STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	06/30/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by:	F157	DISCLAIMER "THIS PLAN OF CORRECTION IS THE CENTER'S CREDIBLE ALLEGATION OF COMPLIANCE. PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF 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." **F157** 1. Resident #81's physician will be notified of blood sugar changes per physician orders. 2. All residents have the potential to be affected by this practice. Physician orders regarding blood sugar parameters will be followed. 3. All licensed nurses will be inserviced regarding following physician orders. Blood sugar parameters will be audited by Unit Managers weekly for one month and then monthly to ensure compliance. Director of Nursing is responsible for overall compliance. 4. Results of audits will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	

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

An ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that oth ufeguards 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 157	Continued From page 1 Based on staff interview, policy and procedure review, and medical record review, the facility failed to notify a physician of blood sugar changes for one (#81) of two sample residents with diabetes. The findings were: Review of the diagnoses report form from 8/26/05 revealed resident #81 was admitted with diagnoses including insulin dependent diabetes. Review of the resident's documented blood sugar levels revealed this resident had fluctuating blood sugars ranging from a low of 37 mg/dL (milligrams per deciliter) to a high of 290 mg/dL. Review of the 8/26/04 physician's orders revealed staff were to notify the physician if the resident's blood sugar was less than 60 mg/dL. Review of the diabetic monitoring flow sheet for June 2005 revealed the resident's blood sugar was below 60 mg/dL two times; on 6/6/05 at 7 AM it was recorded as 50 mg/dL, and on 6/12/05 at 11:30 AM it was recorded as 56 mg/dL. Review of the resident's medical record including the diabetic monitoring flow sheet and the interdisciplinary progress notes revealed the physician was not notified of either of these two incidents. Interview with the third floor unit manager on 6/30/05 at 9:25 AM revealed staff knew they were to call the physician regarding the resident's low blood sugar. However, she confirmed there was no documentation that provided evidence the physician was notified of the low blood sugar levels. Review of the facility's policy and procedure on blood sugar monitoring dated 9/26/03 revealed staff were instructed to check the physician's order for blood sugar testing. Further review revealed the following instructions under the heading of documentation guidelines: a. [Follow the] "physician's order."	F 157		

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F 157	Continued From page 2 b. [Document] "adverse effects noted, as well as: date and time of physician notification, response and new orders if applicable." c. "Notification of physician of results and new orders if applicable."	F 157	**F241** 1. Residents #89 and #106 will be fed by staff sitting and talking with the resident in an appropriate manner. Residents #86 and #81 will be addressed in a dignified manner with appropriate language. Resident #81's wheelchair cushion will be cleaned as needed or replaced if necessary. 2. All residents have the potential to be affected by this practice. All residents will be fed by staff sitting and talking with the resident in an appropriate manner. No Nurse or C.N.A will have their personal cell phone with them during patient care times. All staff will address residents in a dignified manner with appropriate language. Nurses and C.N.A's will provide care and discuss care issues with residents appropriately. Wheelchairs and cushions will be cleaned daily and as needed. 3. Frequent rounds by Unit Managers and Nurses on each unit will be made during each shift to observe daily cares. Random observance of meal times by Unit Managers to assure appropriate feeding techniques are being used. Residents rights and dignity will be discussed in next Resident Council Meeting. All appropriate staff will be inserviced on resident rights and dignity. Audits will be conducted five times a week for two months, then weekly for one month, then monthly by Unit Managers on each floor for cleanliness of wheelchairs and cushions. 4. Results of rounds, daily observances of meals, inservices, and audits will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: August 12, 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, resident and staff interview, and review of staff training documentation, the facility failed to ensure dignity was maintained for two (#81 and #106) of 21 sample residents and two (#86 and #89) non-sample residents. The findings were: 1. On 6/27/05 at 6:45 PM, licensed practical nurse (LPN) #2 was observed feeding non-sample resident #89. Instead of sitting in a chair at eye level to the resident, the LPN stood over the resident. At 6:55 PM, LPN #2 was again observed feeding sample resident #106 in the same manner. 2. Observation on 6/29/05 at 2:40 PM revealed certified nurse aide (CNA) #5 had an electronic device in her pocket which started playing in the presence of resident #86. After she turned the device off, the CNA stated "I feel like such a turd" for leaving this (the electronic device) on after	F 241		

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F 241	Continued From page 3 lunch. Interview with the resident on 6/30/05 at 11:05 AM revealed he/she was a Christian and did not want to hear words like that ("turd"). The resident further stated he/she had told staff he/she did not like bad words spoken in his/her presence. 3. On 6/29/05 at 4:55 PM, observation revealed CNA #5 provided perineal care for resident #81. During the process, the resident stated he/she did not like perineal care because it was cold. In addition, the resident stated he/she did not like the CNA performing the perineal care. The CNA stated, "Believe me I don't like it either. I don't do pericare because I want to." Interview with the resident on 6/30/05 at 11:10 AM revealed he/she felt very bad when the CNA talked to him/her that way. 4. On 6/29/05 at 1:30 PM, observation revealed a strong urine odor in the room of resident #81. Further observation revealed the cushion on the resident's wheelchair was wet with urine. Observation at 4:55 PM revealed CNA #5 and the assistant director of nursing (ADON) were prepared to transfer the resident into his/her wheelchair for the evening meal. At that time, the surveyor stated (privately) to the CNA and RN that the wheelchair cushion had been wet with urine at 1:30 PM. The CNA placed her hand on the cushion and said, "Well it's dry now." They proceeded to transfer the resident into the wheelchair and on to the cushion. The strong urine odor remained. 5. Review of facility staff training documentation dated 3/23/05 ("Nursing Assistant Expectations List") revealed "...always talk to the residents respectfully...when feeding the residents, sit and	F 241		

