PoC received & approved with change on pages 2 + 14. Approval for changes given via telephone by DON on 1/14/11 at 935 Jim Linda Brown RN

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

PRINTED: 12/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING _____ B. WING _____	12/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1111 LANE 12 LOVELL, WY 82431

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON- Director of Nursing CNA- Certified Nurse Aide COTA - Certified Occupational Therapy Assistant MDS- Minimum Data Set RD - Registered Dietitian Less commonly used abbreviations will be annotated in each deficiency	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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	F 157	F157 The facility will immediately inform the resident physician and legal representative or interested family member of accidents which result in injury to the resident, significant changes in the resident physical, mental, or psychosocial status, a need to alter treatment significantly, or decision to transfer or discharge a resident from the facility.	01/28/11

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

Mary Bair RN | Acting Administrator | 1-7-2011

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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Wyoming Dept of Health

JAN 12 2011

Office of Healthcare Licensing and Surveys

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F 157	Continued From page 1 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.	F 157		
	This REQUIREMENT is not met as evidenced by: Based on staff interview, physician interview, and medical record review, the facility failed to notify the physician of changes in condition which created an immediate jeopardy for 1 of 14 sample residents (#72) who experienced a significant change in condition. The findings were: Review of the medical record for resident #72 showed s/he experienced multiple episodes of coughing/choking during meals while being fed by staff over the past year. Additionally, this same resident experienced eight episodes of seizure activity over the past year. Continued review of the medical record showed the physician was only notified of one episode of seizure activity (7/22/10) and was not notified at all of the resident's coughing/choking episodes. Interview with a family member on 12/15/10 at 9:06 PM revealed the family was not notified of any coughing/choking episodes or seizure activity. Refer to Federal citation F309 for details related to this immediate jeopardy situation. The immediate jeopardy was abated on 12/16/10 at 10:32 AM.		A)Resident #72 was evaluated on 12/15/10 by a provider in regards to seizures, choking, and medications. B)All nurses will be educated on the importance and procedures of immediately reporting changes in condition to the physician and legal representative/family member. 01/28/11 C)Resident #72 underwent swallow evaluation performed by a speech therapist. 12/16/10 D)Mandatory in-service for all C.N.A.'s on Aspiration precautions and proper seating during meals was completed. 12/22/10 E)Chart reviews were performed on all residents to identify potential choking risks and care planned accordingly. F)The Registered Dietician will observe each dining area monthly and report to DON any concerns. G) Monitoring & audit results will be reported quarterly as part of the facility QA Program. added c telephone permission of Tracey Hanson DON on 1/14/11 @ 3:35 PM LB	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

LB

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F 225	Continued From page 2 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, medical record and policy review, and staff interview, the facility failed to	F 225	F225 A)The facility will ensure all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law. The facility will thoroughly investigate all alleged violations and prevent further potential abuse while the investigation is in progress and report results to the administrator and other officials in accordance with state law. A)Resident #38 has been assessed for injuries of unknown source and interventions placed as appropriate. B)Education will be provided to all nursing staff on reporting injuries of unknown sources and facility abuse prevention plan. C)24 hour report sheets will be reviewed three times per week and as needed by nursing supervisor to monitor resident #38 and all residents for potential injuries of unknown source. Results will be reported quarterly as part of the facility Quality Assurance Program. A)Resident #38 has been assessed for injuries of unknown source and interventions placed as appropriate.	01/31/11

