9/10/05 through 9/19/05, on 9/26/05, 9/28/05, 9/29/05, and 9/30/05. f. Review of MARs for July 2005 revealed the resident received Restoril at bedtime in July 2005 (for 31 days), August 2005 (for 31 days) and from 9/1/05 through 9/13/05 (thirteen days). g. On 9/16/05 the Restoril was changed to PRN (as needed). Review of the physician progress note for 9/16/05 indicated the resident's family felt there was overuse of the Restoril. Although the medication order was changed to PRN, the resident continued to get a daily bedtime dose of Restoril from 9/19/05 through 9/29/05 and from 10/3/05 through 10/18/05. There was no consistent documentation of the reason and effectiveness of giving the PRN medication during this time period.	F 329	F-329 UNNECESSARY DRUGS It is the practice of this facility to ensure that each resident's drug regimen is free of any unnecessary drug used in excessive dose or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of the fore mentioned reasons.	

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F 329	Continued From page 73 The facility failed to ensure resident #4 only received a hypnotic when other possible reasons for insomnia have been ruled out and failed to ensure daily use of the hypnotic was less than 10 continuous days unless an attempt at a gradual dose reduction was unsuccessful. 2. Review of the medical record for supplemental resident #17 revealed the resident was admitted to the facility on 11/1/04 with diagnoses of spinal cord injury, hypertension, schizophrenia and osteoporosis. The resident was started on Temazepam (Restoril) 15mg at bedtime PRN (as needed) on 9/9/05 for insomnia. According to drug manufacturer's information Restoril may cause lethargy, drowsiness, daytime sedation, dizziness, irritability, memory impairment and gastrointestinal discomfort. The resident was also on Risperdal and Paroxetine for schizophrenia. a. Although the night shift nurse documented episodic sleeplessness, review of the resident's medical record showed no evidence that a comprehensive sleep assessment had been conducted to identify his/her sleep pattern/sleep disturbance, history of and possible reasons for any insomnia such as night noise, pain, caffeine, medication side effect, or possible infections. (Cross Reference F272: the facility failed to assess the sleep patterns for the continued use of sedative/hypnotic medications). b. Review of the resident's care plan did not reveal a care plan regarding the resident's insomnia which would include non-pharmacological nursing interventions, managing pain prior to administration of a hypnotic or monitoring of the resident's hours of sleep for effectiveness of interventions. (See	F 329	1) Resident #4 has had a Sleep Assessment completed. Care Plan has been completed to indicate other means of resident achieving sleep without use of hypnotic. Reason for giving the PRN hypnotic will be documented after other means; Sleep medication will only be given to this resident if he continues to have a problem with sleep after resident has been checked for pain, temperature of the room, that the room is dark and quiet, offered food, or a back rub have been unsuccessful. Resident # 17 has had a Sleep Assessment completed. The care plan will be completed for insomnia to use other means for the resident to achieve sleep and only after failure of these efforts will the hypnotic be used as ordered taking into consideration need for short term use. Sleep medication will only be given to this resident if he continues to have a problem with sleep after resident has been checked for pain, temperature of the room, that the room is dark and quiet, offered food, or a back rub until after 10PM. Resident # 17 remains uncooperative with his intake of caffeine and tobacco. 2) All hypnotics have been identified and assessed. Corrective action taken as needed. 3) Nursing Staff has been trained on the sleep assessment P&P and the use of the hypnotic P&P on 11/30/05. The Director of Nurses reviews the MAR's and marks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 74 F279 regarding the facility's failure to develop comprehensive care plans.) c. Although the medication order was for this hypnotic on a PRN basis, the resident received (per Medication Records and Controlled Drug Administration Records) a daily bedtime dose of Restoril from 9/9/05 through 9/27/05 (nineteen days) and from 10/2/05 through 10/18/05 (seventeen days). There was no consistent documentation of the reason and effectiveness of giving the PRN medication during these time periods. Medication records show the Restoril was often given with two Tylenol for pain. d. In an interview with the night nurse on 10/20/05 at 7:30 AM she indicated that the resident received this hypnotic on a nightly basis. The facility failed to ensure resident #17 only received a hypnotic when other possible reasons for insomnia have been ruled out. The facility failed to ensure daily use of the hypnotic was less than 10 continuous days unless an attempt at a gradual dose reduction was unsuccessful.	F 329	out the tenth day for a hypnotic/sedative to ensure at a minimum the medication will not be given in excess of 10 days. The DON or designee also reviews the medication sheets weekly for compliance. The nursing staff is to document the efforts made as an alternative to a sleeping medication and document the outcomes of the alternatives. The pharmacy consultant will monitor monthly the documentation of the use of hypnotics and the alternative measures implemented. The pharmacy consultant will discuss any concerns, with recommendations for corrective action, as indicated, to the Director of Nurses with review during the Quality Assurance Committee meeting. 4) This is to be monitored by the DON and Pharmacy Consultant weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion Date is: 11/30/05**	
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	F 353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

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F 353	Continued From page 75 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 the observations, record review, and resident, family, and staff interviews, it was determined that the facility failed to provide sufficient nursing staff to meet the needs of the residents. The facility had a census of 37 residents. The direct resident care was provided by certified nurse aides (CNAs) with the nurses passing medications and doing treatments. The failures are evidenced by the deficient practices cited in this survey report and residents, family and staff who commented on the shortage of staff to provide range of motion exercises to residents assessed to need these services, to serve the meals in a timely manner, to assist the residents with activities of daily living (ADLs), and to supervise residents. For specific details refer to F241, F309, F311, F318, and F324. The findings included: 1. On 10/18/05 and 10/19/05, during interviews with a family member, he/she stated that the facility had been really short of staff. The family	F 353		