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F 241	Continued From page 4 feed them...if wheelchairs are soiled with food, urine or anything else, it must be cleaned promptly..."	F 241	**F253** 1. Resident #81's wheelchair cushion will be cleaned as needed or replaced if necessary. 2. All residents have the potential to be affected by this practice. All showers will be cleaned per cleaning instructions and contact time followed appropriately. All shower rooms will be cleaned daily and deep cleaned weekly including any cabinets, light fixtures, heat registers, and vents. Baseboard tiles in the shower room on third floor will be repaired. 3. Unit managers will audit shower rooms five times a week on rounds for cleanliness. All appropriate staff will be inserviced on reporting needed maintenance repairs. All appropriate staff will be inserviced on how to correctly use Q128 disinfectant in the shower rooms. All Housekeeping staff will be inserviced on proper cleaning of all items in the shower rooms. All nursing staff and Housekeeping staff will be inserviced on proper cleaning techniques of feces on the floor. 4. Results of rounds, inservices, and audits will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	
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, staff interview, review of policies and procedures, and review of staff training documentation, the facility failed to provide housekeeping services to maintain a sanitary interior for two of five bathing areas. In addition, the facility failed to provide a clean, sanitary wheelchair cushion for one (#81) sample resident. The findings were: 1. On 6/28/05 at 10:50 AM, certified nurse aide (CNA) #31 cleaned the shower stall located in the third floor shower room on C hall. The CNA failed to rinse the shower floor of feces before spraying the Q128 disinfectant on the shower stall surfaces. In addition, the CNA allowed the disinfectant to be in contact with the shower surfaces for only 40 seconds before rinsing. At this time, review of the cleaning instructions posted on the shower room wall showed that visibly soiled surfaces were to be rinsed before applying the cleanser. Furthermore, the recommended contact time was ten minutes. 2. Observation of the shower room located on the third floor C hall revealed the following concerns:	F 253		

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F 253	Continued From page 5 a. The Rubber Maid cabinet had a green dried substance and dirt build up in its interior. b. There was dirt/dust build up, and part of a large bulb-syringe and a wash cloth between the Rubber Maid cabinet and the shower stall. c. There were dead flies in both of the fluorescent light fixtures. d. There was dust build up on the heating register. e. There were six buckled base board tiles in the shower stall which left an opening for water seepage into the sheet rock. f. There was lint build up on the shower room ceiling vent. 3. Observation of the second floor "seaside" bathing room on 6/29/05 at 2:10 PM showed three small spots of a brown substance on the floor of the shower area. At 2:13 PM the second floor unit manager confirmed the floor was not clean and identified the substance as feces. At that time the unit manager stated the bath aides were to clean the showers after each resident's use. In addition, the manager stated this particular room was used by staff to provide showers for residents from first floor. Interview with certified nurse aide #30 at 2:15 PM on 6/29/05 confirmed the first floor staff bathed a resident in the seaside shower room after lunch. 4. On 6/28/05 at 9:15 AM, observation revealed a strong urine odor in the room of resident #81. On 6/28/05 at 11:40 AM and on 6/29/05 at 1:30 PM, observation again revealed a strong urine odor. Further observation on 6/29/05 at 1:30 PM revealed the cushion on the resident's wheelchair was wet with urine. Observation at 4:55 PM revealed CNA #5 and the assistant director of nursing (ADON) were prepared to transfer the	F 253		

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F 253	Continued From page 6 resident into his/her wheelchair for the evening meal. At this time, the surveyor stated privately to the CNA and RN that the wheelchair cushion had been wet with urine at 1:30 PM. The CNA placed her hand on the cushion and said. "Well it's dry now." They proceeded to transfer the resident into the wheelchair and on to the cushion. No staff member attempted to clean or disinfect the cushion or to replace it with a new one. The strong urine odor remained. Review of facility staff training documentation dated 3/23/05 ("Nursing Assistant Expectations List") revealed that if a ...wheelchair is soiled with food, urine or anything else, it must be cleaned promptly.	F 253		
F 279 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		

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F 279	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to assure that the care plan for 1 of 24 sample residents (#43) included all orders for care and services staff were to provide. The findings were: Review of a physician's 6/23/05 order revealed resident #43 was to have ace wraps over both legs to help prevent edema, but the wraps were not to cover any wounds. Review of the current care plan by two surveyors showed the order was not addressed. Observation on 6/27/05 at 5:45 PM, 6/28/05 at 3:05 PM, 6/29/05 at 11:30 AM, and 6/30/05 at 11:03 AM showed the resident was without ace wraps on either leg. Interviews with the resident on 6/28/05 at 4:07 PM and on 6/30/05 at 11:03 AM revealed the resident had not asked that the wraps be left off. Interview with nurse aide #1 on 6/30/05 at 11 AM revealed she had worked at the facility for two weeks, but was unaware of the order for daily use of ace wraps. The aide stated she thought the wraps were only to be applied when the resident complained of pain in his/her legs.	F 279	**F279** 1. Resident #43's care plan will be reviewed and updated as needed. 2. All residents have the potential to be affected by this practice. Comprehensive care plans will include all individualized ~~orders for~~ care and services to be provided by the staff. Resident care will be provided to each resident as in accordance with the July 2005 Wyoming Nurse Practice Act. 3. Unit Managers will audit all resident care plans to ensure all care issues are being addressed. Care plans will be reviewed in Care Plan meetings on a quarterly, annual, or significant change basis with interdisciplinary team members to assure individual residents needs are being met. All appropriate staff will be inserviced on how and when to read a care plan. 4. Results of audits and inservices will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS	F 281		