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F 225	Continued From page 3 ensure an injury of unknown origin was reported and investigated for 1 of 1 sample residents (#38) with an injury of unknown origin. The findings were: On 12/14/10 at 2:20 PM, observation showed resident #38 had a series of bruises extending from the groin area down to the ankle on both lower extremities. The bruises were brown in color and of varying sizes with some blending together. Interview with RN #1 at the time revealed she was unaware of the bruised areas and did not know what happened. The following concerns were identified: a. During an interview on 12/14/10 at 2:25 PM, CNA #1 stated she noticed the bruising on the resident earlier that day when she provided incontinence care, but "didn't even think about it." b. On 12/14/10 at 5:20 PM, RN #1 stated the bruising looked about a week old. She looked through the 24 hour report, and stated there was no mention of that bruising. She stated when an injury of unknown origin was discovered, an incident report should be filled out, and an investigation done. Further medical record review showed no documentation of the bruising prior to the surveyor's observation of it on 12/14/10. c. During an interview on 12/15/10 at 10:55 AM, the bath aide (CNA #2) stated the resident had a bath yesterday afternoon (12/14/10). She stated she noticed bruising to the resident's upper inner thighs, but the bruises were faded, and not new. She stated she did not notify the nurse because she would only report bruising if it was something "new." She further stated the resident was bathed last Friday, but she could not recall if the resident had bruising then. d. During an interview on 12/15/10 at 11:15 AM, the DON stated staff had not reported the	F 225		

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F 225	Continued From page 4 bruising to her, therefore an investigation had not been done. Review of the facility's "Abuse Prevention Plan" policy (No 1.10.1, revised 4/15/08) revealed "Any person witnessing or suspecting an abusive incident including injury of unknown source should report it to the Charge Nurse immediately...the incident will also be reported immediately to the CEO, the State Ombudsman, the appropriate law enforcement official or DFS, as well as the State Survey and Licensing Agency...All alleged violations including injuries of unknown source will be investigated as quickly and as thoroughly as possible."	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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, medical record review, and staff interview, the facility failed to ensure 10 of 10 residents (#4, #10, #13, #34, #38, #48, #50, #55, #57, #58) who received pureed textured diets were treated in a dignified manner related to meal options. In addition, the facility failed to ensure residents were treated with dignity and in a homelike environment during dining, affecting sample residents #38, #51, #52, #55, #58, #70, #72 and non-sample resident #74. The findings were: Observation during meals in the secure care unit	F 241	F241 The facility will 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.	01/31/11

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F 241	Continued From page 5 (SCU) on 12/14/10 at 7:45 AM, 12/14/10 at 5:40 PM, and 12/15/10 at 5:43 PM revealed the plates, glasses and utensils were left on the plastic serving trays, instead of placing the items directly on the table. This was done for all residents, including sample residents #38, #58, #55, #51, #52, #70, and #72. Review of the care plans for those residents showed no mention of the trays. Interview with the DON on 12/16/10 at 8:15 AM revealed meal trays were not to be left on the table during the meal unless the resident specifically asked for it. If a resident asked to have the tray left during the meal, his or her care plan was to reflect it was the resident's preference. The DON further stated all staff were educated not to leave the meal trays unless a resident expressed s/he wanted the tray left. Review of the 6/24/10 and 9/10/10 quarterly MDS assessments for resident #70 showed s/he required total assistance with meals and was unable to make his/her needs known. Observation of the breakfast meal on 12/14/10 showed CNA #4 stood while feeding the resident throughout the entire meal. Interview with the CNA on 12/15/10 at 4:13 PM revealed she was unaware standing to feed a resident did not maintain a resident's dignity. Interview with the DON on 12/16/10 at 8:02 AM revealed all staff were trained to sit while assisting residents with meals. Observation of the breakfast meal on 12/14/10 showed CNA #4 piled multiple soiled clothing protectors on the table where non sample resident #74 was still seated. Interview with the DON on 12/16/10 at 8:02 AM revealed staff were educated to place soiled linen in the laundry carts. Interview with the CNA on 12/15/10 at 4:13 PM	F 241	A)Plates and glasses are removed from plastic serving trays to include but not limited to residents #38, #58, #55, #51, #52, #70, and #72 unless care planned per resident request. B)Random dining room rounds will be done weekly by nurse supervisor and charge nurse. A) The facility will ensure all staff are seated while feeding residents at mealtimes. B)Random dining room rounds will be done weekly by charge nurse and nurse supervisor. A)The facility will ensure clothing protectors and all soiled linens are placed in laundry carts according to facility policy. B)Monitoring of compliance of staff will be done weekly by the charge nurse and nurse supervisor.	