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F 353	Continued From page 76 member stated the resident had not received the two baths a week as scheduled. When the bath scheduled for Wednesday was missed, the resident was not bathed until Saturday. The family member indicated that the resident was to have medication one hour before the meals. He/she commented that due to staffing, the medication was not always given at the time that it should be given and then the resident had difficulty when it was mealtime. The family member said that the staff used to do exercises with the resident but it was not effective, so the family member now does arm exercises. The family member revealed that at night no one (staff) watches the residents. There are wandering residents who go into his/her resident's room and the resident is helpless to protect him/herself from these residents. Review of the resident's record evidenced a letter of complaint, dated 9/29/05, from the family member. The following concerns were identified in this letter: "New help should be trained for more than just one day ..." Baths not given as scheduled. "Severe cuts and bruises on ... hands and arms." Water and snacks placed out of reach. Medications and ointments not given as ordered. Ants and flying ants in resident room. Lack of responsible person - buck passing.	F 353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 77 2. On 10/19/05 at 4:00 PM, in a resident interview, the resident revealed that sometimes staff do not come to assist him/her as fast as he/she would like. The resident said that this was especially true on nights and weekends. The resident stated that at night wandering residents come in his/her room. These residents don't bother anything but may use the floor for the bathroom. According to the resident, staff are busy at night, so they are not available to stop the wanderers. 3. Review of the facility's "Bath Schedules" for October, 2005 evidenced that 24 of the 39 residents listed on the forms lacked documentation to show that they received their baths as frequently as scheduled. The schedule showed that from 10/1/05 through 10/19/05, these 24 residents missed between one and four baths/showers. No refusals were charted for these residents on the days when they did not receive their scheduled baths/showers. 4. See F318 for the specifics regarding the facility ' s failure to provide restorative care. The RA verified that she is currently the only staff member providing restorative services. She stated that she is scheduled to work Wednesday through Sunday from 6:00 AM to 10:00 AM or 11:00 AM. She indicated that she has been the only RA providing restorative since she started working as an RA about four or five months ago. She confirmed that the previous RA also worked alone. In an interview with the Director of Nursing on 10/20/05 at 7:45 AM, she indicated that residents received restorative services only when restorative staff was available. 5. In an interview with a group of residents on	F 353	F-353 NURSING SERVICES – SUFFICIENT STAFF It is the practice of this facility to provide 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. Refer to Wyoming Health Department Survey F353.	

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F 353	Continued From page 78 10/19/05 at 9:00 AM, they indicated that they had to "stand around to wait for meals" because there was not enough staff to serve the meal. The group of residents indicated the facility was often short of staff especially on weekends. 6. In an interview with CNA #3 on 10/19/05 at 7:15 AM, she indicated that she regularly worked on the night shift. She stated that sometimes when arriving for that shift she found that residents had not been toileted or changed before they were put to bed. She stated that at times the staffing on the night shift was only one nurse and one aide. On those nights she was only able to make two rounds to provide toileting and assistance to incontinent residents instead of rounds every two hours 7. Review of staffing schedules for 6/"/05 through 10/20/05 revealed nine registered nurses/licensed practical nurses and twelve CNAs were employed through a staffing agency. 8. Only one CNA and one nurse were scheduled for the following dates (night shift): a. June: On 6/4/05, 6/10/05, 6/11/05, 6/12/05, 6/15/05, 6/16/05, 6/17/05, and 6/27/05. On 6/22/05 the two CNAs who worked the night shift had also worked an 8-hour evening shift. On 10 of the 30 days in June the Director of Nursing worked at a staff nurse to fill in for uncovered nursing shifts. b. July: On 7/3/05, 7/7/05, 7/8/05, 7/9/05, 7/10/05, 7/14/05, 7/21/05, 7/22/05, 7/23/05, and 7/26/05. The CNA working the night shift on 7/8/05, 7/9/05, 7/10/05, 7/21/05 and 7/28/05 had previously worked the 8-hour evening shift. The night shift on 7/29/05 was covered by two	F 353	1) Agency staff did not report to the facility as the agency had committed. Agencies are requested to provide license/certification of staff provided, background screens, evidence of TB tests. Additional orientation for Agency staff is provided including: facility tour, mission and values, resident's rights, confidentiality and privacy, abuse prevention, chain of command, shift routines, daily assignment sheets and documentation including meal intake and ADL flow sheet, fire panel and emergency procedure, break and meal policies, telephone use, and infection control policies, general safety rules, smoking policy. The facility has recently has had success with hiring more staff. Night staff is monitoring for wandering residents to enable other residents to have restful sleep. Baths have been checked and given at frequency scheduled and if a resident refuses, an alternate time is planned. A licensed nurse with experience in restorative working with the physical therapist is now responsible to be sure that level 2 and level 3 restorative care is being provided and documented. Orientation for pool staff will be contained in a binder that will be reviewed with the pool/agency staff when they arrive in the facility. Prior to the survey and ongoing, a orientation checklist designed for temporary agency staff is completed to indicate needed information has been completed and orientation completed. Pool/agency staff will be teamed with a facility staff member for the first shift worked.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 79 uncertified nurse aide(s)-(NAs). The Director of Nursing (DON) indicated that NAs could only work with direct supervision of an experienced certified nurse aide. c. August: Two night shifts in August were covered by uncertified nurse aides (8/24/05 and 8/25/05). On 10 of the 31 days in August, the Director of Nursing worked at a staff nurse to fill in for uncovered nursing shifts. d. September: On 9/3/05, 9/7/25 through 9/19/05, 9/25/05 and 9/26/05. The DON worked as a CNA for five shifts in September. Eleven night shifts in September were covered by uncertified nurse aides (9/3/05, 9/6/05 through 9/10/05 and 9/13/05 through 9/17/05). The night shift on 9/26/05 had only one nurse scheduled and no CNAs. e. October: On 10/4/05, 10/6/05, 10/7/05, 10/9/05, 10/10/05, 10/13/05. 10/14/05, and 10/20/05. The night shift on 10/4/05 was covered by one uncertified nurse aide.	F 353	Uncertified staff will also be teamed with an experienced facility staff member. Whenever the night shift has been covered by a temporary agency staff member and/or uncertified nursing assistant, an experienced licensed nurse or certified nursing assistant is on duty to ensure adequate provision and supervision of care which includes but not limited to the Director of Nurses or Assistant Director of Nurses providing direct resident care. Nursing staff will make continued rounds to ensure resident safety. Residents who are up during the night will be given activities from the activity boxes to meet their needs for activities. 2) The staffing needs to have been reviewed by the Administrator or DON 3) The NH, and DON have implemented several recruitment and retention strategies such as extensive advertisement contracted for NA course and hire on bonuses and differential	
F 371 SS=E	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, record review and staff interview, it was determined that the facility failed to store, prepare, and distribute food in a manner which minimized the potential for food-borne illnesses. The findings included: 1. On 10/18/05 starting at 9:29 AM, during the	F 371	4) The DON and NHA or designee will monitor compliance weekly for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion date is: 11/30/05**	