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 281	Continued From page 8 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed physician's orders for one (#81) of two sample residents with a diagnosis of diabetes. The findings were: Review of the diagnosis report form from 8/26/05 revealed resident #81 was admitted with diagnoses including insulin dependent diabetes. Observation on 6/28/05 at 12 noon revealed licensed practical nurse (LPN) #11 checked the resident's blood sugar level. During an interview at this time, the LPN stated she would hold the noon injection of insulin because the resident's blood sugar level was 98 mg/dL (milligrams per deciliter). However, review of the 5/14/05 physician's orders revealed an order to hold the Humalog insulin before meals when the finger stick blood sugar was less than or equal to 80 mg/dL. According to the July 2001 Wyoming Nurse Practice Act, nurses shall provide care according to the direction of a licensed physician.	F 281	**F281** 1. Resident #81's blood sugar parameters will be followed per physician order. 2. All residents have the potential to be affected by this practice. All physician orders will be followed as written. 3. Unit Managers will audit residents with blood sugar parameters for following physician orders five times a week for one month, weekly for two months, and then monthly. All licensed nurses will be inserviced on following physician orders. 4. Results of audits and inservices will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	
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 physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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 309	Continued From page 9 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of staff training documentation and facility protocols, the facility failed to provide services to maintain the highest practicable level of well-being for 3 of 21 sample residents (#48, #77, #114). One resident (#77) was not provided care to minimize or prevent pain. One resident (#114) at risk for skin breakdown was not provided repositioning assistance. One resident (#48) was not provided toileting assistance to minimize bowel incontinence. The findings were: PAIN 1. Review of the 5/27/05 admission face sheet for resident #77 revealed the resident had sustained a right femur fracture. Observation on 6/29/05 at 8:45 AM showed the resident had a brace on his/her right leg. The following concerns were noted: a. Review of the resident's June 2005 care plan showed he/she was to be medicated for pain per physician's orders and to monitor for effectiveness. Review of the June 2005 medication administration record (MAR) showed the resident could receive Ultracet one or two tablets every four hours when necessary for pain. On 6/29/05 at 8:45 AM during the breakfast meal the resident sat in a wheelchair on the third floor. The resident was refusing to eat breakfast and complained of pain in his/her right leg stating, "My leg, my god damn leg." Interview with the unit	F 309	**F309** 1. Resident #77 will be assessed for a routine pain management program. Resident #114 will be repositioned every two hours and provided with a rest period every morning. Resident #48 will have a new bowel and bladder assessment done and protocol for positioning and toileting put in place. 2. All residents have the potential to be affected by this practice. Each resident will receive the necessary care and services to maintain the residents highest level of function. 3. All nursing staff will be inserviced on pain management program and toileting/repositioning policy and procedures. All residents most recent MDS will be reviewed for risk of pain to ensure they have a pain management program and care plan is updated by Unit Managers. Unit Managers will review all residents for toileting/repositioning needs and update C.N.A. ADL sheets and care plans. Unit Managers will conduct random audits for compliance of toileting/repositioning. All appropriate staff will be inserviced on toileting/repositioning schedules for residents in bed and wheelchairs. Director of Nursing will perform random audits of repositioning and toileting schedules to ensure compliance by nursing staff and Unit Managers. 4. Results of inservices, rounds, and audits will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	

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F 309	Continued From page 10 manager at that time revealed although the resident was able to state when he/she was in pain, the resident was not going to receive pain medication. She stated the nursing staff were afraid to give the resident pain medication when needed because the resident's son didn't want the resident to have any. She further stated that in the past, when the nurses gave the resident pain medication, the resident's son would get upset and confrontational with the staff. After the surveyor spoke with staff, and after staff deliberation and a directive by the director of nursing (DON) and the unit manager, the resident was medicated for his/her pain. Observation on 6/29/05 at 9:15 AM revealed the resident was lying in his/her bed asleep and appeared comfortable. b. Interview with the DON on 6/29/05 at 9 AM revealed the resident should have been on a pain management program. REPOSITIONING: 2. Review of an interdisciplinary note dated 12/24/04 showed resident #114 had two stage II pressure wounds to the buttocks. Review of an interdisciplinary note dated 1/14/05 showed the wounds were healed. Review of the 3/31/05 Resident Assessment Protocol (RAP) module for pressure ulcers showed the resident had a history of pressure ulcers related to decreased mobility. Review of the 6/24/05 Braden Scale (for predicting pressure sore risk) showed the resident had very limited mobility (unable to make frequent or significant changes independently). Review of the care plan dated 6/13/05 showed "...When resident is out of bed, change position q [every] 2 hrs by toileting, boosting, shifting of weight, ambulating, or return to bed for rest." Review of the certified nurse aide (CNA) care	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	06/30/2005

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MOUNTAIN TOWERS HEALTHCARE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 309	Continued From page 11 plan summary sheet (undated) showed the resident was a two person extensive assist for transfers. Review of the resident rest schedule dated 6/05 showed the resident was to be laid down in the morning. Observation on 6/28/05 from 9:30 AM until 1:15 PM showed the resident was seated in a Broda chair (wheeled chair with straps between the legs). The resident was not repositioned during the continuous observation (3 hours 45 minutes). During an interview on 6/30/05 at 8:40 AM, CNA #33 stated the resident was in a Broda chair with straps, therefore could not get out of the chair by himself/herself. The CNA further stated the resident should be laid down in the mornings. Review of staff training documentation dated 3/23/05 ("Nursing Assistant Expectation List") revealed residents must be repositioned at least every two hours. Review of staff training documentation dated 5/2/05 ("Resident Positioning in Wheelchair") showed residents in wheelchairs need to be repositioned every hour by nursing staff. Review of the facility's "Wound Management Protocols" (5/8/05) showed residents with Braden scale scores between 14 and 17 would be provided with a rest period every morning (the Braden scale dated 6/24/05 for this resident was 16). 3. Review of the 5/27/05 admission Minimum Data Set (MDS) assessment showed resident #48 required total assistance from staff for repositioning, transferring, and bed mobility. Further review of that assessment showed the resident was admitted with diagnoses which included aphasia (inability to speak or to speak correctly). On 6/28/05 at 9:15 AM observation showed resident #48 seated in the second floor	F 309		

