STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING _____ B. WING _____	06/30/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER HEALTHCARE AND REHAB	1002 FOREST DRIVE RIVERTON, WY 82501

(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 164 SS=D	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This Requirement is not met as evidenced by: Based on observation, it was determined that the facility failed to provide privacy during the provision of personal cares for five supplemental residents (#18, #19, #20, #21, and #23). The findings included: On 6/29/05 from 4:45 AM to 6:00 AM, the following observations were made: Supplemental residents #18, #19, and #20 resided in the same room. When the two Certified Nurse Aides (CNAs) and the surveyor entered the residents' room, there was a strong urine odor. The CNAs were observed to toilet residents #18	F 164	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F-164 483.10(d) FREE CHOICE This Requirement will be met as evidenced by: All staff will be in serviced on privacy and confidentiality related to all personal and clinical records, accommodations, medical treatments, written telephone communications, personal care, visits and meetings of family resident groups. All staff were in serviced on Resident Rights on 06/30/2005. And will be in serviced again on 07/28/2005	08/19/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ED	07/30/05

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

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F 164	Continued From page 1 and #20. The bathroom door was left open while the residents were using the the bathroom. No privacy curtains were pulled during this observation. Supplemental resident #21 was provided pericare in his/her bed. The privacy curtain was not closed and the room door was open during this procedure. Supplemental resident #23 was provided pericare in his/her bed. The privacy curtain was not closed and the room door was open.	F 164	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F164 483.10(d) FREE CHOICE Continued from page 1 All nursing staff has been in serviced on privacy on 06/30/2005 And will be in serviced again on 08/14/2005.	08/19/05
F 170 SS=B	483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This Requirement is not met as evidenced by: Based on resident and staff interview, it was determined that the facility failed to deliver mail to the residents on Saturday. The findings included: A Resident Group Interview was conducted on 6/28/05 at 10:30 AM. During the interview residents were asked if they received mail on Saturdays. All five of the residents in the group interview stated that they had not received mail on Saturdays and none were sure if mail was ever delivered to the facility on Saturdays. During an interview with the facility administrator and the Director of Nursing (DON), on 6/29/05 at 2:00 PM, they indicated that mail was delivered to the business office and that activity staff delievered the mail. Later in the day, they commented that depending on the time of the	F 170	Resident care will be monitored by SDC, or designee, for privacy. Results of monitoring will be presented at the monthly Performance Improvement meeting until any and all problems are resolved.	

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F 170	Continued From page 2 mail delivery, the mail might not be delivered to residents on Saturdays.	F 170	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 223 SS=G	483.13(c) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This Requirement is not met as evidenced by: Based on observation, record review, and resident, family, and staff interview, it was determined that the facility failed to ensure that residents were free from verbal, physical, and mental abuse. The findings included: 1. Resident #4 medical record review revealed the resident was admitted to the facility from the hospital on 3/14/05. Resident diagnoses included: gastroparesis, atherosclerotic cardiovascular disease with chronic atrial fibrillation, CHF (congestive heart failure), hypertension, arthritis, DJD (degenerative joint disease), dehydration, bilateral pleural effusion and depression. a. Review of the current MDS (minimum data set) dated 6/9/05 identified the resident's cognitive skills as modified independence- usually understood and usually understands. It also identified the resident as needing supervision with transfers, ambulation, toilet use and personal hygiene. b. During interview with resident #4 on 6/28/05 at 9:10 AM and 2:00 PM the resident voiced concerns with a nurses aide who works on the night shift [Staff #1]. The resident stated, "I've got a problem with the night shift. There is an aide [name] working nights and I'm afraid of her. She grabbed me by my arm and jerked me over	F 223	F 223 483.13 (b) ABUSE This requirement will be met as evidenced by: All staff has in serviced on resident abuse, including sexual, physical, and mental abuse. Corporal punishment and involuntary seclusion was also a part of this in service on 06/30/05. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. This will be accomplished by 1. a. Resident #4 has been discharged 2. b. Employee #1 is no longer employed at the facility. 3. c. Employee #2 is on FMLA.	8/19/05

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F 223	Continued From page 3	F 223		

to my bed. I had gotten up to use the bathroom and my roommate wanted our door open so as I was opening it that aide [Staff #1] came in. She said, 'Get back to Bed' and grabbed my arm an jerked me to the bed. That wasn't right. I reported it but she lied about it and she still works here. I'll stay with my story until my dying day and she knows what she did. I'm still afraid of her [name of Staff #1]."

c. Family interview on 6/28/05 at 4:00 PM confirmed the resident had reported problems with staff treatment. The family member stated, "Mom is very sharp for her age. She told me about an aide working at night that had pushed her. She told me another staff had taken her to the office to reported it. I think it happened about a month ago. I don't know what was done about it. I know that staff [Staff #1] is still working nights and that Mom is afraid of her. So now when I'm here visiting she says she hates to see night come. I know its because she is afraid of that particular aide."

d. During observation on 6/29/05 at 5:02 AM Staff #2 (day aide) entered resident # 4's room to answer the call light. Resident #4 was standing in the bathroom. Resident #4 reported to Staff #2 that [name of Staff #1] "hurt my leg . She is so rough and she moved my leg too fast."

e. Interview on 6/29/05 with Staff #2 after leaving the resident's room confirmed that resident # 4 had reported rough treatment by [Staff # 1] before. Staff #2 said, "I have reported 3 or 4 issues of staff treatment. I took the resident to the DON (director of nursing) office so [Resident #4] could report it because I didn't feel anything was getting done. I think that was about a month ago when the [Resident #4] reported

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F 223	Continued From page 4 being grabbed or pushed. I will tell the charge nurse what the resident reported to me this morning about [Staff #1]. I do know that there are other residents that are very afraid of [Staff #1]." 2. Resident #13 medical record review revealed the resident was admitted to the facility from the hospital on 6/01/05. Resident #13's diagnoses included: hypothyroidism, hypertension, severe osteoporosis, failed left total hip with revision and cable placement and asthma. a. Review of the current MDS (minimum data set) dated 6/11/05 identified the resident's cognitive skills as independent and needing extensive assistance with bed mobility and transfers. b. During interview with resident #13 on 6/29/05 at 1:40 PM the resident voiced concerns with a nurses aide who works on the night shift [Staff #1]. Resident # 13 stated, "I have had some real concerns with the treatment of a staff person [Staff #1] working on the night shift. When I first came in I had to use the bedpan at night. The one night it spilled as [Staff #1] was taking it out. I told her the bed was wet and she ignored me so I had to lay in a wet bed the rest of the night. Then when you would ask for the pan you would get it rammed under you. The one night [Staff #1] was helping my roommate and I told her I needed to use the bedpan and she said, 'Oh shit!' I did tell the [DON] about these issues. [Staff #1] makes you feel guilty for having to go to the bathroom. Then when I needed help to get up on my legs [Staff #1] totally ignored me. I did tell [night charge nurse] and the Physical Therapist. One night I needed help to go to the bathroom. I told [Staff #1]. She sat in the chair and talked to my	F 223	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F223 483.13 (b) ABUSE Continued from page 5 2. Resident #13 has been discharged from the facility. Employee #1 is no longer employed at the facility.	08/19/05

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F 223	Continued From page 5 roommate and said, 'You can do it on your own. I couldn't stop you from falling anyway! I know I'm not to get up without help because I have had one fall already. She is not careful with you and won't go slow. It really scares me. I had an issue last night because [Staff #1] came into my room and sprayed the room. The heavy spray gave me a headache. I told [Staff #1] the spray gave me a headache and it took me an hour to get a Tylenol. I reported it to the RN and [DON] came in this morning to talk about it. I have dreaded night to come because I'm scared of [Staff #1] because you never know what is going to happen." c. During interview with resident #13 on 6/30/05 at 7:45 AM reported, "[Staff #1] came in my room last night I was really surprised because the DON told me she wouldn't be in my room again. She only emptied the trash but I was glad I didn't have to go to the bathroom last night." 3. The PT (Physical Therapist) was interviewed on 6/29/05 at 3:20 PM concerning resident # 13's reporting of staff mistreatment. The PT confirmed that resident # 13 did report staff mistreatment and it was talked about at the resident's care plan meeting on 6/21/05. Staff 1 had refused to help [Resident # 13] to the bathroom. PT reported that resident # 13 is stand by assist and is not to be walking without staff assistance and help. The PT was then asked if she was aware of any other incidents with this particular staff [Staff 1]. PT stated, "I had an issue with the same nurse aide about 6 months ago. I wrote it up and gave it to the nurse [Staff Development Coordinator]. The incident was with Staff #1 being verbally aggressive with a resident coming from lunch."	F 223	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F223 483.13 (b) ABUSE Continued from page 5 Continued from page 5	08/19/05