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F 371	Continued From page 80 Initial tour of the dietary department with the Certified Dietary Manager (CDM) present, the following observations were made: a. There were coffee grounds spilled on the blue tray which was placed under the coffee maker and in the drawer located beneath the coffee maker b. The handles and fronts of the cupboards were spotted, sticky, and/or greasy to touch. c. There were two open boxes of corn starch on the shelving located above the counter (by the steam table). d. There were flies landing on the steam table and the stove. e. The three compartment sink contained several dirty utensils and pans. The CDM indicated that the sinks are sanitized and used to wash produce. Note: The kitchen area had one handwashing sink and the three compartment sink. f. In the outside walk-in freezer unit, there was a half of a ham. The open end of the packaging was loosely covered with foil. When the foil was removed, the ham appeared dried out. There was a chunk of ice on the floor under the condenser tubing. This piece of ice was approximately three inches in diameter by one and a half inches high. g. In the dry storage area in the kitchen area, there were two bags of cornbread mix which had been used. One bag was standing open; the other was closed. Neither bag was dated. The CDM confirmed that the facility policy was for open items to be dated. There was also an open	F 371		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 81 box of All Bran. There was Med Pass 2.0 in a carton. The box that the Med Pass came in was stuck to the shelf with dried Med Pass that had spilled or leaked at some point in time. h. In the walk-in refrigerator, there were drops of milk on the edge of the top shelf. The CDM lifted a gallon of milk and stated that it was leaking. A cardboard flat with egg shells and whole eggs was sitting on top of the case of shell eggs. i. In the dietary storage room, located across from the nurses' station, there was a five pound plastic bucket of peanut butter. The bottom and side of the bucket was cracked and open wide enough that the peanut butter was visible. Crumbs were spilled on the top shelf. There were open and/or undated boxes of carrot cake mix, yellow cake mix, and icing mix. The shelves in this storage area were wooden, painted shelves which were rough, especially on the edges, and had areas where the paint was missing. These shelves were not cleanable. The temperature in this storage unit was 82.2 degrees Fahrenheit. j. The CDM verified that this room was hot and that she needed a fan in this room. 2. On 10/19/05 at 7:23 AM, observations in the dietary department revealed the following: There was still coffee grounds in the drawer under the coffee maker. In the dry storage area in the kitchen area, there was a large plastic container with peanut butter in it. The CDM verified that this was the peanut butter from the cracked bucket of peanut butter. The cook and the CDM were observed cracking	F 371	F-371 SANITARY CONDITIONS – FOOD PREP & SERVICE It is the practice of this facility to store, prepare, distribute, and serve food under sanitary conditions. 1) The kitchen has been thoroughly cleaned and a checklist of routine cleaning as been completed as follows: drawer under the coffee maker cleaned, open boxes of corn starch thrown away, dried out ham discarded, corn bread mix discarded, peanut butter in cracked container thrown away. All open items have been covered after being opened and used. Monitoring to be sure doors are closed to prevent flying insects form getting into kitchen, exterminator has completed rounds and will continue such. Sinks are sanitized before fresh produce are placed in them. All items in the freezers will be properly sealed or placed in covered containers. The condenser has been checked and area cleared of ice. Open items in storage have been covered and dated. Storage areas will be routinely cleaned according to the cleaning schedule and area will be monitored by the CDM. Refrigerated area has been cleaned and the routine cleaning schedule will be followed and monitored by the CDM.	

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

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F 371	Continued From page 82 one egg against another egg when they were frying eggs. The CDM was not wearing gloves while preparing the eggs. She was coughing into her arm while standing at the stove. She obtained packages of ketchup from the dry storage room and returned to cooking eggs without washing her hands. The egg shells were placed back in the flat with whole eggs. After the meal service was completed, the CDM placed the five remaining eggs in a bowl. These eggs were observed to have the liquid from the used eggs on their shells. Observations of the fried eggs which had been served to the residents revealed that some soft egg yolks and egg smears were found on the plates. One resident verified that the egg was soft cooked. 3. On 10/19/05 at 8:00 AM, observation of the refrigerator located in the activity room revealed that there was no log for monitoring the temperatures. The Activities Director and the Social Services Director verified that the refrigerator was used for residents' drinks and that no monitoring log was being kept. 4. On 10/19/05 at 9:37 AM, observation of the nourishment refrigerator at the nurses' station evidenced three weight loss shakes, three bottles of water (one with a first name on it), and resident food/fluids. The nurse consultant was present and stated that she would verify whether or not the shakes and water were staff items. On 10/20/05 the nurse consultant verified that the items did belong to staff members and that the items had been removed from the refrigerator. Review of the monitoring log for this refrigerator evidenced that no temperatures were recorded for 10/3, 10/12, and 10/15/05.	F 371	Storage area was cleaned and painted. CDM will monitor the temperature as a thermometer has been placed in the area. The CDM will monitor the storage of items being covered and dated if opened. A fan has been placed in the area to manage the temperature. Cooks in serviced that only pasteurized eggs will be used and only one egg at a time will be cracked. The Dietary staff was in serviced on 11/08/05 on the food preparation and storage Policy and Procedure and cleaning procedures. A thermometer was placed in the Activity room refrigerator and a monitoring log is in place for monitoring the temperature. The activity staff monitors this. Staff has been reminded to keep their items in the refrigerator provided for them. The DON will check the refrigerator routinely. A temperature-monitoring log has been place with the refrigerator for the night nurse to record the temperature. The DON will monitor that the temperatures are recorded at least weekly. 2) CDM completed a thorough inspection of the kitchen and storage area to identify any other cleaning or storage. Needs and corrective action taken as needed 3) The dietary staff was in serviced on 11/08/05 on food preparation storage P&P and cleaning procedures.	