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F 309	Continued From page 12 commons area. Further observation showed the resident remained there until 11 AM when staff took the resident to his/her room to be weighed. After weighing the resident, certified nurse aides (CNAs) #30 and #47 failed to check the resident's brief for incontinence before returning him/her to the commons area where s/he remained until 1:05 PM when taken back to the room. Observation at 1:15 on 6/28/05 showed the resident was incontinent of bowel. In addition, the resident's buttocks had a red rash with numerous small open areas where feces touched the skin. The resident was unable to speak but moved away while being cleansed, and CNA #30 stated the resident had recently had several incontinent bowel movements which seemed to burn the skin. Despite knowing about the problems which resulted from the resident's bowel incontinence, staff failed to check and/or change his/her incontinence brief for four hours.	F 309		
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, medical record review, and staff interview, the facility failed to provide services to maintain the ability for toilet use for one of thirteen sample residents (#114) who had the ability to use a toilet. The findings were: Review of the 6/14/05 quarterly Minimum Data	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	06/30/2005

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F 311	Continued From page 13 Set (MDS) assessment showed resident #114 required extensive staff assistance for toilet use. Review of the care plan dated 6/13/05 revealed the resident was to be assisted to toilet per the toileting schedule. However, observation on 6/27/05 at 7 PM showed certified nurse aide (CNA) #7 and the unit manager (a licensed practical nurse) laid the resident down in bed, and then checked the resident for incontinence. The resident was not offered, or put on, the toilet. On 6/28/05 at 1:15 PM, CNAs #33 and #34 laid the resident down in bed, and then checked the resident for incontinence. Again, the resident was not offered, or put on, the toilet. During an interview on 6/29/05 at 4 PM, the restorative nurse stated the resident should be put on the toilet because the resident had the ability to use the toilet. The restorative nurse stated she encouraged staff to put the resident on the toilet because it benefited the resident. On 6/30/05 at 8:40 AM, CNA #33 confirmed the resident had the ability to use the toilet.	F 311	**F311** 1. Resident #114 will be assisted to the toilet per toileting schedule. 2. All residents have the potential to be affected by this practice. All residents will be given the appropriate treatment and services to maintain or improve his or her abilities. 3. Each resident will be assessed for required assistance with toileting. All nursing staff will be inserviced on toileting policy and procedure and toileting schedules. Unit Managers to ensure compliance of toileting schedules and assistance will conduct random audits five times a week. 4. Results of assessments, inservices, and audits will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of meal intake records and facility policies, the facility failed to provide necessary services to maintain nutrition for four (#77, #81, #98, #106) of eleven sample residents	F 312		

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	535013	A. BUILDING _____ B. WING _____	06/30/2005

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F 312	Continued From page 14 who required assistance with dining. In addition, the facility failed to provide good personal hygiene during three of ten observations of perineal care for residents (#77, #85, #99). The findings were: NUTRITION: 1. Review of the 5/17/05 quarterly Minimum Data Set (MDS) assessment for resident #98 revealed he/she required extensive assistance with eating. Observation on 6/27/05 at 6:15 PM revealed the resident received his/her dinner tray; staff removed the cover and placed the tray in front of the resident. Continuous observation on 6/27/05 from 6:15 PM to 6:40 PM (25 minutes) revealed no staff assisted or encouraged the resident to eat. Review of the monthly meal and fluid intake record revealed the resident ate only ten percent of his/her evening meal on 6/27/05. 2. Review of the 9/8/04 significant change and the 5/10/05 quarterly MDS assessments revealed resident #81 required staff assistance with eating. Observation of the evening meal on 6/27/05 revealed the resident received his/her dinner at 6:15 PM; staff removed the cover on the plate and placed it in front of the resident. Continued observation revealed the resident sat sleeping in his/her wheelchair from 6:15 PM until 6:45 PM (30 minutes) during which time no staff member assisted the resident. Review of the monthly meal and fluid intake record revealed the resident ate 35% of the evening meal on 6/27/05. 3. a. Review of the 6/24/05 admission MDS assessment for resident #106 revealed he/she was admitted with diagnoses including demential other than Alzheimer's disease and chronic obstructive pulmonary disease. Further review	F 312	**F312** 1. Residents #77, #81, #98, and #106 will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Residents #77, #85, and #99 will receive appropriate perineal care. 2. All residents have the potential to be affected by this practice. Residents will be given the necessary services to maintain nutrition. Residents will be provided with good personal hygiene. 3. Unit managers will monitor dining service five times a week during rounds to assure each resident is being assisted appropriately at meals, appropriate seating arrangement and adequate staffing. All nursing staff will be inserviced on not placing food in front of residents until staff is available and ready to assist. All nursing staff will receive 1:1 peri care training. Unit managers will audit for odors and completeness of C.N.A documentation. 4. Results of rounds, inservices, and audits will be brought to the monthly Performance Improvement Committee meeting for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	