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F 241	Continued From page 6 revealed she was unaware of the need to place the soiled clothing protectors in a cart prior to transporting them to laundry. During observation of the evening meal preparation on 12/14/10 at 2:30 PM, cook #1 prepared pureed food for residents who had physician orders for pureed diets. The cook stated that residents on pureed diets were not offered food choices. Interview with the dietary manager on 12/15/10 at 10:10 AM revealed there was one sample resident (#38) and nine non-sample residents (#4, #10, #13, #34, #48, #50, #55, #57, #58) who had pureed diet orders. She confirmed the facility did not provide an alternative or second option, and the cook determined what was to be pureed. Observation of the evening meal service on 12/14/10 from 5:30 PM to 6:30 PM revealed residents who did not have pureed diets were offered an option of homemade tomato soup and sandwich or chicken casserole as the main dish. However, residents with pureed diet orders were not offered the same option. Instead all residents who received pureed diets were served pureed chicken casserole. None of these residents was offered the choice of an alternative.	F 241	A)All residents including residents receiving pureed textured diets including residents #4, #10, #13, #34, #38, #48, #50, #55, #57, #58 are offered more than one meal choice at meal times. B)Random menus will be selected and monitored weekly by Dietary. Results will be reported quarterly as part of the facility Quality Assurance Program.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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	F 280	F280 The facility will ensure a comprehensive care plan will be developed within seven days after completion of the comprehensive assessment, prepared by the Interdisciplinary Team, and periodically reviewed and revised by team of qualified persons after each assessment and as needed.	01/28/11

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F 280	Continued From page 7 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 observation, medical record review, and staff interview, the facility failed to ensure the care plan was updated to reflect current status for 2 of 14 sample residents (#38, #72). The findings were: 1. Refer to F315 for details regarding the facility's failure to update the plan of care related to bladder incontinence for resident #38. 2. Refer to Federal citation F309 for details regarding the facility's failure to update the care plan for resident #72 to address his/her seizure activity and choking potential while eating.	F 280	A)Care plans will be reviewed and updated by the Interdisciplinary Team quarterly following the assessment. Care plans will be updated for resident #38 and #72 and all other resident daily as needed by charge nurse. B)Charge nurses will be educated on care planning requirements. C)Compliance will be monitored by weekly rounds by nurse supervisor to compare changes to 24 hour sheet to ensure care plan was updated. D)Results will be reported quarterly as part of the facility Quality Assurance Program.	
F 285	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after	F 285	F285 The facility will not admit any residents without screening for metal illness or mental retardation prior to admission by completing a PASRR on the resident before admission.	01/28/11

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F 285	Continued From page 8 January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 285	A)A checklist titled "New Admission Medicaid Schedule" is in place to track pre-admission requirements including PASRR requirements done by the nurse supervisor. B)Monitoring of compliance of completion of PASRR will be done with each admission by nurse supervisor. C)Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 285	Continued From page 9 interview, the facility failed to screen 2 of 17 residents (#12, #3) for mental illness or mental retardation prior to admission. The findings were: Review of medical record for resident #12 revealed the resident was admitted to the facility on 8/9/10. Further review of the record revealed facility staff did not complete the Preadmission Screening and Resident Review (PASRR) until 11/23/10. Review of the medical record showed resident #3 was admitted on 5/27/10. However, review of the Pre-Admission Screening and Resident Review (PASRR) showed it was dated 11/23/10. During an interview on 12/15/10, the RN (#2) responsible for the PASRR confirmed the assessment was late, and should have been completed prior to admission. The administrator was interviewed on 12/16/10 at 8:48 AM at which time she also verified she had failed to complete the PASRR forms for the above two residents prior to admission.	F 285		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and	F 309	F309 The facility will ensure each resident will receive the necessary care to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with comprehensive assessment and plan of care.	01/28/11