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F 223	Continued From page 6 4. On 6/29/05 at 9:30 AM, during an interview with the Director of Nursing (DON), she stated that she just became aware of an abuse compaint and that staff #1 was suspended until the investigation was completed. She said that if the complaint was founded, the staff member would be terminated. If not, the facility would determine if the staff member needed education or what. The DON revealed that sample resident #13 complained that staff member #1 had sprayed air freshener in the resident's room, that call lights were not answered, and Tylenol was not given to him/her for an hour when his/her headache was very bad. The DON indicated that the resident was tearful, which was unusual for this resident. The DON attributed some of this to the resident's roommate having kept the resident awake. The DON indicated that the Administrator was told by a CNA that she heard that sample resident #4's had hip pain as result of the treatment by _____ (staff #1). The DON stated that this resident's physician was contacted and the resident would be sent to the hospital to have an x-ray. 5. During observation on 6/28/05 at 6:30 PM resident # 29 was observed propelling self in wheelchair in main dining room. Resident # 29 proceeded to eat left over food setting on the table from the meal service. Staff #3 (CNA) approached the resident and was observed to shake her finger at the resident's face. Then seeing a surveyor watching at the end of the dining room, the staff left the dining room. Resident # 29 was approached by the surveyor and the resident stated, "They treat you like a dog around here." Staff #3 was then asked about the	F 223	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F223 483.13 (b) ABUSE Continued from page 6 4. Resident #13 discharged from facility. Employee #1 no longer employed at Facility. 5. Nursing staff has been in-serviced on Resident abuse on 6/30/2005. Resident #29 is very confused and does not remember incident. Social Services, Nursing, and Activities staff visit regularly to check on his well being. He is often tearful but concerns are not related to staff treatment. Staff #3 has been given individual counseling and education regarding stress management and appropriate communications with residents. Staff Development Coordinator will meet with staff member #3 on monthly basis for review of concerns and progress.	08/19/05

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F 223	Continued From page 7 incident with Resident # 29 in the dining room. Staff #3 stated, "I told [him/her] we couldn't have him/her eating food off the other resident plates but [he/she] has Alzheimer's so [he/she] keeps doing it." Interview with the Administrator on 6/30/05 related that Staff #3 had reported self as having been verbally aggressive with the resident. 6. Resident #1 medical record review revealed the resident was readmitted to the facility from the hospital on 5/5/05. Resident #1's diagnoses included: right femoral neck fracture, hypertension, anemia, angina, gastroesophageal reflux, URT (upper respiratory infection), UTI (urinary tract infection) and arthritis. a. Review of the current MDS (minimum data set) dated 5/13/05 identified the resident's cognitive skills as modified independence and needing extensive assistance with bed mobility, transfers and toilet use. b. Review of the "Interdisciplinary Progress Notes" dated 5/09/05 at stated, "Pt. (patient) reports that "I was doing fine until last night when they got me up to go to the bathroom...they just grabbed that leg and moved it so fast...now it's just killing me." Performed basic LE (lower extremity) exis (exercises) in supine with assist and then applied moist hot pack to R (right) hip..." c. Review of the "Pain Assessment" dated 5/11/05 under comments stated, "Res awake alert slightly confused able to rate pain, understands pain scale. Res. states [sign no] pain at this time, when pain gets bad increased to 8 of 10." The area of additional information stated pain is increased by (describe circumstances or activities) stated, "Rough treatment".	F 223	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F223 483.13 (b) ABUSE Continued from page 7 6. Follow up with resident by Social Services staff indicates resident has adjusted well to setting, has shown continual improvement in therapy, no increase in pain indicators. "Likes staff that cares for her." Social Services staff will continue to visit on random basis to assure resident is satisfied with care.	08/19/05

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F 223	Continued From page 8 There was no documentation or evidence that the facility had followed up on resident allegation of rough treatment. Interview with the Administrator and DON on 6/30/05 revealed they were aware of the allegations of staff mistreatment reported by resident #4 and #13. However Staff #1 was still working on the night shift and these residents continued to express fear of Staff #1.	F 223	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 241 SS=E	483.15(a) QUALITY OF LIFE 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, it was determined that the facility failed to provide care for residents in a manner which enhanced the residents' self worth and individuality. The findings included: 1. Through out the survey Staff #2 was observed providing cares to residents in their rooms and in the dining room passing meal trays. Staff 3 did not address the residents by their names in a manor to maintain there individuality and dignity. Staff #2 addressed the residents with names which included, "Babe, Honey, Sweetie and Sweetie Pie." 2. Interview with resident #4 on 6/28/05 at 9:10 AM the resident voiced concerns with staff going through his/her dresser and using the resident's supply of disposable briefs for a roommate. The resident stated, "They shouldn't be going through a persons belongings without asking. Those were	F 241	F 241 483.15(a) QUALITY OF LIFE This Requirement will be met as evidenced by: Resident #4 has been discharged. Staff member #2 has received one on one education regarding resident dignity and individuality. Staff member #2 has been specifically educated regarding use of endearing names. Resident#4 has been discharged. All staff will be educated related to dignity, respect, and individuality. Staff will be educated regarding use of personal belongings for other residents and the necessity of asking permission to look in residence's drawers and closets. The CAN Care plan for resident #28 has been revised to include proper care after meals. Resident #28 will have unsoiled clothing at all time	08/19/05

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F 241	Continued From page 9 specially marked and then I run out. Those are mine because my family buys them." a. Family interview on 6/28/05 at 4:00 PM confirmed buying the resident pull-up type briefs and marking the front for the resident to use. b. During interview with staff (registered nurse) on 6/30/05 staff was told of resident concerns with going through belongings without permission and taking briefs. Staff then went to the resident's room and spoke to the resident. The resident reported that staff (CNAs) were going through personal belongings without asking and using briefs for roommate. The staff (registered nurse) told the resident the issue would be addressed and that they should not be doing that. 3. Observations were made of supplemental resident # 28 on 06/28/05. The resident was first observed after the breakfast meal at 9:00 AM. The resident was seated in a wheelchair and was observed to be able to ambulate very slowly in the wheelchair without assistance. The resident was located in front of the nurse's station after having left the main dining room area. At this time two Certified Nursing Assistants (CNA) were observed to speak with the resident and direct the resident toward the hallway where the resident's room was located. The resident's shirt and lap of the resident's pants were observed to have been soiled and stained with a large amount of smeared on food from the breakfast meal. At 9:25 AM supplemental sample resident #28 was observed seated in a wheelchair in the hallway near his/her room. The resident's shirt and pants remained unchanged. One CNA spoke	F 241	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 241 483.15(a) QUALITY OF LIFE Continued from page 9 Staff will receive training regarding resident dignity. Resident appearance will be monitored for maintenance of dignity and cleanliness. Results of any discrepancies will be reported at the monthly Performance Improvement meeting with related education as indicated.	08/19/05

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F 241	Continued From page 10 to the resident and asked the resident where he/she was going. The CNA moved the resident to the side of the hallway to allow room for another resident to pass by in their wheelchair. Supplemental sample resident #28 was observed again, at 10:15 AM, in his/her wheelchair. The resident was positioned at the nurse's station. A CNA was asked where the resident had been and the CNA responded that the resident had been taken out for a walk around the neighborhood. The resident was observed to continue to be wearing the same shirt and pants that had been soiled with food from the morning breakfast meal. Observation was made of the main dining room during the noon meal at 12:45 PM. Supplemental resident #28 was observed seated at a dining table with two other residents. The resident was observed to be wearing the same shirt and pants that had been soiled from the breakfast meal. Supplemental sample resident #28 was observed at 1:00 PM seated in his/her wheelchair at the nurse's station. The resident was still wearing the same shirt and pants that had been soiled during the breakfast meal.	F 241	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 246 SS=D	483.15(e)(1) QUALITY OF LIFE A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This Requirement is not met as evidenced by: Based on observation, record review, and	F 246	F246 483.15(e) (1) QUALITY OF LIFE This requirement will be met as evidenced by:	08/19/05