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F 312	Continued From page 15 revealed the resident was cognitively impaired and required staff assistance with eating. Observation of the evening meal on 6/27/05 revealed the resident received his/her tray at 6:15 PM, but was not assisted by staff until 6:55 PM (40 minutes). Review of the meal intake record revealed the resident only consumed 40% of the evening meal on 6/27/05. b. According to the June 2005 care plan, the resident was to be assisted with meals. However, on 6/28/05 from 12:45 PM until 12:50 PM, the resident sat with a lunch tray in front of him/her. At 12:51 PM the resident took one bite of food independently. At 12:53 PM he/she took another bite. From 12:54 PM until 1 PM, the resident just sat staring at his/her spoon. From 1:04 PM to 1:05 PM the resident sipped on her juice. At 1:07 PM the resident was asleep. At 1:10 PM the resident took another sip of juice and was told by certified nurse aide (CNA) #37 to eat. The CNA then took the resident's tray away, but left a health shake and apple juice. At 1:14 PM the resident took a sip of the health shake. At 1:18 PM the resident just sat and stared around the room. At 1:22 PM the resident was asked by a staff person if she was done. Although the resident stated he/she was not finished, no staff assistance was provided. When observation ceased at 1:30 PM, the resident was again asleep. 4. Review of the 6/2/05 admission MDS assessment for resident #77 revealed the resident was admitted with diagnoses including cerebral vascular accident, dementia other than Alzheimer's disease, renal failure and congestive heart failure. Further review revealed the resident was cognitively impaired and required extensive staff assistance with eating. On 6/28/05 at 12:30	F 312		

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F 312	Continued From page 16 PM, the resident received his/her lunch tray, and the food items were left uncovered. However, the resident was not fed by staff until 12:45 PM (15 minutes). Review of the meal intake record showed the resident ate 25% of the lunch meal on 6/28/05. PERINEAL CARE: 5. On 6/29/05 at 2:50 PM CNA #5 was observed providing perineal care for resident #85. Interview with the CNA at that time revealed the resident sometimes had vaginal discharge which required thorough cleansing. She further stated when she had provided perineal care earlier, she had not used periwash cleanser so she would cleanse the perineal area again. Observation revealed the CNA wiped back to front five times during the perineal care. Interview with the CNA at that time revealed the procedure was to wipe front to back. Review of the facility's 9/26/03 policy on incontinence and perineal care #65006 revealed staff should wipe from front to back when cleansing a resident's perineal area. 6. On 6/28/05 at 9:45 AM CNA's #13 and #45 provided care to resident #77 after an episode of liquid stool incontinence. The resident's rectal area was not thoroughly cleansed of feces, nor was perineal or anterior perineal cleansing provided. 7. On 6/28/05 at 10:10 AM, CNA's #13 and #37 provided care to resident #99 after an episode of urinary incontinence. The resident was extremely odorous of urine. Although the resident's buttock and rectal area was cleansed, no cleansing was provided to the resident's anterior perineal area. In addition, the resident remained odorous of urine.	F 312		

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	535013	A. BUILDING _____ B. WING _____	7/21/05 KC 06/30/2005

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F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, and family interview, the facility failed to ensure that two (#77, #48) of 3 sample residents received appropriate care for indwelling urinary catheters. In addition, for five (#41, #52, #81, #111, #114) of 14 sample residents, the facility failed to provide appropriate treatment to restore as much bladder function as possible. The findings were: 1. Review of the June 2005 physician orders showed resident #77 was receiving Macrodantin 100 mg prophylactically for a history of chronic urinary tract infections (UTIs). Review of the June 2005 care plan showed that catheter care was to be provided after any incontinence episode. However, on 6/28/05 at 9:45 AM certified nurse	F 315	**F315** 1. Residents #77 and 48 will receive appropriate care for their indwelling catheters. Residents #'s 41, 52, 81, 111, and 114 will be provided appropriate treatment per assessment to restore as much bladder function as possible. 2. All residents have the potential to be affected by this practice. All residents with urinary catheters will receive appropriate catheter care. All residents will be assessed for bowel and bladder retraining and provided with the appropriate treatment to restore as much bladder function as possible. 3. All residents will have new bowel and bladder assessments completed and appropriate action taken by Unit Managers. Unit Managers will assess all residents with foley catheters for appropriateness. All staff will be inserviced on following toileting schedules per care plans. All nursing staff will be inserviced on cath care, foley bag position, cleaning, and leg bag usage. 4. Results of the assessments, inservices, and audits will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	

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F 315	Continued From page 18 aides (CNAs) #13 and #45 provided care to the resident after he/she had sustained an episode of liquid stool incontinence. The CNAs failed to cleanse the resident's indwelling urinary catheter. 2. Review of the 5/31/05 significant change MDS assessment showed resident #111 was frequently incontinent of bladder (incontinent daily, with some control). Review of the updated bladder assessment dated 9/8/04 showed the resident was frequently incontinent. The assessment documented the resident's toileting schedule to help manage incontinent episodes was: in the morning, before and after meals, at bedtime, and every two to three hours at night. Review of the care plan dated 6/6/05 showed the resident should be offered and encouraged to use the toilet before and after meals. Observation on 6/28/05 from 9:28 AM until 1:15 PM (after the breakfast meal until after the lunch meal) showed the resident was seated in a dining room chair in the dining room/activity area. The resident was not encouraged or offered toileting assistance. Later, at 1:26 PM, the resident was observed walking in his/her room. Interview at that time with CNA #33 revealed the resident had not been assisted to the toilet by any staff, but the CNA was going to take the resident at that time. Observation at 1:28 PM revealed the CNA assisted the resident into the bathroom. The back of the resident's pants were visibly wet, and there was a urine odor. Interview with the CNA at 1:35 PM revealed the resident had been incontinent of bladder. During an interview on 6/29/05 at 4:00 PM, the restorative nurse stated staff should follow the toileting schedules on the care plans. The restorative nurse stated two to three hours is the longest a resident should go without toileting	F 315		