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

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F 371	Continued From page 83 5. On 10/20/05 at 10:22 AM, observations were made in the dietary storage area (located across from the nurses' station and where the temperature had been 82.2 degrees Fahrenheit when it was checked by the surveyor on 10/18/05). The food items which have storage directions for storage in a "cool dry area" included brownie mix, semi-sweet chocolate chips, and non dairy creamer. The CDM was present and verified that these items were to be stored in a cool dry area.	F 371	4) The CDM will monitor the temperature of the storage area and covered and dated opened supplies at least weekly. The activity director will monitor the temperature in the activity refrigerator at least weekly. Administrator will monitor that all logs are in place and temperatures recorded. The Administrator or designee will monitor compliance weekly on all monitoring tools for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly.	
F 388 SS=D	483.40(c)(3)-(4) FREQUENCY OF PHYSICIAN VISITS Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This Requirement is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure the physician made the required visits to assess one of ten sample residents (#8). This resident was seen by the Physician Assistant (PA), without alternating visits by the physician. The findings included: Review of the physician progress notes for sample resident #8 evidenced that the resident was seen by the attending physician on 1/18/05, 2/23/05, and 4/19/05 and by the PA on 5/23/05,	F 388	Completion date is: 11/22/05 F-388 FREQUENCY OF PHYSICIAN VISITS It is the practice of this facility to have physician visit initially and alternate between the physician and visits by the physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. 1) Resident #8 was visited by his attending Physician on 11/15/2005 2) The Health Information Manager has reviewed the status of physician visits for all residents. Corrective action taken if needed 3) The Health Information Manager and the PA have met to work out the schedule of visits to assure that rotation of visits by the physicians meet regulation.	

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F 388	Continued From page 84 8/22/05, and 9/28/05. There was no evidence found to indicate that the resident was being seen by the physician and the PA on an alternating basis. Additionally, the resident was not seen every sixty days as required (5/23/05 to 8/22/05). The surveyor requested additional documentation to show that the resident had been seen by the physician. No physician visits information was provided to the surveyor.	F 388	4) The HIM or designee will monitor compliance weekly on all monitoring tools for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion date is 11/18/05**	
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 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that routine medications were available in a timely manner to meet two of ten sample residents' (#6 and #10) and two supplemental sample residents' (#17 and #24) needs, as ordered by the physicians. The findings included: 1. Resident #10 medical record review revealed the resident had been admitted to the facility on 4/29/96 with diagnosis including: brain condition, quadriplegia, CVA (cerebral vascular accident), osteoporosis, chronic prostatitis, GERD (gastroesophageal reflux disease) and contractures.	F 425		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	10/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 85 Review of the MDS (minimum data set) dated 7/28/05 identified the resident as having full loss of ROM (range of motion) with limitation on both sides for hands, legs and feet. Review of the plan of care dated as 7/05, 8/05 (crossed off) and 11/05 identified the resident at risk for decline in ROM related to contractures and physical restraint use secondary to spastic quadriplegia, CVA (cerebral vascular accident), osteoporosis, safety, and positioning. Review of the "Interdisciplinary Progress Notes" dated 7/25/05 stated, "In the past two weeks I have placed 2 calls to ___(name of pharmacy) and 2 calls to ___(name) Family practice regarding resident not having his prescription filled for Baclofen. ___(name of pharmacy) stated they need preauthorization from the physician and the staff at ___(name family practice) assured me this was faxed to them. I will pass this info to day nurse in report and ask that another call to ___(name of pharmacy) is made". There was no follow up documentation to address the resident not getting prescribed medication or monitoring for adverse side effects due to withdrawal from this medication. Review of "Physician's Orders" dated September 2005 identified the resident on Baclofen 10 mg 1/2 tablet three times a day, "Must stay on Baclofen, cannot use anything else 1-26-05". The facility was asked to provide documentation of consultant pharmacist reports for review. The reports were not given to surveyors for review at the time of survey. There was no documentation to show how the facility had addressed the issue of ordered medications not being available for	F 425	**F-425** PHARMACY SERVICES It is the practice of this facility to provide routine and emergency drugs and	

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

OMB NO. 0938-0391

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F 425	Continued From page 86 administration. Interview with the DON (Director of Nursing) on 10/20/05 at 8:30 AM revealed there had been issues with medications being available and getting some refills timely due to needing preauthorization. The DON reported, "This is an issue and we are working on it" Reference: "Nursing 2006 Drug Handbook 26 th Edition" identifies Baclofen as skeletal muscle relaxant. "Action -Hyperpolarizes fibers to reduce impulse transmission. Appears to reduce transmission of impulse from the spinal cord to skeletal musole, thus decreasing the frequency and amplitude of muscle spasms in patients with spinal cord lesions. ... Nursing considerations ... Don't withdraw drug abruptly after long term use unless severe reactions demand it, doing so may precipitate seizures, hallucinations, or rebound spasticity..." 2. Review of the Controlled Drug Administration Record for the Temazepam dispensed to sample resident #4 revealed that a medication dose was taken from this resident's supply and used for sample resident #6 (in mid May 2005). 3. Review of the Controlled Drug Administration Record for the Temazepam dispensed to sample resident #4 from 8/19/05 through 10/17/05 revealed that five medication doses were taken from this resident's supply and used for supplemental sample residents #17 and #21. 4. In an interview on 10/20/05 at 7:30 AM with the night nurse, she indicated that if a medication was not available for a resident, medications were taken from medications dispensed to other residents. When asked for evidence that these	F 425	biological items to its residents, or obtain them under an agreement as described in 483.75(h) of this part. 1-Resident #10 was discharged on 9/25/2005 the facility has discussed medications that require a preauthorization. The facility will pull the Medication sticker at day 15 and request a preauthorization request from the Pharmacy. The preauthorization request will be placed in the physician's folder and the preauthorization will be taken to the physician's office. 2) The medication status on all residents has been reviewed to assure meds available as ordered. 3) It has been emphasized and staff in serviced that they are not to borrow medications from one resident to another. Also, the reorder procedure is to be followed which is that medications are reordered when there is a three day supply remaining. 4) The DON, NHA, and pharmacy consultant or designee will monitor compliance weekly on all monitoring tools for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. Completion date is: 11/22/05	

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

Printed: 12/02/2005
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
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F 425	Continued From page 87 medications were then returned to the resident she verified there was no evidence that the medications had been returned.	F 425		
F 432 SS=E	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to store drugs and biologicals in locked storage areas and to ensure that medications were stored at proper temperatures . The findings included: 1. Observation on 10/19/05 at 7:40 AM during the medication pass, the nurse went to the nurses' station, took a magnet off the refrigerator and opened the cabinets. The cabinets contained medications and the nurse reported that she was looking for a medication which was not on the medication cart. The medications noted in the	F 432	F-432 STORAGE OF DRUGS AND BIOLOGICALS It is the practice of this facility to store all drugs and biological items in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.	