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F 309	Continued From page 10 medical record review, the facility failed to provide care and services to identify risk factors or potential treatment goals for 1 of 8 sample residents (#72) with swallowing issues. In addition, the facility failed to ensure 1 of 4 sample residents (#72) who were on anti-seizure medications received the care and services to identify risk factors or potential treatment interventions for seizure activity. The facility's failure to provide services related to the resident's swallowing difficulty as well as for potential choking related to an unaddressed seizure activity resulted in an immediate jeopardy situation. The findings were: 1. Regarding swallowing difficulties and potential for aspiration: Review of the 4/22/10 annual and the 7/22/10 quarterly MDS assessments for resident #72 showed s/he had swallowing and chewing problems. Review of the 10/20/10 quarterly MDS assessment showed the resident received a mechanically altered diet and was totally dependent on staff for feeding. Observation of the resident on 12/14/10 from 7:53 AM to 8:25 AM revealed the resident was seated in a reclined position while being fed by a CNA. The resident's head was extended back toward the chairback. During the observation the resident coughed three times while being fed, and an upper airway rattling, or gurgling noise was heard. Observation of the resident on 12/14/10 from 5:30 PM to 6:06 PM during the evening meal showed the resident was again seated in a reclined position while a CNA fed him/her. The resident's head was again observed to be extended back toward the chairback. This observation also showed the resident coughed during the meal, and an upper	F 309	A)Dietician will observe each dining area monthly and report to DON any concerns. 12/20/10 B)Each C.N.A. employed attended mandatory in-service for aspiration precautions and proper seating during meals. 12/22/10 C)All residents identified as at risk for choking were evaluated by a speech therapist and care plans were revised. 12/19/10 D)Random observation of two dining rooms at mealtime will be done weekly by a nurse supervisor. 01/28/11 E)Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 309	Continued From page 11 airway rattling was heard. The following concerns were identified related to the lack of assessment and care provided to the resident in regard to his/her swallowing difficulties: a. Review of the nurses' notes revealed the following: 1. on 2/16/10 at 6 PM the resident choked on sputum during dinner, 2. on 2/22/10 at 8 AM the resident was fed by staff and had "a lot of coughing".... 3. on 3/2/10 at 10 AM "loose moist cough." 4. on 3/20/10 at 2 PM resident had "very cool moist cough." 5. on 3/21/10 at 2 PM the resident continued with "very moist cough." 6. 6/2/10 at 2 PM the the resident had loose moist cough. 7. on 6/11/10 at 2 PM the resident had a loose moist cough. 8. on 6/18/10 at 9 AM the resident had a loose moist cough,. 9. on 8/13/10 at 6 AM the resident had loose cough. 10. on 8/20/10 at 10 AM the resident chokes easily and had a "very loose moist cough." 11. on 11/13/10 at 10 AM, the resident had difficulty swallowing and a loose moist cough. 12. on 12/26/10 at 12 noon the resident had loose moist cough. 13. on 11/27/10 at 8 AM the resident had loose moist cough. 14. on 11/28/10 at 12 noon the resident was coughing. b. Review of the nutrition risk assessments dated 2/2/10, 4/21/10, 7/20/10, and 10/21/10 showed the resident had swallowing and chewing problems. The dietitian recommended a	F 309		

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F 309	Continued From page 12 mechanical soft diet with ground meat. c. Interview with CNA #6 on 12/15/10 at 4:05 PM revealed he was aware the resident had difficulty swallowing at times during meals. When asked what he would do during the resident's coughing/choking episodes; the CNA said he would cover the resident's mouth to make sure s/he did not "spew food" on other residents. When asked if he thought it would help to sit the resident up straighter in the chair the CNA said, "Yes, I should have done that." Interview with CNA #4 on 12/15/10 at 4:13 PM revealed she knew to sit the resident up during coughing/choking episodes. However, observation of breakfast on 12/14/10 from 7:53 to 8:25 AM showed the CNA did not reposition the resident upright despite three episodes of coughing and choking. d. Review of the medical record showed no evidence a swallowing evaluation was ordered or performed even though dietary had identified swallowing as a problem for this resident on the 2/2/10 nutritional assessment. Interview with the resident's physician on 12/15/10 at 2:10 PM verified he was unaware of the resident's swallowing difficulties and, therefore, no swallowing evaluation had been ordered for this resident. e. According to The Lippincott Manual of Nursing, Seventh Edition, 2001 residents with difficulty swallowing should be referred to a speech therapist to determine what consistency of food is safe for the resident to swallow; and techniques such as sitting upright, tucking and turning the head to facilitate swallowing (pp. 180-181). The manual also documented a resident's cough should be evaluated in relationship to food intake (p. 196). From the time the problem was identified on 2/2/10 until the survey in December	F 309		