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F 315	Continued From page 19 assistance. 3. Review of the 6/14/05 quarterly MDS assessment revealed resident #114 was frequently incontinent of bladder (incontinent daily, with some control). Review of the 4/1/05 bladder assessment showed the resident was incontinent and a toileting schedule was in place to assist with minimizing incontinent episodes. Review of the care plan dated 6/13/05 showed the resident should be assisted to toilet before and after meals. Observation on 6/28/05 from 9:30 AM until 1:15 PM (after the breakfast meal until after the lunch meal) revealed the resident was seated in a Broda chair (wheeled chair with straps between the legs) in the dining room/activity area. The resident was not offered or taken to the bathroom. At 1:15 PM, CNAs #33 and #34 transferred the resident to bed and provided incontinence care for the resident. Interview with CNA #34 at that time revealed the resident was "wet". During an interview on 6/29/05 at 4:00 PM, the restorative nurse stated staff should follow the toileting schedules on the care plans. The restorative nurse stated two to three hours is the longest a resident should go without toileting assistance. 4. Observation on 6/27/05 at 5:58 PM and on 6/28/05 at 9:15 AM showed resident #48 had an indwelling urinary catheter. At 1:05 PM on 6/28/05 observation showed certified nurse aide (CNA) #30 held the resident's catheter drainage bag above her head to straighten the tubing, and dark amber urine ran back up the tubing. Further observation at 1:10 PM showed CNA #15 emptied the catheter bag but failed to cleanse the	F 315		

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F 315	Continued From page 20 spigot before or after draining the bag. Review of the facility's 9/26/03 policies and procedures, "Urine Drainage Bag PRO 66201-08" and "Indwelling Urinary Catheter Insertion PRO 66201," revealed keeping the drainage bag and tubing below the level of the bladder and cleansing the spigot were not addressed. However, according to Mosby's 3rd edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, 2004, "Urine in the bag and tubing is a medium for bacterial growth, and infection can develop if urine is allowed to reflux (return to the bladder). Review of the 2004 sixth edition of "Clinical Nursing Skills" by Smith, Duell, and Martin showed "Swab end of spigot with antimicrobial swab before replacing into bag sleeve." 5. Observation of hall A on the second floor of the facility on 6/27/05 at 7:05 PM showed CNAs #11 and #15 assisted resident # 41 to the toilet. There was a strong smell of urine as the resident stood up from the wheelchair. The resident's slacks were wet from the mid-lower back to mid-thigh, and drops of urine had collected in the low spots of the wheelchair pad. During the observation, interview with CNA #15 revealed two aides were supposed to be assigned to hall A, but they were short staffed that night. The CNA further stated the resident had not been to the toilet since 2 PM (a five hour time span) as he was alone and had been unable to assist the resident. 6. Review of the 5/18/05 MDS assessment showed resident #52 was incontinent of bladder two or more times per week and was on a scheduled toileting plan. According to the care plan, staff were to toilet the resident in the morning, before and after meals, at bedtime, and	F 315		

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F 315	Continued From page 21 as needed. Interview with a family member on 6/28/05 at 11:46 AM revealed the resident required staff assistance to use the toilet. Observation on 6/28/05 from 9:17 AM until 11:46 AM showed resident #52 was involved in activities or therapy. At 11:46 AM a family member arrived and stayed with the resident. At 2:50 PM on 6/28/05, interview with the family member revealed the resident was incontinent of urine during lunch. The family member stated the resident was not assisted to the toilet before lunch, and staff were not available to provide assistance when they rang the call bell during the meal. 7. Review of the 11/22/04, the 2/16/05, and the 5/10/05 quarterly Minimum Data Set (MDS) assessments for resident #81 revealed he/she was frequently (daily with minimal control) incontinent of urine. On 6/28/05 at 1:34 PM observation revealed CNA #37 and licensed practical nurse (LPN) #11 transferred the resident from the wheelchair to the bed then provided perineal care. Observation at this time revealed the resident's incontinence brief was saturated with urine and there was a strong urine odor. Interview with the CNA on 6/28/05 at 1:34 PM confirmed the incontinence brief was saturated with urine. The following concerns were identified: a. Observation from 9:15 AM until 1:34 PM revealed the resident was not toileted prior to the noon meal or during the four hours and nineteen minutes of observation. b. During interview with CNA #37 on 6/28/05 at 1:34 PM, she stated she had not toileted the resident since breakfast but was unsure of the exact time. c. Review of the resident's 5/05 care plan revealed the resident was to be toileted every	F 315		

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(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 315	Continued From page 22 morning, before and after meals, at bedtime, and as needed. Interview with CNA #37 confirmed the resident was to be toileted before and after meals, at bedtime, and as needed.	F 315	**F327** 1. Hydration needs will be met for residents #99 and #100. 2. All residents have the potential to be affected by this practice. All residents will be provided with sufficient fluid intake to maintain proper hydration and health. 3. Unit Managers will check five times a week to ensure fluids of appropriate consistency are available to each resident at bedside, at mealtime and inbetween meals during rounds. All nursing staff will be inserviced on offering fluids when repositioning, providing cares, meal times, per resident request, and passing ice water on each shift and prn. Random audits of ice water in rooms will be conducted by Executive Director and Director of Nursing. 4. Results of rounds, inservicing and audits will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	
F 327 SS=D	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of staff training documentation, the facility failed to ensure the hydration needs were met for 2 (#99, #100) of 21 sample residents. The findings were: 1. Review of the 4/9/05 quarterly Minimum Data Set (MDS) assessment for resident #100 showed he/she was totally dependent on staff for his/her oral intake. Review of the resident's estimated fluid needs dated 10/28/04 showed the resident required 1,560 milliliters (ml) of fluid daily. However, review of the 4/05, 5/05 and 6/05 intake sheets with the third floor unit manager on 6/29/05 at 2:35 PM, revealed the resident's average fluid intake was only 800-900 ml. During observation of care on 6/28/05 at 1025 AM, staff failed to give the resident a drink of water. Interview with CNA #13 on 6/28/05 at 12:10 PM revealed the resident would sometimes go an entire day without urinating. On 6/29/05 at 3:45 PM on the resident's bedside table were a clean cup, a clean paper wrapped straw situated on top of a clean water pitcher filled with fresh water. At 5:10 PM the resident's water pitcher, straw and	F 327		