OMB NO. 0938-0391

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F 432	Continued From page 88 cabinets included vitamins, laxatives, antiacids, aspirin, Tylenol and liquid cough medicine. The nurse confirmed that any staff could access the medications as well as laboratory supplies kept in the cabinets. 2. On 10/19/05 at 9:30 AM, observation of the cupboards situated above the counter top at the nurses' station evidenced that the cupboards contained stock medications and intravenous (IV) supplies. The cupboards were locked with magnetic latches that unlocked when another special magnet was placed over the latch. The magnet used to open the cupboards was kept on the refrigerator located below the counter at the nurses' station. This system of storage allowed easy access by anyone. 3. Observation during the environment tour on 10/19/05 from 3:10 PM to 4:40 PM with the Administrator and the maintenance staff revealed issues with the storage of drugs. The medication cabinets located in the nurses station had a magnetic lock entry. The magnet that was used to open the cabinets was kept on the outside of a small refrigerator located in the bottom cabinets. The surveyor was instructed by maintenance staff on how to open and access the cabinets which contained medications. The Administrator and the maintenance staff confirmed anyone watching or observing a nurse accessing the medication cabinets with the magnet could repeat the process and gain access. This created the potential for the access of medications by the unauthorized persons. 4. On 10/20/05 at 9:00 AM, review of the medication list identified 39 different medications being kept in the magnetic cabinets at the nurses station.	F 432	All residents (current and future) have the potential to be affected by the same deficient practice including resident #8. 1. The cupboards that had childproof magnets are now all keyed and there is a key on each of the nurses' key rings. The nurse in responsible to be checking and recording the refrigerator temperature on the monitoring log daily. 2) The locks for all medications have been checked to assure that they are properly secure. 3) On 11/30/05, the nurses have been instructed on their responsibility of making sure medications are locked in designated cabinets or carts, the checking of the temperature daily of the medication and nourishment refrigerator, and documentation on the designated logs. Nurses were instructed on the responsibility 4) The DON and NHA will monitor or designee will monitor compliance weekly on all monitoring tools for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. Completion date is: 11/2005	

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F 432	Continued From page 89 5. On 10/19/05 at 9:30 AM, review of the log for the medication refrigerator located at the nurses' station revealed that the temperature was not documented on 10/3, 10/5, 10/8, 10/12, 10/15, and 10/18/05. The facility failed to ensure drugs are stored in a manner that allows only those individuals authorized to administer the drugs access to them.	F 432		
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 record review, observation, and staff interview, it was determined that the facility failed to establish and/or implement an infection control program in order to provide a safe, sanitary, and comfortable environment which minimized the potential for the spread of infection among the residents. The findings included:	F 441		

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F 441	Continued From page 90 1. During the initial tour of the facility on 10/18/05 at 8:30 AM, nursing staff on initial tour identified resident #16 as having a MRSA (Methicillin Resistant Staphylococcus Aureus) infection of the urine. The staff identified the resident as being on alternating antibiotics for the infection for a long time. 2. Review of the "Infection Control Program" and interview with the Director of Nursing (DON) on 10/19/05 at 7:30 PM revealed that there had been changes in staffing and she had been doing the duties of the ICC (Infection Control Coordinator) the past couple of months. a. The monthly tracking logs for October 2005 had not been started. The DON stated that the procedure used for tracking infections was done at the end of each month. She stated, "I look through the MAR (Medication Administration Record) to see who has been started on an antibiotic. Then I put them down on the infection control log. I don't separate the chronic infections from the acute infections". The DON was asked how many current residents had MRSA and she reported, "I don't know. I usually put them on my log but some are ongoing or residents with histories of MRSA. I mark a map of the rooms but I don't know right now who has what type of infection. There is no specific policy or procedure that I'm aware of for infections like MRSA and VRE (vancomycin resistant enterococci). I was going to plan an inservice but it hasn't been done yet." b. Review of the infection control logs for September 2005 listed 6 residents with infections and three of those residents were listed multiple times. They also had multiple antibiotics used with no documentation of cultures or follow up	F 441		

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F 441	Continued From page 91 documented. c The tracking sheet for August 2005 was not in the manual and not available for review at this time. d. The July 2005 tracking sheet identified three residents with MRSA of the urine and 6 other residents with urinary tract infections without the organism identified or cultures being done to ensure effective antibiotic use. There was no documentation of the response to the antibiotic or if the infection was resolved. e. A concurrent surveillance of residents having signs and symptoms of infections was not done to ensure timely follow up prevention of infections in the facility. f. There was no tracking of the infection control rate or percent of infections for each month. 3. The infection control issues identified during survey were reviewed on 10/19/05 at 7:30 PM with the DON. The DON reported that the facility was using universal or standard precautions facility wide and that if there was excessive drainage or potential for contamination, contact precautions would be used. The following infection control issues were reviewed with the DON: a. Resident #2's medical record identified the resident as having a left lower lung congestion and the resident was put on antibiotics on 10/14/05. During observation of the resident's room, a fan was noted setting on the dresser. The fan was on and blowing in the direction of the resident. The	F 441		

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F 441	Continued From page 92 fan had a build up of dust and debris on the covering as well as the blades and was in need of a thorough cleaning. Observations during the provision of care on 10/18/05 at 5:20 PM and on 10/19/05 at 11:20 AM revealed the resident had an open ended gastrostomy tube. The administration set up for the tube feeding also had an open end which was not capped. Interview with staff on 10/19/05 at 11:20 AM reported that the feeding bag and tubing were changed every 24 hours and that the end of the tubing should be capped to prevent contamination. This staff also reported that the end of the feeding tube itself was not being plugged because it had been cracked at one time and had to be replaced. The staff verified that they were leaving the end of the tubing open. b. Review of the facility policy on "Nursing Procedures / Gastrointestinal Care / Tube Feeding" was not dated. It did state, "6. Assure patency and position before administering feeding. a. Remove cap or plug from tube.... 17. To discontinue gastric feeding:... 18. Cover end of feeding tube or cap." This policy was not being followed. c. Reference: Fundamentals of Nursing, The Art and Science of Nursing Care, Fourth Edition-Lippincott : page 1113 "Procedure -Administering a tube feeding...e. Clamp the tube immediately after water has been installed. Disconnect from the tube. Clamp tube and cover end with sterile gauze secured with rubber band or apply cap...Clamping the tube prevents air from entering the stomach. Cover on the end of the tube deters entry of microorganisms and protects patient and linens from fluid leakage from tube..."	F 441		

CONTINUE FROM PREVIOUS PAGE 0001

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F 441	Continued From page 83	F 441		

d. Resident #16 was identified on the initial tour of the facility on 10/19/05 at 8:30 AM as having MRSA of the urine and staff was unsure if any precautions were put in place.