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F 309	Continued From page 13 2010, there was no evidence the facility had consulted a speech therapist despite the resident's documented history of swallowing difficulties. 2. Regarding potential choking and/or aspiration during seizure activity: Review of the nursing notes for resident #72 showed the following entries: a. 1/28/10 at 4:20 AM, CNA summoned nurse due to the resident appearing to be having a seizure, vital signs were normal. b. 2/28/10 at 8 AM, question seizure during breakfast c. 5/1/10 at 6 AM seizure episode d. 6/13/10 at 5 AM seizure during pericare, scant blood visible in saliva, has small cut on left outer tongue. e. 6/25/10 at 4:50 AM seizure, clinic notified at 10:15 AM f. 9/24/10 at 5 AM, body limp, foam coming from mouth seizure, no vital signs taken. g. 10/30/10 at 7 AM seizure, aspirated, suctioned h. 11/4/10 at 2 AM, seizure activity, snoring with gurgling sounds, unable to suction, head of bed elevated. Review of the entire medical record showed, with the exception of one time (6/25/10), the physician was not notified of the resident having seizure activity. When interviewed on 12/15/10 at 2:10 PM, the resident's physician stated he was unaware the resident was having seizure activity so often (eight times during an eleven month period). He stated that was a serious problem. The physician stated the resident was on the anticonvulsant, Depakote, but it was primarily used to control the resident's behaviors.	F 309	F309 A)All staff will be educated and follow the seizure policy/procedure for any resident experiencing seizure like activity. - vital signs will be taken at the time of seizure. - staff to stay with the resident and monitor during seizure and ensure open airway and after seizure to ensure uneventful postictal period. - place on side with pillow at head of bed to keep head flexed, slightly forward and prevent the tongue from occluding the airway. - vital signs and level of consciousness will be monitored every 15 minutes for four hours to ensure resident does not aspirate or choke. - physician will be notified immediately. - family or legal representative will be notified. - care plan will be updated.	01/28/11

resident #72 and allegation pen summary of DON on 1/14/11 at 2:35 pm. LB

LB

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F 309	Continued From page 14 Interview with a family member on 12/15/10 at 9:06 PM revealed the resident had no history of seizures. Review of the nursing notes and vital sign flowsheets revealed vital signs were not taken at the time of each seizure, and there was no evidence the resident was monitored. Interview with the resident's nurse practitioner on 12/16/10 at 8:20 AM revealed the seizure activity was most likely due to the resident's end stage Alzheimer's disease. She stated the providers should be notified so the seizures could be managed. The nurse practitioner said she would expect staff to at least monitor vital signs and the level of conscious every fifteen minutes for 3 to 4 hours to ensure the resident did not aspirate or choke on any fluids. According to Smith, Duel and Martin in "Clinical Nursing Skills,"Seventh Edition, 2008: a resident having a seizure should be placed on his or her side with a pillow at the head of the bed in order to to keep the head flexed slightly forward and prevent the tongue from occluding the airway. The resident's side rails should be in the raised position and staff should remain with the resident during the seizure to ensure the airway is not occluded and afterward to ensure s/he has an uneventful postictal period. Finally, the physician should be notified (p. 154). On 12/15/10 at 4 PM the interim administrator and DON were notified of the immediate jeopardy situation. On 12/15/10 at 4:55 PM, the DON stated she had educated the evening staff regarding this resident's coughing/choking concerns and how to intervene. Observation of that evening meal showed the resident again had coughing /choking episodes, but staff sat him/her upright as directed. In addition, the resident was	F 309	B)Compliance will be monitored weekly by reviewing 24 hour report sheet and nurses notes on residents with a history of seizure activity. C)Results will be reported quarterly as part of the facility Quality Assurance programs.	01/28/11