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	535013	A. BUILDING _____ B. WING _____	06/30/2005

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F 327	Continued From page 23 cup remained intact and untouched. At 5:45 PM the resident's lips were noted to be dried and cracked. 2. Review of the 4/9/05 quarterly Minimum Data Set (MDS) assessment showed resident #99 required extensive assistance with oral intake. Review of the resident's June 2005 physician orders showed the resident received cranberry tablets one daily for recurrent urinary tract infections (UTIs). Review of the resident's current estimated fluid needs showed the resident required 1,728 milliliters (mls) of fluid daily. However, review of the 6/05 intake sheets with the third floor unit manager on 6/29/05 at 2:35 PM revealed the resident's average fluid intake was only 840 mls. During observation on 6/28/05 at 10:10 AM the resident was assisted to bed. The resident was incontinent of urine which was extremely odorous. However, both CNA #13 and #37 failed to give the resident a drink of water. On 6/29/05 at 05:35 PM, the resident was being cared for by CNA #46 and the registered nurse (RN) supervisor. Although the resident's lips were visibly dried and cracked, and his/her urine was pungent and visibly concentrated (having stained the pad underneath him/her), neither staff offered the resident a drink of water. 3. Interview with the third floor unit manager on 6/29/05 at 2:35 PM revealed staff were instructed to provide fluids to residents when providing cares. Review of facility staff training documentation dated 3/23/05 ("Nursing Assistant Expectations List") revealed "...all residents should be offered fluids frequently throughout the day....make sure residents' water pitchers are kept full at all times and within their reach...offer fluids each time you give them cares..."	F 327		

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F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure two of thirteen sample residents (#111, #118) with physicians' orders for oxygen received it in accordance with the orders to maintain oxygen saturation levels. The findings were: Review of physician's orders for resident #111 showed an order dated 5/6/05 to titrate oxygen to keep the oxygen saturation level at or above 88%. Review of a 5/11/05 physician progress note showed the resident had worsening COPD [chronic obstructive pulmonary disease], and now required oxygen 24 hours per day. Observation on 6/27/05 from 5:50 PM until 7:31 PM revealed the resident did not have oxygen on. At 7:31 PM, the unit manager (a licensed practical nurse) assessed the resident's oxygen saturation level at the request of the surveyor; it fluctuated between 80% and 81%. The unit manager stated the resident was usually on 2 liters of oxygen per	F 328	**F328** 1. Resident #111 will be provided with oxygen and oxygen sats checked per physician order. Resident #118 expired. 2. All residents have the potential to be affected by this practice. All residents will be provided with oxygen and oxygen saturations per physician orders. 3. Unit Managers will check for oxygen being placed on residents who have orders for oxygen during rounds. Unit Managers will audit oxygen sats to physician orders weekly for one month and then monthly for one quarter and as needed thereafter to ensure compliance. Unit Managers will monitor all physician oxygen orders for completeness. 4. Results of rounds and audits will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	

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F 328	Continued From page 25 minute to maintain saturation levels above 88%. The unit manager also stated the resident did not normally wear oxygen during meals. Review of a 3/17/05 physician order and the June 2005 physician's orders for resident #118 showed an order to titrate oxygen in order to maintain oxygen saturation levels above 88%. Observation on 6/27/05 from 5:49 PM until 7:30 PM showed the resident was not utilizing oxygen. At 7:30 PM, the unit manager (an LPN) assessed the resident's oxygen saturation level at the request of the surveyor; it was 84%. The nurse manager stated "...yep, need to get oxygen on him."	F 328		
F 353	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		

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F 353	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident and family interviews, review of the resident status report, and medical record review, the facility failed to provide sufficient staff to provide care and services to minimize bladder incontinence and/or maintain nutrition for six of 21 sample residents (#41, #52, #77, #81, #98, #106) and one non-sample resident (#89). The residents resided on the second and third floors. The findings were: 1. a. Observation on the days of the survey revealed three certified nurse aides (CNAs) provided care for 34 residents on the third floor. Review of the resident status report revealed 14 of the 34 residents required staff assistance and/or were totally dependent upon staff for eating. In addition, 10 residents required the assistance of two staff for transfers and another two residents required extensive assistance with transfers. b. Confidential interview with a staff member on 6/30/05 at 8 AM and a second staff member at 8:10 AM revealed there was not enough staff to meet all resident needs and to accomplish all the required tasks. The staff members further stated beds did not get made, sheets did not get changed as needed (observation on 6/29/05 at 3:30 PM revealed sheets on the bed of resident #81 had a large urine stain), and residents were not toileted as often as needed.	F 353	**F353** 1. Sufficient staff will be scheduled on 2nd and 3rd floors to provide care and services to minimize bladder incontinence and/or maintain nutrition for resident #'s 41, 52, 77, #81, 98, 106, and 89. Staffing will be based on acuity 2. All residents have the potential to be affected by this practice. Sufficient staff will be provided per acuity on a 24 hour basis to assure care is provided in accordance to the resident care plans. New staff are consistently being hired. 3. Director of Nursing will audit staffing ratios each day to assure adequate staffing per acuity levels on each floor. Director of Nursing will continue to advertise and hire as appropriate. The Director of Nursing will present a time management inservice for appropriate nursing staff. 4. Results of the audits and inservices will be brought to the monthly Performance Improvement Committee for review, comments, and suggestions. 5. Compliance Date: August 12, 2005	