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F 246	Continued From page 11 resident, family, and staff interview, it was determined that the facility failed to accommodate the individual needs of one of 17 sample residents (#4) and two supplemental residents (#18 and #24). The findings included: 1. On 6/29/05 at 4:50 AM, during rounds (to toilet and change residents), the two Certified Nurse Aides (CNAs) entered the room of resident #18. The resident was seated on the edge of the bed and repeatedly stated "I have to go to the bathroom." As the staff took the resident to the bathroom, the resident commented that he/she was not sure if he/she would make it to the bathroom because he/she needed to go so badly. Observation revealed that the resident's call light was lying on the floor at the head of the bed, where the resident could not reach it to call staff for assistance. 2. Resident # 4 medical record review revealed the resident was admitted to the facility from the hospital on 3/14/05. Resident diagnoses included: gastroparesis, atherosclerotic cardiovascular disease with chronic atrial fibrillation, CHF (congestive heart failure), hypertension, arthritis, DJD (degenerative joint disease), dehydration, bilateral pleural effusion and depression. a. Review of the current MDS (minimum data set) dated 6/9/05 identified the resident's cognitive skills as modified independence - usually understood and usually understands. It also identified the resident as needing supervision with transfers, ambulation, toilet use and personal hygiene. b. Review of the "Nursing Assessment" on admission identified the resident as having moderately impaired vision.	F 246	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F246 483.15(e) (1) QUALITY OF LIFE Continued from page11 Resident #4 has been discharged Resident #18 has call light within reach at all times. Resident #24 has had care plan modified to include resident need for straw with liquids. Resident requesting night lights will have same placed in room. Nursing staff will be educated related to provision of care to meet individual needs. Staff and residents will be monitored to insure provision of individual needs are met. Results will be present at monthly Performance Improvement Meeting with further action as needed.	08/19/05

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F 246	Continued From page 12 c. Review of the "Fall Risk Assessment" dated 6/16/05 identified resident # 4 at a score of 21 which indicated the resident was a high fall risk. d. Interview with resident #4 on 6/28/05 at 9:10 AM the resident voiced concerns with staff not leaving the bedside lamp turned on at night and having no night light in the bathroom. The resident described problems with impaired vision due to macular degeneration and fear of falling when having to use the bathroom at night. The resident reported that staff had been asked to leave the light on however it was frequently turned off. e. Family interview on 6/28/05 at 4:00 PM confirmed the resident had problems with impaired vision due to macular degeneration. The family member related resident not wanting to attend activities due to impaired vision. f. Review of the plan of care dated 6/6/05 did not address resident # 4's problems with impaired vision. g. Interview with the MDS Coordinator on 6/30/05 confirmed that the resident did have problems with vision and it was not addressed in the resident's plan of care. The facility failed to ensure the resident's environment accommodated the individual needs with this resident who had impaired vision and high risk for falls. 3. Resident # 24 was observed on 6/28/05 during the breakfast meal. The resident was seated at the table in a wheelchair attempting to drink from a cup. The resident was noted to having liquid	F 245	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

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F 246	Continued From page 13 spills down the front of his/her shirt. The resident was noted to have tremors of the right hand and arm when attempting to drink. Another resident # 1 asked the surveyor to get resident #24 a straw. Resident #1 stated, "I gave [him/her] a drink but [he/she] told me [he/she] needed a straw in order to drink. [Resident] will be waiting a long time if staff has to get it." The resident was then asked if he/she used a straw. The resident stated, "I use a straw but I haven't asked them yet. I have to ask or I don't get it. I spill a lot without it." The noon meal and supper service also revealed the resident was not provided a straw to drink with. The facility failed to provide care to meet the resident needs and also maintain the residents dignity with resident attempting to feed self.	F 246	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 248 SS=E	483.15(f)(1) QUALITY OF LIFE The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: Based on record review, observation, and resident and staff interview, it was determined that the facility failed to provide ongoing, appropriate activities to meet the needs of individual residents. The findings included: 1. Record review of the posted Activity Schedule in the Special Care Unit (SCU) indicated that the following activities were planned for on 6/28/05: 9:00 AM Wash Wagon 9:30 AM Helping Hands	F 248	F248 483.15(f)(1) QUALITY OF LIFE This requirement will be met as evidenced by: An Activities Coordinator has been hired to conduct activities within the Special Care Unit. The Activities Coordinator will ensure that all activities programs are designed to meet the interests and physical, mental and psychological well-being of each resident. A daily activities schedule will be prepared and followed by the Activities Coordinator and SCU staff.	08/19/05

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F 248	Continued From page 14 10:00 AM Bake Bread 10:30 AM Puzzle Time 11:00 AM Manicures 12:00 PM Musical Memories 2:00 PM Glamour Hour 3:00 PM Building Blocks 4:00 PM Table Tennis Observations in SCU on 6/28/05 revealed the following: 9:00 AM - residents still eating breakfast 9:30 AM - last resident finished breakfast; no activities involving other residents 10:05 AM - no activities being conducted; only other staff present in addition to the charge nurse and Certified Nursing Assistant (CNA), was a restorative aide that was providing restorative therapy with one of the resident. 10:10 AM - a relief CNA came to the Unit to relieve the morning staff for lunch break; no activities were being conducted 3:30 PM - one resident was playing with plastic blocks; other residents were sitting or wandering; no organized activity was occurring 4:00 PM - no activities being conducted; a social service staff person was on duty relieving the afternoon charge nurse and CNA for lunch Record review of the June 2005 Activity Resident Daily Flow Sheets for SCU revealed that no documentation was noted for 6/26 and 6/28/05 for the following residents: #5, #8, #30, #31, #32, #33, #34, #35, and #36. An interview with the Activities Director (AD) on 6/29/05 at 10:20 AM revealed that an Activity Assistant (AA) is assigned on a daily basis to the SCU from 9:30 - 12:30 AM and during this time, scheduled activities are conducted. The charge	F 248	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F248 483.15(f)(1) QUALITY OF LIFE Continued from page 14 Accurate Activity Resident Daily Flow sheets will be done daily by Activities personnel. Appropriate staffing levels will be maintained at all times to insure that the posted daily Activities Schedule is followed. A report of activities will be presented at the monthly Performance meeting with further action as needed.	

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F 248	Continued From page 15 nurse for the SCU is responsible for conducting daily activities from 2:00 - 4:30 PM. The AD stated that all activities are documented on the flow sheets by the AA and/or SCU staff. Upon reviewing the Daily Flow Sheets with the surveyor, the AD noted that the recording of the activities conducted was sporadic and codes recorded were inaccurate or placed in the wrong columns. During an interview with the charge nurse and CNA on 6/29/05 at 9:05 AM, the charge nurse verified that she is responsible for conducting the afternoon activities. She said she attempted to do the activities but time is limited because regular staffing on the unit consists of one charge nurse and one CNA and resident needs have priority. The CNA stated that sometimes AAs will start an activity and then are pulled by the AD to another area. It is difficult for the regular staff to continue the activity. In another interview with the SCU charge nurse on 6/29/05 at 10:55 AM, she verified that activity staff is not in the SCU as indicated on the posted activity schedule. During another interview with the charge nurse on 6/30/05 at 10:15 AM, she stated that the presence of activity staff in the morning helps in keeping residents occupied and provides time for staff to perform resident cares. 2. During the Resident Group Interview, conducted on 6/28/05 at 10:30 AM, residents stated that most of the activities were " geared towards kids. " The residents stated that the facility used to have crafts that were a part of the activity program and would like to see crafts put	F 248	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 248 483.15 (f)(1) Continued from page 16	08/19/05