4. During an interview on 10/20/05 at 8:00 AM with the Nurse Consultant, a copy of a procedure for infection control for "Methicillin Resistant" was provided to the surveyor. The consultant reported that the policy and procedure was from a manual in the Administrator's office. The policy was not dated or signed.

5. Interview with the DON on 10/20/05 at 8:30 AM revealed she was unaware of the procedure for infection control for "Methicillin Resistant" provided by the consultant. At this time the DON provided the infection control log for August 2005.

6. Reference: CDC (Center for Disease control) Antimicrobial Resistance - Multi-drug Resistant Organisms in Non-Hospital Healthcare Settings: They are bacteria and other microorganisms that have developed resistance to antimicrobial drugs, ... MRSA (Methicillin Resistant Staphylococcus aureus) and VRE (vancomycin-resistant enterococci) are the most commonly encountered multidrug-resistant organisms in patients residing in non-hospital healthcare facilities. Non-hospital healthcare facilities can safely care for and manage these patients by following appropriate infection control practices. Current prevention methods is an ongoing investigation. No single prevention approach is likely to work alone. Careful handwashing is important for prevention of spread of many infections including Staph aureus... "

7. Observation of the room where sample

F-441
INFECTION CONTROL

It is the practice of the facility to have 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 has an infection control program to investigate, control and prevent infections in the facility; and decides what procedures such as isolation should be applied to an individual resident; and maintains a record of incident and corrective actions related to infections.

1- The Director of Nurses has assigned the infection control tracking and monitoring to ADON. The ADON will track location of infections in the facility and do cause analysis. Individual tracking of a resident who has reoccurring infections will be done to determine any cause and effect factor.
She will do in servicing with staff on infection control and infection control with residents with MRSA.
All fans have been cleaned and put on a cleaning schedule. This was done on 10/19/05
The housekeeping supervisor and the NHA monitor this. Resident # 2 - The tube is not to be capped for this specific resident pre physician's order but will be

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F 441	Continued From page 94 residents #5 and #7 resided was made on 10/18/05 at 4:10 PM. Several drops of blood were noted on the floor in front of the bathroom. a. When asked about the blood, the CNAs indicated that resident #7 had open areas on his/her buttocks that were bleeding. The surveyor asked to observe the open areas when the CNAs were doing pericare. The CNA indicated during the pericare that the area, which was covered with DuoDerm dressing needed to be changed. The DON came to change the dressing and the blood was brought to her attention. The DON indicated that blood spills should be cleaned up immediately. b. Observation at 7:30 AM on 10/19/05 the next morning revealed there continued to be several drops of dried blood in the same area on the floor in front of the bathroom as noted the day before. 6. Record review of sample resident #4's medical record revealed the resident had been readmitted to the facility on 12/11/03 with diagnoses that included spinal stenosis, duodenal ulcer, anemia, depression, hypertension, and affective psychosis. a. The resident had complaints relating to a urinary tract infection in May 2005. A urinalysis with a culture and sensitivity (C&S) was conducted on 6/28/05 and the resident was started on Bactrim DS for seven days. b. The results of C&S completed on 7/1/05 showed Streptococcus agalactiae which was sensitive to several medications but was not sensitive to Bactrim. There was no evidence that the nursing staff contacted the physician to ensure that was the antibiotic that he/she wanted	F 441	covered with sterile gauze. Staff is being in serviced on clamping the tubing and covering it with a sterile gauze. Staff will also be in serviced on placement of the tube to avoid tubing from being under the resident. This is monitored by the DON. Resident # 7 has been tested for scabies and test was negative. The physician determined it to be "Neurodermatitis" and prescribed medication he felt appropriate. 2) All residents who currently have an infection have been identified. The nurses will follow the CDC guidelines for determining an infection. 3) In the review of the medical records, the pharmacy consultant will review antibiotic use and the indications of the antibiotic use for the infectious agent. They will review to ensure the resident was not allergic to the antibiotic used, if there had been a reaction to antibiotic use, and appropriate follow-up as needed has been documented. The antibiotics used in the month will be reviewed with the medical director for his consideration of appropriateness for the infectious agent, and interaction with other medications. This will also be part of the Quality Assurance Committee monthly review. This process will be ongoing monthly for the next year and quarterly there after. Whenever a resident exhibits a rash or any signs/symptoms of an infection, the resident's physician will be notified. The nurse will document the findings, notify the physician and legal representative, request orders, document treatment	

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F 441	Continued From page 95 to continue. 9. Review of the medical record for sample resident #7 revealed the resident was admitted to the facility in November 1984. The resident's current diagnoses included pruritis, dysphasia, osteoporosis, seizure disorder and organic brain syndrome. a. According to The Merck Manual, 16th edition, Section 16 " Dermatologic Disorders " , pruritus can be related to anything from dry skin to undiagnosed cancer. Pruritus can be a symptom of infection such as scabies or body lice, an allergic reaction to certain medications, foods or other chemicals reacting with the resident's skin. Pruritis is marked by intense irritation and itching. b. Observations of the resident's buttocks showed deep raw areas where the resident had scratched until the skin was open and bleeding. Record review showed the facility attempted to find the cause for this pruritis, i.e. medication side effects, behaviors and urinary tract infection. There was no evidence the facility had evaluated the possible food allergies or possible infectious cause for the resident's itching such as scabies or lice.	F 441	implemented, and establish/implement a care plan addressing the specific problem/needs. The Assistant Director of Nurses will investigate the causative factors and follow the CDC guidelines for determining an infection. The Assistant Director of Nurses will follow-up to ensure appropriate treatment has been implemented and educate the staff as needed. The ADON will confer with the resident's attending physician or medical director as needed. Staff was in serviced on 11/22/05 on cleaning blood spill areas with blood spill kits. 4) The NHA, DON and Housekeeping supervisor or designee will monitor compliance weekly on all monitoring tools for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion date is: 11/30/05**	
F 465 SS=F	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide a safe, functional and comfortable environment for the residents, the staff, and the public. This was related to not	F 465		

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	535051	A. BUILDING _____ B. WING _____	10/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HILLS MANOR	1210 CANYON HILLS ROAD THERMOPOLIS, WY 82443