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F 353	Continued From page 27 2. Confidential interview with a family member on 6/29/05 revealed concerns pertaining to facility staffing. The family member stated that during the survey there was more staff on the floor assisting with dining, feeding, and providing incontinence care for residents. The family member also voiced concern that his/her family member would not be fed if he/she could not come in to provide the assistance. 3. Observation of hall A on the second floor of the facility on 6/27/05 at 7:05 PM showed CNAs #11 and #15 assisted resident # 41 to the toilet. There was a strong smell of urine as the resident stood up from the wheelchair. The resident's slacks were wet from the mid-lower back to mid-thigh, and drops of urine had collected in the low spots of the wheelchair pad. During the observation, interview with CNA #15 revealed two aides were supposed to be assigned to hall A, but they were short staffed that night. The CNA further stated the resident had not been to the toilet since 2 PM (a five hour time span) as he was alone and had been unable to assist the resident. 4. Review of the 5/18/05 Minimum Data Set (MDS) assessment showed resident #52 was incontinent of bladder two or more times per week and was on a scheduled toileting plan. According to the care plan, staff were to toilet the resident in the morning, before and after meals, at bedtime, and as needed. Interview with a family member on 6/28/05 at 11:46 AM revealed the resident required staff assistance to use the toilet. Observation on 6/28/05 from 9:17 AM until 11:46 AM showed resident #52 was involved in activities or therapy. At 11:46 AM a family member arrived and stayed with the resident. At 2:50 PM on 6/28/05, interview with the family	F 353		

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F 353	Continued From page 28 member revealed the resident was incontinent of urine during lunch. The family member stated the resident was not assisted to the toilet before lunch, and staff were not available to provide assistance when they rang the call bell during the meal. 5. Review of the 11/22/04, the 2/16/05, and the 5/10/05 quarterly Minimum Data Set (MDS) assessments for resident #81 revealed he/she was frequently (daily with minimal control) incontinent of urine. On 6/28/05 at 1:34 PM observation revealed CNA #37 and licensed practical nurse (LPN) #11 transferred the resident from the wheelchair to the bed then provided perineal care. Observation at this time revealed the resident's incontinence brief was saturated with urine and there was a strong urine odor. Interview with the CNA on 6/28/05 at 1:34 PM confirmed the incontinence brief was saturated with urine. The following concerns were identified: a. Observation from 9:15 AM until 1:34 PM revealed the resident was not toileted prior to the noon meal or during the four hours and nineteen minutes of observation. b. During interview with CNA #37 on 6/28/05 at 1:34 PM, she stated she had not toileted the resident since breakfast but was unsure of the exact time. c. Review of the resident's 5/05 care plan revealed the resident was to be toileted every morning, before and after meals, at bedtime, and as needed. Interview with CNA #37 confirmed the resident was to be toileted before and after meals, at bedtime, and as needed. 6. Review of the 5/17/05 quarterly MDS assessment for resident #98 revealed he/she required extensive assistance with eating.	F 353		

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F 353	Continued From page 29 Observation on 6/27/05 at 6:15 PM revealed the resident received his/her dinner tray; staff removed the cover and placed the tray in front of the resident. Continuous observation on 6/27/05 from 6:15 PM to 6:40 PM (25 minutes) revealed no staff assisted or encouraged the resident to eat. Review of the monthly meal and fluid intake record revealed the resident ate only ten percent of his/her evening meal on 6/27/05. 7. Review of the 9/8/04 significant change and the 5/10/05 quarterly Minimum Data Set (MDS) assessments revealed resident #81 required staff assistance with eating. Observation of the evening meal on 6/27/05 revealed the resident received his/her dinner at 6:15 PM; staff removed the cover on the plate and placed it in front of the resident. Continued observation revealed the resident sat sleeping in his/her wheelchair from 6:15 PM until 6:45 PM (30 minutes) during which time no staff member assisted the resident. Review of the monthly meal and fluid intake record revealed the resident ate 35% of the evening meal on 6/27/05. 8. a. Review of the 6/24/05 admission MDS assessment for resident #106 revealed he/she was admitted with diagnoses including demential other than Alzheimer's disease and chronic obstructive pulmonary disease. Further review revealed the resident was cognitively impaired and required staff assistance with eating. Observation of the evening meal on 6/27/05 revealed the resident received his/her tray at 6:15 PM, but was not assisted by staff until 6:55 PM (40 minutes). Review of the meal intake record revealed the resident only consumed 40% of the evening meal on 6/27/05. b. According to the June 2005 care plan, the	F 353		

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F 353	Continued From page 30 resident was to be assisted with meals. However, on 6/28/05 from 12:45 PM until 12:50 PM, the resident sat with a lunch tray in front of him/her. At 12:51 PM the resident took one bite of food independently. At 12:53 PM he/she took another bite. From 12:54 PM until 1 PM, the resident just sat staring at his/her spoon. From 1:04 PM to 1:05 PM the resident sipped on her juice. At 1:07 PM the resident was asleep. At 1:10 PM the resident took another sip of juice and was told by certified nurse aide (CNA) #37 to eat. The CNA then took the resident's tray away, but left a health shake and apple juice. At 1:14 PM the resident took a sip of the health shake. At 1:18 PM the resident just sat and stared around the room. At 1:22 PM the resident was asked by a staff person if she was done. Although the resident stated he/she was not finished, no staff assistance was provided. When observation ceased at 1:30 PM, the resident was again asleep. 9. Review of the 6/2/05 admission MDS assessment for resident #77 revealed the resident was admitted with diagnoses including cerebral vascular accident, dementia other than Alzheimer's disease, renal failure and congestive heart failure. Further review revealed the resident was cognitively impaired and required extensive staff assistance with eating. On 6/28/05 at 12:30 PM, the resident received his/her lunch tray, and the food items were left uncovered. However, the resident was not fed by staff until 12:45 PM (15 minutes). Review of the meal intake record showed the resident ate 25% of the lunch meal on 6/28/05.	F 353		