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F 248	Continued From page 16 back in as part of the activity program. The residents stated that the activity program lacked variety and felt that the facility needed to change the activity program to meet the needs of the residents.	F 248	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 248 483.15 (f)(1) Continued from page 16	
F 253 SS=E	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to maintain a sanitary, orderly environment for the residents residing in the facility. The findings included: 1. Observation was made of resident room 38 on 6/27/05 during a tour of the facility at 3:30 PM. In resident room 38 an area above the heat register in the toilet room was observed to be unpainted. 2. Observation was made of resident room 39 on 6/27/05 during a tour of the facility at 3:30 PM. In resident room 39 the cove base was observed to be loose and pulling away from the wall in the area located under the sink. 3. During the initial tour of the Special Care Unit on 6/27/05 at 5:00 PM, observation revealed the following: a. Room 17 - dripping faucet in the bathroom b. Room 21 - dripping faucet in the bathroom c. Sections of chair rail were missing in the alcove in the middle of the main hallway.	F 253	F253 483.15(h)(2) ENVIRONMENT This requirement will be met as evidenced by 1. The area of the wall above the heat Register in the bathroom in resident room #38 Will be painted 2. The cove base in resident room #39 was Inspected and found not to be loose and Pulling away from the will. This will be Double -checked and repaired as necessary. 3. Valves have been ordered to fix the Dripping faucets in resident rooms 17 and 21. The section of missing chair Rail will be replaced. 4. The dresser drawer and slow draining sink in resident room #36 have been fixed. The combs have been removed. Staff has been in-serviced to label all residents personal belongings	08/19/05

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F 253	Continued From page 17 4. On 6/28/05, starting at 8:35 AM, the following observations were made: a. In room 36: Dresser drawer was broken; slow draining sink, two unlabelled combs were lying by the sink. b. In room 44: Unlabelled emesis basin and toothbrush lying by the sink; toilet was running; open packet of Hypergel Wound dressing on bedside stand. 5. On 6/29/05 at 5:00 AM, during an observation of resident care in room 11, the staff prepared to leave the room. The light above supplemental resident #20's bed was turned on. The surveyor asked if the resident liked to have a light on when he/she slept. The two Certified Nurse Aides (CNAs) stated that the light would not turn off, so it was left on. 6. On 6/29/05 at 5:30 AM, during an observation of resident care in room 35, the water was turned on in the sink in the room. The sink was draining slowly, allowing the sink to fill up with water. 7. On 6/29/05 at 6:22 AM, the back hall floor tile from the nurses' station to the community room and down the hall toward the purple sage dining room was observed to have numerous dark spots and stains. These same spots were observed on 6/28/05. 8. Observations during the general environment tour on 6/29/05 from 9:45 AM to 11:20 AM with the maintenance staff, housekeeping staff and the Administrator present identified the following: a. The housekeeping closet was in need of cleaning. The floor and base boards had a dark	F 253	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 248 483.15 (f)(l) Continued from page 17 F253 483.15(h)(2) ENVIRONMENT The toilet in resident room 44 has been repaired. The emesis basin and toothbrush have been discarded. Staff has been in-serviced on proper labeling and storage of resident personal items. The would gel has been discarded. 5. 3-way switches have been ordered and will be installed to provide appropriate light levels. 6. The sink in resident room 35 has been repaired. 7. The back hall floor tile has been cleaned thoroughly. Regular floor maintenance schedules will be prepared and followed. 8A. The housekeeping closet has been cleaned and organized. The housekeeping carts have been thoroughly cleaned at the car wash. A cleaning schedule for the carts will be prepared and followed. B. The faucet in resident room #36 has been repaired. C. The dresser in resident room #44 has been repaired.	08/19/05

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F 253	Continued From page 18 dirty build-up. The floor sink had a wire front which was rusted with red discoloration down the front of the sink and the floor. The sink contained a large type strainer which had a large amount of dirt and debris sitting in it. The 3 cleaning carts sitting in the room had a build up of dust and dirt. The mop buckets on each cart had a black build-up of residue. The housekeeping staff confirmed the carts had been taken to the car wash in the past for cleaning but had not been done for approximately 6 months. The Administrator confirmed the above observations and instructed staff to take carts for cleaning and put on a cleaning schedule. b. In room 36: leaky faucet at the sink. c. In room 44: dresser door front broken off.	F 253	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from page 18 F253 483.15(h)(2) ENVIRONMENT Housekeeping and maintenance reports will be given at monthly Performance Improvement meetings with follow-up as necessary	08/19/05
F 272 SS=B	483.20(b) RESIDENT ASSESSMENT A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272		

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F 272	Continued From page 19	F 272	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 272 483.20 (b) RESIDENT ASSESMENT Continued from page 19	08/19/05

Physical functioning and structural problems;

Continence;

Disease diagnosis and health conditions;

Dental and nutritional status;

Skin conditions;

Activity pursuit;

Medications;

Special treatments and procedures;

Discharge potential;

Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and

Documentation of participation in assessment.

This Requirement is not met as evidenced by:
Based on record review, it was determined that the facility failed to accurately complete the Resident Assessment Instrument (RAI) as specified and required for nine of 17 sample residents (#5, #6, #12, #10, #7, #17, #3, #9, and #2). The findings included:

1. Record review of sample resident #7's 1/27/05 Resident Assessment Protocol (RAP) Summary sheet evidenced that there was no date for the H & P (history and physical exam). Review of the residents 5/12/05 assessment revealed that the RAP Summary sheet was not signed.

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F 272	Continued From page 20 2. Record review of sample resident #17's 4/20/05 RAP Summary sheet revealed that the date of the assessment information was not present for all triggered problem areas. 3. Record review of sample resident #3's 11/22/04 RAP Summary sheet evidenced that the location of the assessment information was not specific and lacked the dates of the specific assessment information. 4. Record review of sample resident #9's 9/29/04 RAP Summary sheet evidenced that the location of the assessment information was not specific and lacked the dates of the specific data used to make the determination for or against care planning for this resident. 5. Record review of the RAP Protocol Summary dated 3/13/05 for resident #5 under the Location and Date of RAP Assessment Documentation column showed no date for the ADL Function/Rehabilitation Potential, Dehydration/Fluid Maintenance and Dental Care triggers. 6. Review of the RAP Protocol Summary for resident #6, dated 5/1/05, found the summary to not provide the date for the assessments related to visual function, and dehydration/fluid maintenance. 7. Review of the RAP Protocol Summary for resident #12, dated 1/10/05, found the summary to not provide the date for the assessments related to urinary incontinency and indwelling catheters, falls, and pressure ulcers.	F 272	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 272 483.20 (b) RESIDENT ASSESMENT Continued from page 20	08/19/05

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F 272	Continued From page 21 8. Review of the RAP Protocol Summary for resident #10, dated12/29/04, found the summary to not provide the date for the assessments related to cognitive loss, psychosocial well-being, and mood state. 9. Review of the RAP Protocol Summary for resident #2, dated 5/3/05, found the summary to not provide the date for the assessments related psychosocial well-being, mood state, activities, and dehydration/fluid maintenance	F 272	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 272 483.20 (b) RESIDENT ASSESMENT Continued from page 20	08/19/05
F 279 SS=E	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This Requirement is not met as evidenced by: Based on record review and resident and staff interview, it was determined that the facility failed to develop care plans to address the assessed needs of seven of 17 sample residents (#14, #4,	F 279	F279 483.20(k) RESIDENT ASSESMENT This Requirement will be met as evidenced by: The facility will develop a comprehensive care plan for each resident that indicates 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 will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. It will also include required or needed services that are not provided due to the resident's right to refuse treatments.	08/19/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING _____ B. WING _____	06/30/2005

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WIND RIVER HEALTHCARE AND REHAB	1002 FOREST DRIVE RIVERTON, WY 82501