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F 465	Continued From page 96 ensuring backflow devices were functioning to protect the water system. The findings included: Observation on 10/19/05 from 3:10 PM to 4:40 PM during a tour of the environment with maintenance and the Administrator the following issues were identified: 1. The shower room by station one had one shower area with two showers. The showers each had a hose with a hand held shower head attachment. The hoses were long enough to enable the shower heads to access the floor. The shower floor had a gradual slop to the drain which allowed water to collect before draining. This had a potential for the shower heads to have contact with water from the drain. There was no back flow devices on the showers. Interview with the maintenance staff at the time of the observation confirmed the showers did not have a back flow device to ensure prevention of back siphonage of contaminated water into the potable water system. 2. Observation of the beauty shop revealed a hair washing sink which had a hose with a hand held spray nozzle. The spray nozzle could reach the bottom of the sink. There was no back flow or antisiphonage device on the water system. 3. There was an area in the dining room where the vinyl flooring was cracked. The area was just inside the dining room entrance which was a high traffic area for residents and staff. The cracked area was approximately 12 inches in length and was separated by approximately a 1/2 inch with the flooring starting to lift up, leaving a trip hazard and the surface difficult to clean.	F 465	**F-465** OTHER ENVIRONMENTAL CONDITIONS It is the practice of the facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. 1-Back flow devices will be installed in shower heads, in the beauty shop on the spray nozzle as soon as order is received. Dining room floor will be replaced once all bids are obtained. 2) All showerheads have been inspected and corrective action will be taken as indicated. 3) Maintenance supervisor will install back flow devices when received. 4) Maintenance supervisor or designee will monitor compliance weekly on all monitoring tools for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion date is: 11/30/05**	

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F 498 SS=F	483.75(f) PROFICIENCY OF NURSE AIDES The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This Requirement is not met as evidenced by: Based on record reviews and staff interview, the facility failed to ensure that nurse aides (NAs) who were working at the facility but who were employed by a staffing agency were certified, had background checks done, had tuberculosis testing, and were adequately oriented to the facility. The findings included: 1. Review of personnel files revealed the facility failed to implement their current policies regarding abuse and neglect. The facility failed to ensure that all individuals (including pool agency staff) who provided personal care to the residents did not have a history of abuse/neglect before providing care to the residents (see F226 regarding the facility's failure to develop and implement all required abuse policies and procedures including orientation of staff to those policies.) a. The current abuse policy (#401) indicated that all potential employees will be screened to avoid hiring those with a history of abuse or potential abuse. Policy (#401) titled "Abuse Prevention", indicated that background checks/licenses/certifications will be completed on all new hires at time of employee. b. Review of the contract between the facility and the staffing agency revealed when pool staff were assigned to the facility the staffing agency would fax copies of resume, skills checklist, individual contract, immunization record (for	F 498		

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F 498	Continued From page 98 Hepatitis B, MMR/titer, TB Skin Test), and licensure/certification to the facility at the time of assignment. The contract did not specify how the staffing agency/facility would ensure that individuals from the staffing agency had no findings of abuse with this state Board of Nursing or Nurse Aide registry. The contract did have a stipulation that the agency and its employees agreed to comply with all of the facility's policies and procedures. c. In an interview with the facility Administrator on 10/19/05, he indicated that the staffing agency was responsible for ensuring their staff had current licenses and CBI (criminal background investigation) checks. He indicated that when pool staff nurses/certified nurse aides (CNAs) are first assigned that the staffing agency was to send the results of the CBI Check, copy of the individual's license and evidence of tuberculosis (TB) testing. This information was requested on CNA #1, #2 and #3 who were employed by the staffing agency. i. According to facility staffing schedules, CNA #1 was first assigned to the facility on 7/14/05. No employee information was present in the facility until requested by the survey team. The Administrator indicated he had contacted the staffing agency for the contractual information. The CBI check had been completed on 10/9/05 and faxed to the facility on 10/20/05. CNA #1's immunization record showed no evidence that a TB test had been conducted. ii. According to facility staffing schedules CNA #2 was first assigned to the facility on 9/25/05. No employee information was present in the facility until requested by the survey team. The Administrator indicated he had contacted the staffing agency for the contractual information.	F 498	F-498 PROFICIENCY OF NURSE AIDES It is the practice of the facility to ensure that nurses aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and in the plan of care. 1) No agency staff will be employed without the agency providing the staff's applications/resumes, license/certifications, background checks, skills checklist, and immunization records for employees. Refer to F-353. Employee handbook addressing prevention and reporting of resident abuse does speak to employee being able to report events without fear of retribution. 2) The files of all currently employed agency staff has been received to assure employees have a license, CBI, results of PPD are available and orientation records are complete. 3) The DON has informed the pool agencies who provide supplemental staff to the facility of the above requirements. The facility staff and agency staff were in serviced on the abuse policies on 11/22/05.	

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F 498	Continued From page 99 The CBI check had been completed on 10/6/05 and faxed to the facility on 10/20/05. CNA #2's immunization record showed no evidence that a TB test had been conducted. Although the CNA had a Wyoming CNA certification, there was no evidence that the facility or the staffing agency had called the Wyoming Board of Nursing to verify licensure status of this individual for possible findings of abuse with this state Board of Nursing or registry. III. According to facility staffing schedules CNA #3 was first assigned to the facility on 9/28/05. No employee information was present in the facility until requested by the survey team. The Administrator indicated he had contacted the staffing agency for the contractual information. The CBI check had been completed on 10/19/05 and faxed to the facility on 10/20/05. Although the CNA had a Wyoming CNA certification, there was no evidence that the facility or the staffing agency had called the Wyoming Board of Nursing to verify licensure status of this individual for possible findings of abuse with this state Board of Nursing or registry. 2. The current abuse policy (#401) indicated that staff would receive in-service training on abuse and neglect upon hire and annually. The facility failed to ensure that all individuals (including pool agency staff) who provided personal care to the residents received initial training and orientation of abuse/neglect policies and procedures and a general orientation to the facility and the residents. a. Review of information on three staffing agency CNAs (#1, #2, and #3) revealed no documentation that they were oriented to the facility or to the facility's current abuse/neglect	F 498	4) The NHA, DON and Housekeeping supervisor or designee will monitor compliance weekly on all monitoring tools for a month and monthly thereafter. Any trends will corrective action taken will be reported to the Quality Assurance and Assessment committee at least quarterly. **Completion date is: 11/30/05**	