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F 309	Continued From page 15 placed in more of an upright position in the recliner and pillows were placed to support the resident's head to promote a more forward position. Review of the resident's care plan showed it was updated to reflect proper feeding assistance. On 12/16/10 at 8:10 AM, the DON notified the survey team that a swallowing evaluation was ordered for 5 PM on that day, and a thorough medical evaluation was scheduled by the resident's nurse practitioner at 9 AM on that day. An all staff mandatory in-service regarding proper positioning was scheduled to be completed by 10/22/10. Until the mandatory in-service was completed, each staff working with this resident was to be instructed individually prior to feeding the resident. In addition, the facility planned to have a licensed staff member monitor each meal on each unit until the mandatory in-service was completed. The completion of the nurse practitioner's physical examination, the scheduled swallowing evaluation, the updating of the care plan, in-service education and monitoring of each meal by a licensed staff member (RN, LPN, COTA, RD) abated the immediate jeopardy situation on 12/16/10 at 10:30 AM.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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.	F 315	F315 The facility will ensure a resident who enters the facility without an indwelling catheter is not catheterized unless 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.	01/28/11

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F 315	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide care to promote continence and keep the resident as dry as possible for 1 of 7 sample residents (#38) who were incontinent of urine. The findings were: Review of a bowel and bladder evaluation dated 11/2/10 showed the urinary catheter for resident #38 was discontinued on 10/28/10. The evaluation documented that staff should "check and change" the resident every two to three hours. However, review of the current care plan (updated 11/4/10) showed the check and change schedule was not included. Observation on 12/14/10 from 7:20 AM until 11:16 AM (3 hours 56 minutes) showed staff did not check the resident for incontinence. At 11:16 AM when CNAs # 3 and # 1 provided care for the resident, the resident was incontinent of urine. During an interview on 12/16/10 at 10:11 AM, RN #3 stated it was her oversight that the care plan was not updated. She further stated that staff were expected to check and change this resident every two to three hours.	F 315	A)The care plan for resident #38 is updated to include the check and change schedule. B)Resident #38 will be checked and changed every two to three hours and as needed. C)Staff will follow bowel and bladder plans for all residents. D)Compliance of staff will be monitored by random observation of residents weekly by nurse supervisor. E)Results will be reported quarterly as part of the facility Quality Assurance Program.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) 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; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	F325 The facility will ensure each resident maintains acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible. Each resident will receive a therapeutic diet when there is a nutritional problem.	01/28/11

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F 325	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure measures were in place to prevent weight loss related to chewing problems and ill fitting dentures for 1 of 5 sample residents (#79) who had dentures. The findings were: Review of the 8/24/10 admission nutrition risk assessment for resident #79 showed the resident had ill fitting dentures. Review of the 9/28/10 dietitian's notes showed the resident was down by four pounds from his/her admission weight of 109 pounds. Review of the 10/28/10 dietitian's notes showed the resident lost another 2.2 pounds. Review of the 11/22/10 nutrition therapy recommendations showed the following information "Loose dentures. FYI what do u [you] think of any intervention (.... [s/he's] lost weight." Review of the 11/25/10 nutrition risk assessment showed the resident had a 7.7% weight loss over three months, had chewing problems and ill fitting dentures. According to these notes, the resident had "chewing difficulties related to loose fitting dentures as evidenced by the need for a mechanical soft diet and observation of dentures moving while the resident talks." The following concerns were identified: a. Review of the initial social service history dated 8/24/10 showed no evidence dental needs were identified as a possible problem for this resident. Review of all social service notes showed no evidence the resident's ill fitting dentures were addressed until 11/22/10 when the	F 325	A)Resident #79 will be assessed for loose fitting dentures. B)Registered Dietician will assess each resident for nutritional problems and communicate problems and interventions to the physician. C)Monitoring of compliance will be done by chart monitoring of two charts per floor weekly by nurse supervisor. D)Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 325	Continued From page 18 dietitian made a recommendation to staff to address the issue following the resident's 7.7% weight loss in three months. b. Review of the "Physician Wish List" for 12/2/10 showed a request to the physician to check the resident's dentures. The time that elapsed between identifying the denture problem and requesting physician evaluation was 90 days (three months). As of 12/13/10, review of medical records and interview with the DON on 12/16/10 at 8:02 AM revealed no action had been taken in regard to the loose fitting dentures.	F 325		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, confidential resident interview, and staff interview, the facility failed to ensure snacks were offered each evening to all	F 368	F368 The facility will ensure each resident received at least three meals daily and the facility offers snacks to each resident at bedtime daily. A)Staff will offer snack to all residents at bedtime daily. B)Random rounds with residents on each floor will be done weekly by a nurse supervisor. C)Results will be reported quarterly as part of the facility Quality Assurance Program.	01/28/11