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F 279	Continued From page 22 #1, #13, #11, #7, and #9). The findings included: Residents (#14, #4, #1, #13, #11, #7, and #9) reviewed on sample were identified as residents admitted to the facility for skilled services and care. Review found that the facility failed to develop initial care plans to guide the residents care until the comprehensive assessments and care plans were completed. Interview with the DON on 6/28/05 related that the charge nurse doing the admission nursing assessment was to start the "Interim" or initial care plan on admission to address resident's individual care needs. The DON was unable to find initial care plans for these residents on the dates they were admitted to the facility. The DON confirmed that initial cares plan had not been developed and were not getting done. 1. Resident # 14 medical record review revealed the resident was recently admitted to the facility from the hospital on 6/24/05 for skilled care. Resident diagnoses included: Right total knee replacement for severe degenerative arthritis, seizure disorder, COPD (chronic obstructive pulmonary disease), hypertension and history of falls. a. Review of the "Interdisciplinary Progress Notes" included: -6/28/05 described the resident as being confused at times, having oxygen on at 2 liters, having complaints of constipation, dizziness and unsteady gait. - 6/26/05 Resident found on floor beside the bed with patient alarm ringing."Dr. notified per fax -Laceration over R (right) eye with steri strips no other injury noted additional pt. alarm and bed boisters to bed." -6/27/05 "Res fell x 2 this shift, [sign for no]	F 279	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F279 483.20(k) RESIDENT ASSESMENT Continued from page 22 1. Resident #14's interim care plan will be updated to include his/her confusion, anxioty, oxygen use, shortness of breath, constipation, dizziness, unsteady gait, fall risk, safety devices and/or interventions to prevent falls, pain and potential for skin issues.	08/19/05 08/19/05

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F 279	Continued From page 23 apparent injury noted. Res with increased anxiety, crying couldn't find her purse or wallet, daughter had taken them home. Res has had numerous previous falls in res room beside bed/in bathroom after using toilet looking frantically for wallet purse which daughter had taken home... no injury noted." b. Review of the "...Interim Plan of Care" had one issue addressed which was dated 6/27/05 (after the fall) Skin -"wound care, laceration upper eye brow steri stripes in place." The "Interim Plan of Care" or initial care plan did not address any other issues or problems. There was no care plan developed to address the resident's fall risk prior to the first fall or interventions to prevent further falls. Some of the other care concerns not address included: the level of assist with ADL's, shortness of breath with oxygen use, resident's confusion, potential skin risk and pain. 2. Resident #13 medical record review revealed the resident was admitted to the facility from the hospital on 6/01/05. Resident #13's diagnoses included: hypothyroidism, hypertension, severe osteoporosis, failed left total hip with revision and cable placement and asthma. Interview with resident #13 on 6/29/05 at 1:40 PM the resident described being bedfast on admission and having to wear a specialty brace that went around the resident's hips and extended down his/her left leg that was to be worn at all times. There was no care plan developed to address these issues or other resident's care needs on admission. 3. Resident #4 medical record review revealed	F 279	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F279 483.20(k) RESIDENT ASSESMENT Continued from page 23 2. Resident #13 has been discharged	08/19/05 08/19/05

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F 279	Continued From page 24 the resident was admitted to the facility from the hospital on 3/14/05. Resident diagnoses included: gastroparesis, atherosclerotic cardiovascular disease with chronic atrial fibrillation, CHF (congestive heart failure), hypertension, arthritis, DJD (degenerative joint disease), dehydration, bilateral pleural effusion and depression. Review of the discharge report from the hospital also identified the resident as being treated on 3/10/05 for MRSA (methicillin-resistant Staphylococcus aureus) of the sputum. The resident was then admitted to the facility 4 days later on 3/14/05. There was no care plan to guide this resident's care including: recent respiratory infection (MRSA), weakness and history of fall with hip fracture and skin care and treatment for open areas. The resident was identified as being admitted to the facility with a Stage III pressure sore on the coccyx. 4. Resident #1 medical record review revealed the resident was readmitted to the facility from the hospital on 5/5/05. Resident #1's diagnoses included: right femoral neck fracture, hypertension, anemia, angina, gastroesophageal reflux, URT (upper respiratory infection), UTI (urinary tract infection), arthritis and pain. There was no care plan to guide this resident's care for being a recent post operative resident as well as having other care needs. 5. Resident # 11 medical record review revealed the resident was readmitted to the facility from the hospital on 4/5/05. Resident # 11's diagnoses included: Alzheimer's disease, BPH (benign prostatic hypertrophy) UTI (urinary tract infection) with MRSA and decubitus on right heel, weakness and falls. There was no care plan to guide this resident's care including the infection.	F 279	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F279 483.20(k) RESIDENT ASSESMENT Continued from page 24 3. Resident #4 has been discharged 4 Resident #1's interim care plan will be developed to guide resident's care. Interim care plan will include mobility, pain, breathing, risk for infection, safety issues, level of assistance required, skin bowel and bladder, etc. 5. Resident #11's interim care plan will be developed to guide resident's care. Care plan will include cognition, bowl and bladder, infection, skin, treatment, weakness, falls, safety, mobility, level of assistance required, etc.	08/19/05 08/19/05

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F 279	Continued From page 25 skin problems and fall risk. 6. Record review for sample resident #7 revealed that the resident was readmitted to the facility on 5/2/05, after a hospitalization. The resident was found to have a Stage 2 pressure ulcer upon return from the hospital. Review of the interdisciplinary progress notes (IPN) evidenced that the resident returned to the hospital for a blood transfusion on 5/10/05. No interim (initial) care plan to address the resident's pressure ulcer or change of status was found in the resident's record. In an interview with the Medical Records supervisor, she verified that there was no interim care plan for the 5/2/05 hospital return found in the resident's medical record. 7. Record review for sample resident #9 revealed that the resident was readmitted to the facility on 9/16/04, following a hospitalization. Review of the resident's medical record evidenced that the resident had several areas of skin breakdown. No interim care plan was found to address the resident's skin breakdown. On 6/30/05 at 10:53 AM in an interview with the Medical Records supervisor and the Medicare Minimum Data Set (MDS) Coordinator, they verified that they could not find an interim care plan for this resident (following the 9/04 hospitalization)	F 279	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F279 483.20(k) RESIDENT ASSESMENT Continued from page 25 6.. Resident #6 has discharged 7. Resident #9's interim care plan will be developed to guide resident's care. Care plan will include skin, bowel and bladder, level of assistance required., mobility, cognition, fall and safety interventions, weakness, etc. This will be accomplished by: A. Admitting nurse will initiate the interim care plan on the day of admission. B. Admitting and all other nurses responsible for the care of the particular resident will update the interim care plan as needed. C. Interim care plan will be utilized until the "initial" care plan is printed. D. Utilization Nurse or designee will do random audits of interim care plans, insuring current care needs are being addressed.	08/19/05
F 281 SS=E	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by:	F 281	F281 483.20(k)(3) RESIDENT ASSESSMENT	08/19/05

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F 281	Continued From page 26 Based on observation, record review, and staff interview, it was determined that the facility failed to follow current professional standards of care when implementing physicians' orders and administering medications to four of 17 sample residents (#14, #11, #16, and #2) and two supplemental residents (#25 and #26). The findings included: On 6/29/05, during observations of medication passes, the following observations were made: 1. At 6:43 AM, when the nurse administered medicine to supplemental resident #25, the resident commented that his/her Xanax and Phenobarb were missed. He/she indicated that the medicine could have been obtained from ____ (local pharmacy) and was not sure why this did not happen. The front hall charge nurse reviewed the resident's 6/05 Medication Administration Record (MAR) and confirmed that the resident had missed a dose of Phenobarb the evening before and that there was none for the resident's 8:00 AM dose on this date. She stated that the medication was ordered three or more days earlier (from the pharmacy used by the facility). Review of the resident's MAR revealed that the resident was to receive Phenobarb 100 mg (milligram) twice a day. No doses were charted on 6/24 and 6/28 at 8:00 PM. There was no explanation on the MAR or in the Daily Skilled Nursing Notes of why the medication was not given. Review of the resident's MAR evidenced that the resident was to receive Xanax 0.25 mg three times a day. The 9:00 PM doses on 6/16 and	F 281	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F281483.20(k)(3) RESIDENT ASSESMENT Continued from page 26 This requirement will be met as evidenced by: 1. Resident #25 has been discharged. 2. Residents #11 and #14 were assessed with no negative outcomes noted as a result of late administration of Tiazac and Protonix.. 3. Resident #26 did receive the proper dosage of Prilosec. 4. Resident #11 was receiving IV Gentamycin for a UTI, which is currently resolved. No negative outcomes were noted related to the missed dose of medication. 5. Resident #16 has discharged. Charge nurses have been in-serviced related to the proper administration of medication, including the "5 Rights of Medication Administration." Charge nurse's will also be in-serviced regarding: Documentation, transcription of physician orders, clarification of physician orders, as needed, and documentation of resident response to medications	08/19/05 08/19/05