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F 498	Continued From page 100 policies. b. In an interview with CNA #3 on 10/19/05 at 7:15 AM, she indicated she had received a limited orientation to the facility. She indicated she had not received orientation regarding abuse/neglect or a copy of the facility's current abuse policy. c. In an interview with CNA #1 on 10/18/05 at 2:00 PM, he indicated he had received a limited orientation to the facility. He indicated he had not received orientation regarding abuse/neglect or a copy of the facility's current abuse policy. When the surveyor interviewed CNA #1 regarding the care needed by resident #5 on 10/18/05 at 1:30 PM, he indicated he was not sure what care was needed. (See F164 regarding specifics regarding observations of exposure of resident #5).	F 498		
F 521 SS=F	483.75(b)(2)-(4) QUALITY ASSESSMENT AND ASSURANCE 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.	F 521	F-521 QUALITY ASSESSMENT AND ASSURANCE It is the practice of the facility to have the quality assessment and assurance committee 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. 1) The Administrator will monitor that the information necessary to identify quality deficiencies is presented to the quality assessment and assurance committee.	

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F 521	Continued From page 101	F 521		

This Requirement is not met as evidenced by:
Based on record review and staff interview, it was determined that the facility failed to identify issues which were problems/concerns related to the quality of care and quality of life for the residents and/or to develop and implement appropriate plans of action to correct quality deficiencies. The findings included:

1. During an interview with the Administrator, who was the Quality Assurance Coordinator, on 10/20/05 8:45 AM, he indicated that the QA (Quality Assurance) Committee met monthly and with the physician in attendance. He reported that issues with falls had been identified and the corporate office had asked about the fall committee. A fall committee was then started the end of July 2005 to review residents who had falls.

2. Based on the findings of deficient practice in this survey, there were areas (including but not limited to quality of life and quality of care issues) which should have been identified and addressed by the facility's QA process. Thus the facility failed to have an effective QA program.

Refer to the following citations for additional for information:

QUALITY OF LIFE:
F241: The facility failed to serve and assist residents with meals in a manner that recognized and enhanced their dignity and failed to ensure staff did not talk about confidential medical information within hearing of residents.

F 241
QUALITY OF LIFE
F 253
ENVIRONMENT
F272
SLEEP PATTERN
F-279
COMPREHENSIVE CARE PLANS
F-280
COMPRESHENSIVE CARE PLAN
F – 309
QUALITY OF CARE
F – 311
ACTIVITIES OF DAILY LIVING
F-318
RANGE OF MOTION
F-323
ACCIDENTS
F-324
ACCIDENTS
F-325
NUTRITION
F-329
UNNECESSARY DRUGS
F-353
NURSING SERVICES – SUFFICIENT STAFF
F-371
SANITARY CONDITIONS – FOOD PREP & SERVICE
F-388
FREQUENCY OF PHYSICIAN VISITS
F-425
PHARMACY SERVICES
F-432
STORAGE OF DRUGS AND BIOLOGICALS
F-441
INFECTION CONTROL

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F 521	Continued From page 102 F253: The facility failed to maintain the facility's environment in a sanitary and orderly manner. F272: The facility failed to assess residents for sleep patterns for the continued use of sedative/hypnotic medications and failed to document the intake of all nutritional supplements and snacks which were assessed and care planned. F279/F280: The facility failed to develop and update comprehensive care plans to meet residents specific needs. QUALITY OF CARE: F309: The facility failed to provide care in a manner which helped residents reach their highest practicable level of physical, mental, and/or psychosocial functioning. F311: The facility failed to provide adequate meal assistance to residents needing supervision, cuaing, and/or physical assistance to eat. F318: The facility failed to provide care planned treatment and services to increase or maintain residents range of motion (ROM). F323: The facility failed to ensure that the environment was as free of accident hazards as possible. F324: The facility failed to ensure adequate staff supervision and assistance to prevent accidents. F325: the facility failed to timely assess and provide interventions to maintain acceptable parameters of nutritional status F329: The facility failed to accurately monitor to	F 521	F-465 OTHER ENVIRONMENTAL CONDITIONS 2) For all tags cited, the Administrator will devise and utilize tools, both audit and otherwise, to measure if the interventions given effectively intervene to assist the resident. 3) The Quality Assurance teams will report and keep all track off all items listed for appropriate interventions. 4) The facility will be using audit forms on a regular basis that will trigger any issues. The forms will be taken to the Quality Assurance Committee for review and action plans completed to follow up on concerns. The audit will be done again before the next QA meeting to note compliance or additional follow up needs. The process has been reviewed with the facility staff. Staff members are encouraged to report any process improvement concerns or issues to the Director of Nurses or NHA. Administration will follow-up on any of these concerns as needed by either appointing a team to carry out the QA process or the QA committee will address the specific issue. CNA's and department managers will complete audits. The results of the audits with corrective action will be reviewed at the QA Committee meeting. Follow-up action will be communicated to the general or involved staff for follow-up compliance. Audit of the plan will be done before the next QA meeting by the designated discipline. **Completion date is: 11/30/05**	

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	535061	A. BUILDING _____ B. WING _____	10/20/2005

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F 521	Continued From page 103 ensure hypnotics were not given in excessive duration. F353: The facility failed to provide sufficient nursing staff to meet the facility-assessed needs of the residents. F371: The facility failed to store, prepare, and distribute food in a manner which minimized the potential for food-borne illnesses. F425: The facility failed to ensure that routine medications were available in a timely manner to meet the residents' needs, as ordered by the physicians. F432: The facility failed to store drugs and biologicals in locked storage areas. F441: The facility failed to establish and/or implement an infection control program in order to provide a safe, sanitary, and comfortable environment which minimized the potential for the spread of infection. F465: The facility failed to provide a safe, functional and comfortable environment for residents, staff and public. This was related to not ensuring that there were backflow devices on hosa to protect the water systems. F498: The facility failed to ensure that nurse aides who were working at the facility for extended periods of time but who were employed by a staffing agency were certified, had background checks done, had tuberculosis testing, and were adequately oriented to the facility. There was no evidence that the nurse aides had acceptable skills to provide direct care to residents. Record review revealed these aides	F 521		

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F 521	Continued From page 104 did not receive any training by the facility.	F 521		