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F 368	Continued From page 19 residents. The census at the time was 82. The findings were: During an interview on 12/14/10 at 10 AM, ten of ten residents all agreed that evening snacks were not offered to residents. The residents stated the facility would provide a snack if they requested one. During observation of the evening meal preparation on 12/14/10 at 2:30 PM, a list was reviewed for evening snacks that included sample resident #30 and non-sample residents #28 and #31. At that time, cook #1 stated she sent evening snacks to residents on the list, and additional snacks for other residents who requested a snack. Interview with CNAs # 7 and #8 on 12/15/10 at 7:15 PM revealed they gave residents on the evening snack list the snack sent from the dietary department. They also stated that snacks were available for other residents upon request. Interview with CNA #9 on 12/15/10 at 7:30 PM, reveaeled evening snacks were provided for specific residents. She further stated snacks were available for other residents upon request.	F 368		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	F441 The facility will follow appropriate infections control practices by handling and transporting soiled linen and clothing according to facility policy. A)Education will be provided to nursing staff on transporting soiled linen using appropriate infection control procedures according to facility policy.	01/28/11

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F 441	Continued From page 20 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure staff followed accepted standards of practice in regard to hand washing and infection control practices for 1 of 14 sample residents (#72). In addition, the facility failed to ensure staff followed infection control policies in regard to gathering soiled linen. The findings were: 1. Review of the 4/22/10 annual and the 7/22/10	F 441	Staff will follow A)Proper infection control practices for all residents including resident #72. B)Monitoring of compliance of staff will be done weekly by the nurse supervisor to include observation of one staff member on each shift transporting soiled linens and one staff member on each shift following proper hand washing practices. C)Results will be reported quarterly as part of the facility Quarterly Assurance Program.	01/28/11

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F 441	Continued From page 21 and 10/20/10 quarterly MDS assessments showed resident #72 was totally dependent upon staff for personal hygiene. Observation on 12/15/10 at 9:14 AM showed the resident was incontinent of urine and feces. Observation showed CNA #5 provided perineal care and after cleansing feces, she failed to remove her soiled gloves prior to placing a clean incontinence brief and straightening the resident's clothing and bed linens. 2. Refer to Federal citation F241 for details regarding piling soiled clothing protectors on a dining table prior to taking to them to the laundry. Interview with the infection control coordinator on 12/15/10 at 1:30 PM revealed soiled clothing protectors should not have been placed on a dining table. Review of the facility policy on collection and transport of soiled linen, reviewed 3/28/05 showed "All....and Care Center units using linen items will, at collection site, bag soiled linen items in laundry bags...."	F 441		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to securely attach handrails in two locations. The findings were: Periodic observations from 12/13/10 at 3:48 PM through 12/15/10 at 2:13 PM revealed two corridor handrails were coming away from the wall near the linen closet room #3208 (5 ft length)	F 468	F468 The facility will equip all corridors with firmly secured handrails on each side. A)Corridor handrails near the linen closet room #3208 and between resident rooms #343 and #344 and all handrails are securely attached.	12/15/10

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F 468	Continued From page 22 and also between resident rooms #343 and #344 (an approximate 15 ft length). As a result, the handrails were unstable for use. Interview with the charge nurse on 12/15/10 at 2:13 PM revealed she was unaware the rails were coming away from the wall. She then stated she would "immediately put in a work order for maintenance to fix the handrails".	F 468	B)Random rounds to check handrails to check will be done weekly on each floor by the nurse supervisor. C)Results will be reported quarterly as part of the facility Quality Assurance Program.	01/28/11