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F 281	Continued From page 27 6/17 and 8:00 AM dose on 6/29 were not charted. The 6:00 AM dose on 6/28 and the 9:00 PM doses on 6/23 and 6/26 were circled as withheld. There was no evidence to explain why these doses were not given and/or were not charted. On 6/29/05 at 9:10 AM, in an interview with the Resident Assessment Coordinator (RAC), she verified that there were intermittent problems with deliveries from the pharmacy. She stated that normally, if the medication does not come in, the local pharmacy is contacted and it supplies the medication. The RAC verified that there was no evidence that the resident received the Phenobarb doses. She was unaware that there was a problem with the resident receiving his/her Xanax. The nurse who was administering the medications stated that the 6:00 AM Xanax for this day was taken out of the emergency drug supply on the secure unit (as reported to her by the night nurse). The RAC and the surveyor checked the medication sign out sheets for the emergency drugs. The RAC verified that the doses in question had been taken from the emergency supply. At 9:20 AM, the medication nurse reported to the surveyor that the resident's Phenobarb and Xanax were delivered by the pharmacy. 2. At 8:20 AM, the nurse administering medications stated that _____ (sample resident #11)'s Tiazac and ____ (sample resident #14)'s Protonix were missing. These were medications scheduled to be given at 8:00 AM. At 12:03 PM, the medication nurse reported to the surveyor that these residents' medications	F 281	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F281483.20(k)(0) RESUDENT ASSESMENT Continued from page 27 Medication pass willl be observed periodically by DNS, or designee, with the results reported monthly at Performance Improvement meetings. Further education will be provided as indicated by report.	08/19/05

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F 281	Continued From page 28 were received from the pharmacy. 3. On 6/29/05 at 7:58 AM, during the observation of a medication pass, the nurse was observed to prepare medications for supplemental resident #26. Included in the resident's medications was Prilosec 40 mg (milligrams) (two 20 mg tablets). The nurse was observed to pour one 20 mg tablet. When she was leaving the medication cart to administer the resident's medications, the surveyor questioned her about the medications. The nurse re-checked the resident's MAR and verified that the resident should receive 40 mg of the medication. She prepared the correct amount and gave the resident his/her medications. 4. On 6/29/05 at 11:45 AM, during the observation of a medication pass, the nurse re-labelled (wrote on the original label) an intravenous medication for sample resident #11. She stated that the pharmacy did not provide new medication (Gentamicin) when the dose was changed on 6/28/05. The bag was originally labelled 320 mg in 100 cc (cubic centimeters). Review of the physician order evidenced that the resident was to receive 250 mg. The telephone order read "Reduce dose to 250 mg, set Dialaflow @ 75 cc and infuse over one hour and then throw the rest away (dated 6/28/05 at 1:30 PM)" and did not include the name of the medication. Review of the MAR evidenced that the resident had not received a dose of Gentamycin on 6/28/05. The nurse confirmed that the resident's intravenous line was out and so no Gentamycin could be given. She further clarified that the lowered dose was based on blood work on 6/27/05. There was no evidence found to show that the appropriateness of the dose was checked with the physician, considering that the resident	F 281	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F281483.20(k)(0) RESIDENT ASSESMENT Continued from page 28	08/19/05

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F 281	Continued From page 29 missed a day of medication. 5. Review of sample resident #16's physician order sheet revealed an order for Xanax 0.5 mg p.o. (orally) T.I.D. (three times a day) and dated 4/21/05. Review of the resident's 5/05 Medication Record evidenced that the order had been transcribed incorrectly as BID.(two times a day). From 5/1/05 through 5/3/05, the nurses gave or attempted to give the medication only two times a day, instead of three as ordered. On 5/4/05, the times on the Medication Record were changed to three times a day (as ordered). From 5/4/05 through 5/11/05, the nurses did not chart this medication as given three times out of 24 possible doses. Standards for nursing practice for administration of medication provide, in pertinent part that: Medications must be accurately administered and documented. Accurate administration includes, in the first instance, a physician order authorizing the administration of the medication; if an order is not clear, the nurse should communicate with the physician to seek clarification. Thereafter, accurate administration includes transcribing the drug order correctly, delivering the correct drug, to the correct resident, by the correct route, in the correct dose. Accurate documentation involves recording information on the drug administered, including the client's response to the medication. See generally: Lippincott, Nursing Drug Guide, 1998 (Lippincott) and Perry & Potter, Clinical Nursing Skills & Techniques; 1998, (Perry & Potter) Fundamentals of Nursing, Potter and Perry, 4th Edition, 1997, Chapter 20, pg 341, "The physician is responsible for directing medical treatment.	F 281	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F281483.20(k)(0) RESIDENT ASSESMENT Continued from page 29	08/19/05

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F 281	Continued From page 30 Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients." 5. Review of the medical record for sample resident # 2 found that the facility had received a faxed lab report from Riverton Memorial Hospital for a potassium level on resident #2, collected on 1/7/05. The result was faxed to the physician on 1/8/05. A second copy of the fax results was noted in the chart. However, the second copy had several hand written physician orders and responses from the doctor, as well as, several handwritten notes and responses from the facility to the physician on the lab sheet. The physician's orders were not dated and the responses from the physician and the facility were not dated. It was unclear as to what issues were being clarified or when they were being clarified by the facility and what orders the physician actually wanted. The facility did not use the facility established telephone order sheets for requesting orders or clarifications to prevent any confusion of physician orders or comments by those providing treatment to the resident.	F 281	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 483.25 Quality of Care This requirement will be met as evidenced by:	8/19/2005

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F 309	Continued From page 31	F 309		

Use F309 for quality of care deficiencies not covered by s483.25(a)-(m).

This Requirement is not met as evidenced by:
Based on observation, record review, and staff interview, it was determined that the facility failed to provide care in a manner which helped four of 17 sample residents (#17, #14, #11, and #2) and one supplemental resident (#19) reach their highest practicable level of physical, mental, and/or psychosocial functioning. The findings included:

1. Resident # 14 medical record review revealed the resident was recently admitted to the facility from the hospital on 6/24/05 for skilled care. Resident diagnoses included: Right total knee replacement for severe degenerative arthritis, seizure disorder, COPD (chronic obstructive pulmonary disease), hypertension and history of falls.

a. Review of the "Interdisciplinary Progress Notes" included:
-6/28/05 described the resident as being confused at times, having oxygen on at 2 liters, having complaints of constipation, dizziness and unsteady gait.
- 6/26/05 Resident found on floor beside the bed with patient alarm ringing."Dr. notified per fax -Laceration over R (right) eye with steri strips no other injury noted additional pt. alarm and bed bolsters to bed."
There was no documentation to show the resident had a complete assessment following the fall with injury. There was no evidence that the facility policy and procedure was followed by starting a "Neurological Assessment Flowsheet" for the resident having had a head injury. The

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1. Resident #14 has been assessed for possible neurologic injury. No negative outcomes have been noted. Resident #14 was placed in a low bed with a mat beside the bed to decrease risk of injury. Resident #14 was also provided with 2 patient protector alarms to alert staff of resident attempt to get up without assistance.

2. Resident #11 had a dime-size wound on toe, which has since healed. Resident #11 developed no further infections.

3. Neurologic assessment of resident #2 indicated no evidence of injury. Bruising to chin and bilateral shins has resolved.

4. Resident #17 has discharged.

5. Resident #19 suffered no ill effects of inaccurate measurement of output.

Licensed Nursing staff will be educated regarding proper neurologic assessment, following policy related to neuro assessment, use of proper documentation

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F 309	Continued From page 32 facility failed to provide necessary care by assessing and monitoring the resident for further injury. -6/27/05 "Res fell x 2 this shift, [sign for no] apparent injury noted. Res with increased anxiety, crying couldn't find her purse or wallet, daughter had taken them home. Res has had numerous previous falls in res room beside bed/in bathroom after using toilet looking frantically for wallet purse which daughter had taken home... no injury noted." b. Review of the facility policy for "Neurological Evaluation" dated 12/11/04 stated the following: " Neurologic vital signs supplements the routine measurements of temperature, pulse rate, and respirations when a resident is suspected to have hit their head (i.e. a fall), has hit their head or has a traumatic brain or spinal cord injury. The physician's order dictates the frequency of neurological evaluation. 2. ... In the event that a specific order cannot be obtained or until physician can be notified, may begin with the following time frames: -every 15 minutes for a hour, then; -every 30 minutes for a hour, then; -every hour for 2 hours, then; -every 4 until physician states it is no longer necessary...." Also attached to the policy was a "Neurological Assessment Flowsheet" staff was to be using to document the assessments. c. Interview with the DON on 6/28/05 confirmed there was no evidence that appropriate resident assessments had been done and that the facility policy for "Neurological Evaluation" was followed. d. Review of the "...Interim Plan of Care" had	F 309	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from page 32 and forms for neuro assessment. Nursing staff will also be educated related to documentation of resident change in condition, i.e. wounds, falls, neuro assessments. Licensed staff will also be educated related to accurate measurement of intake and output and the importance of same. Staff will also be educated regarding use of 24-hour report and the importance of accuracy, completeness and for following corporate policy and procedure. The results of same will be reported at monthly Performance Improvement meetings, with follow-up as needed.	8/19/2005

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F 309	Continued From page 33 one issue addressed which was dated 6/27/05 (after the fall) Skin -"wound care, laceration upper eye brow steri stripes in place." There was no care plan to show interventions staff was to be using in an attempt to prevent further injuries.	F 309		

2. Resident # 11 medical record review revealed the resident was readmitted to the facility from the hospital on 4/5/05. Resident # 11's diagnoses included: Alzheimer's disease, BPH (benign prostatic hypertrophy) UTI (urinary tract infection) with MRSA and decubitus on right heel, weakness and falls.

a. Review of the MDS (minimum data set) dated 4/12/05 identified the resident's cognitive skills as moderately impaired and needing extensive assistance with activities of daily living and having skin breakdown.

b. Observations and interviews included:
-6/29/05 at 4:35 AM the resident was observed during care. The resident was noted to have a dressing on the right great toe. The charge nurse reported that the right great toe dressing was changed by PT (physical therapy).
-6/29/05 at 6:45 PM Staff (registered nurse-MDS coordinator) took resident # 11 to the resident's room to check the resident's right great toe. Staff related that the wound nurse was also coming to check the resident's toe. Staff then removed the resident's slipper and an area of drainage was noted on the outside of the resident's sock over right great toe. The sock was removed with an open area approximately the size of a dime on the end of the resident's toe. The area did not have a dressing. The toe also had swelling and redness around the first joint. Staff (registered nurse-MDS coordinator) reported she was

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unaware of this resident having this open area. The wound nurse then entered the room to see the area and reported she had not been told the resident had this open area. The DON was also asked to check the area and reported she would do some checking to see when this open area was identified. Staff proceeded to treat the area and reported the physician would be notified.
The DON went to check the resident's chart and confirmed there was no documentation of the open area on the right great toe.
The DON then asked the evening charge nurse about the toe. The evening charge nurse stated, "They told me about it yesterday. The resident had been for a ride in the wheelchair (by visitors) and had the injury. I looked at it yesterday afternoon and cleansed it but did not dress it because (Resident) was going to bed. I didn't chart it."
The DON then checked the 24 hour report sheet and verified there was no documentation of this resident's injury. The DON related concern with two shifts failing to document and provide follow-up after an injury. The wound nurse reported the physician would be called and the treatment would be updated on the resident's plan of care.

c. Review of the fax sheet sent to the physician noted open area to right great toe and treatment. The fax also requested x-ray of R (right) great toe, "D/T (due /to) swelling up to 1st joint of toe".

d. Record review documented the resident having a history of MRSA (methicillin-resistant Staphylococcus aureus) infection of the urinary tract and was currently on IV (intravenous) antibiotics for Pseudomonas Aeruginosa infection in the urine. The facility failure to provide

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F 309	Continued From page 35 adequate wound care also places the resident at risk for further infections. 3. Review of the medical record for resident # 2 found that the resident had sustained an unwitnessed fall on 4/10/05 at 11:00 PM. Nursing notes dated 4/11/05 at 6:40 AM note that a nurse and an aide heard a crash and upon entering the room found the resident sitting on the floor in the middle of the room. The notes indicate that the resident suffered a bruise to the right chin and both shins. The nursing note indicates that a baseline neurological assessment check was taken at 11:00 PM on 4/10/05. The resident's record also contains a " Neurological Assessment Flowsheet ", which shows that the facility's neurological assessment protocol was implemented. Review of the facility policy for "Neurological Evaluation" dated 12/11/04 stated the following: " Neurologic vital signs supplements the routine measurements of temperature, pulse rate, and respirations when a resident is suspected to have hit their head (i.e. a fall), has hit their head or has a traumatic brain or spinal cord injury. The physician's order dictates the frequency of neurological evaluation. 2. ...In the event that a specific order cannot be obtained or until physician can be notified, may begin with the following time frames: -every 15 minutes for a hour, then; -every 30 minutes for a hour, then;	F 309		

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F 309	Continued From page 36 -every hour for 2 hours, then; -every 4 until physician states it is no longer necessary...." Also attached to the policy was a "Neurological Assessment Flowsheet" staff was to be using to document the assessments. The " Neurological Assessment Flowsheet " identifies that neurological checks were completed on the resident as follows: 4/10/05 11:00 PM Baseline 4/11/05 2:00 AM 4/11/05 5:00 AM 4/11/05 9:00 AM 4/11/05 11:00 AM 4/11/05 1:00 PM 4/11/05 3:00 PM 4/11/05 5:00 PM No further neurological checks were completed after the 4/11/05 5:00 PM check. The checks done initially after the baseline check on 4/10/05 at 11:00 PM were not consistent with the facility's policy for conducting neurological assessments for persons with potential for head injuries. 4. Review of the 2/10/05 6:40 AM Interdisciplinary Progress Notes (IPN) for sample resident #17 evidenced that the resident had experienced a fall at midnight. "Upon assessment noted ress(resident's) bridge of nose to be cut, 1/2 (centimeters) cut with swelling and bruising. Bleeding stopped instantly... Res moaning in pain. Noted ___ (? meaning) rib area and ____(? meaning) nose when ____ (he/she) touches ____ (his./her) nose..." Vital signs were charted next to the note. Review of the resident's Neurological	F 309		

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F 309	Continued From page 37 Assessment Flowsheet, dated 2/13/05, evidenced that neuro checks were done at 12:30 AM (about 1/2 hour after the fall), 2:30 AM, 4:30 AM, 7:00 AM, 8:00 AM, 11:00 AM, 1:00 PM, 4:30 PM, and 8:00 PM. The neuro checks were not done in accordance with the facility's policy. 5. On 6/29/05 at 5:00 AM, the Certified Nurse Aide (CNA) was observed to empty supplemental resident #19's catheter bag. The bag was quite full and the CNA emptied approximately 900 ccs (cubic centimeters) into the urine graduate measuring container twice (1800 ccs). When the CNA was asked about the resident's output, she stated that it was 900 ccs. The CNA's inaccurate determination of the resident's output could result in an inaccurate assessment of the resident's fluid status.	F 309	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 316 SS=E	483.25(d)(2) QUALITY OF CARE 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, record review, and staff interview, it was determined that the facility failed to ensure that staff provided appropriate treatment and services to prevent or minimize the potential for urinary tract infections through the use of adequate perineal cleansing for three of 17 sample (#3, #11, and #6) and four supplemental residents (#20, #21, #23, and #24) who were incontinent. The findings included: 1. On 6/28/05 at 7:30 AM, two Certified Nurse Aides (CNAs) were observed getting sample	F 316	F316 483.25(d)(2) Quality of Care This requirement will be met as evidenced by: 1. Nursing staff will be inserviced on infection control, wound prevention, and proper technique in providing peri and incontinent care. 2. Nursing staff were inserviced 7/13/2005 on infection control and privacy and dignity issues. 3. Nursing staff were inserviced 7/13/2005 on infection control policies, gloving and hand washing. 4. Review of medical record on resident #11: a. Nursing staff will be inserviced on	8/19/2005

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F 316	Continued From page 38 resident #3 up for breakfast. The CNA verified that the resident's incontinent pad was wet. The CNA cleansed the resident using one periwipe. The resident was lying on his/her left side. Without turning the resident over, the CNAs changed the resident's pad and put a brief on the resident. Review of the resident's laboratory reports revealed that the resident had experienced urinary tract infections (with organism) on the following dates: 11/30/04 - Escherichia Coli (E. Coli) 1/6/05 - E. Coli 1/24/05 - Staphylococcus Epidermidis (Staph E) 1/30/05 - Staph E and Lactobacillus Species (Lacto S) 2/1/05 - Staph E 2/17/05 - Staph E 3/22/05 - Klebsiella Pneumoniae. 2. On 6/28/05 at 8:35 AM, supplemental resident #24's catheter bag was observed to not be covered and the tubing was dragging the floor. On 6/28/05 at 9:45 AM, during the observation of sample resident #9's cares, supplemental resident #24 was also observed. Resident #24's catheter bag did not have a cover on it and the tubing was dragging the floor. Since resident #9's privacy curtain was not closed during the provision of cares, resident #24 was observed with his/her catheter tubing lying on the floor for approximately 15 minutes. At 11:59 AM, resident #24 was observed in the hallway with his/her catheter tubing dragging the floor. 3. On 6/29/05 from 4:45 AM to 6:00 AM, the following observations were made:	F 316	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from page 38 wound prevention. b. Nursing staff will be inserviced on completion of all physician orders. c. Nursing staff were inserviced 7/13/2005 on infection control, gloving and hand washing. Nursing staff will be inserviced on notification of Charge Nurse and Restorative Nurse of any skin issues. Nursing staff will be inserviced on proper catheter and perineal care for men, and hand washing for all residents. Staff #1 is no longer employed at the facility. 5. Nursing staff will be inserviced on providing proper catheter care. Continued compliance will be accomplished by: 1. Staff Development Coordinator will conduct random audits of catheter care provided for both men and women and educate as needed. 2. Staff Development Coordinator will conduct random audits of hand washing techniques and provide education as needed. 3. Staff Development Coordinator will conduct random audits of proper glove use and provided education as needed.	8/19/2005

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a. Supplemental resident #20 was taken to the bathroom to toilet. The incontinent pads on the resident's bed were wet, as verified by one of the two Certified Nurse Aides (CNAs) who was assisting the residents in this room. The other CNA removed the resident's wet incontinent pad. After the resident was toileted, the CNA washed the resident's buttocks and the back of the resident's legs with one wash cloth. The resident's front groin and perineal area were not observed to be washed.

b. Supplemental resident #21's incontinent pad was changed while the resident was lying in bed. The CNA verified that the pad was wet. The CNA washed the front perineal area and turned the resident to his/her left side. The right buttock was washed and an incontinent pad was applied. The left buttock was not cleansed.

c. Supplemental resident #23's incontinent brief was wet and was changed by the CNA. The CNA used a peri-wipe to wash the resident's front perineal area and the left buttock. The brief was applied without the resident's right buttock being cleansed.

The residents were not offered water to drink.

4. Resident # 11 medical record review revealed the resident was readmitted to the facility from the hospital on 4/5/05. Resident # 11's diagnoses included: Alzheimer's disease, BPH (benign prostatic hypertrophy) UTI (urinary tract infection) with MRSA and decubitus on right heel, weakness and falls.

a. Review of the MDS (minimum data set) dated 4/12/05 identified the resident's cognitive

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4. Skin reports will be completed at the time of bathing by Bath C.N.A. Verbal report of any potential skin issue will be given to Charge Nurse and Restorative Nurse when found. Skin reports will be filed in skin book daily.
5. Treatment plan will be developed by Restorative Nurse or designee when any potential or current issues are found.
6. Restorative Nurse or designee will be responsible for assessment and documentation of skin issues no less than weekly.
7. Treatment orders will be checked, per treatment record, daily by floor nurses to ensure compliance with physician orders.
8. Random observations will be utilized by all staff on a daily basis to ensure resident privacy and dignity is provided.
9. Ongoing inservices will be provided by Staff Development Coordinator/Infection Control or designee as required for infection control, perineal care, catheter care, hand washing, wound prevention

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F 316	Continued From page 40 skills as moderately impaired and needing extensive assistance with activities of daily living and having skin breakdown. b. Record review revealed the resident was readmitted to the facility with a MRSA (methicillin-resistant Staphylococcus aureus) infection of the urinary tract. The resident was currently on IV (intravenous) antibiotics for Pseudomonas Aeruginosa infection in the urine had an indwelling Foley catheter in place. The resident also had diarrhea in the hospital and was set up to have a Clostridium difficile antibody but diarrhea stopped and test was not completed. c. Observations on 6/29/05 at 4:35 AM the resident was observed with Staff #1 providing care. Staff #1 was observed coming out of the resident's room wearing gloves. The staff went back into the room after getting liners from the linen closet with gloves on. The resident was resting in bed on left side with feces on soaker pad and brief. Staff #1 rolled down brief and wiped the resident's right buttock and rectal area (rectum appeared red), placed clean brief under the resident with soiled gloves and turned the resident on to his back. Staff then wiped down over the resident's scrotal area. Then with same soiled gloves Staff did catheter care.Staff then wiped the resident's hands with same wipe used for catheter care. Staff also failed to ensure foreskin was adequately cleansed. d. On 6/29/05 at 11:45 AM, sample resident #11's catheter tubing was observed dragging on the floor under his/her wheelchair as the resident was pushed in his/her room and in the hall. 5. Catheter care was observed for sample resident #8 on 6/28/05 at 7:50 AM. The resident was lying in bed on his/her back. The CNA	F 316	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from Page 40 reporting, treatment, completion of physician orders, privacy and dignity, and glove use.	8/19/2005

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F 316	Continued From page 41 providing catheter care was observed to use a peri wash disposable wipe to provide catheter care. The CNA wiped around the catheter tubing at the meatus. Without folding the wipe or changing wipe, the CNA proceeded to wipe the catheter tubing from approximately five inches above the meatus down toward the meatus five times. The CNA did not change the wipe or fold prior to re-wiping the catheter. After wiping the catheter the CNA then continued to wipe around the meatus several times without changing the wipe or folding the wipe to prevent contamination of previously cleaned areas.	F 316	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 323 SS=E	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide an environment that was as free as possible from accident hazards. The findings included: 1. In room 36 on 6/28/05 at 8:35 AM, a mattress (floor) pad was observed to be leaning against the bathroom door and bedside stand. On 6/29/05 starting at 9:45 AM during the environmental tour of the facility with the maintenance staff, housekeeping staff and Administrator, the mattress was observed to be standing up by the resident's bed with the resident in bed. 2. In room 44 on 6/28/05 at 8:40 AM, folding chairs were leaning on the resident's walker,	F 323	F323 483.25(h)(1) Quality of Life This requirement will be met as evidenced by: 1. Mattress leaning against bathroom door and beside bedstand was removed from room 36 and appropriate safety measures have been taken. 2. Folding chairs leaning against resident's walker and bathroom door in room 44 have been removed. 3. Wheelchair arms on resident #37's wheelchair have been ordered and will be replaced. 4. Nurses will be educated on the importance of locking medication carts when not in continuous view. 5. Outlet covers will be purchased and placed in outlets of resident rooms located in the Special Care Unit. 6. Bolt locks on closet doors in rooms 30 and 43 have been removed to allow	8/19/2005

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F 323	Continued From page 42 which was leaning against the wall next to the bathroom door. 3. On 6/28/05 at 12:30 PM, during an observation of the noon meal in the purple sage dining room, the arm rests on supplemental resident #37's wheelchair were torn and cracked. 4. On 6/29/05 at 5:54 AM, the back hall medication cart was unlocked. The nurse was observed to walk away from the cart which was positioned at the nurses' station. The nurse walked down the hallway where the purple sage dining room was located. She was gone from the area for two minutes, but the cart remained unlocked for several minutes while the nurse talked with the oncoming nurse inside of the nurses' station. 5. During the initial tour of the Special Care Unit on 6/27/05 at 5:00 PM, observation revealed that the outlets in the resident's rooms were not covered. 6. Observations during the general environment tour on 6/29/05 from 9:45 AM to 11:20 AM with the maintenance staff, housekeeping staff and the Administrator revealed that electrical outlets in the Special Care Unit were not covered. The Administrator reported that all outlet in the unit were suppose to have a cover or guard. The Administrator stated, "Outlets are suppose to be covered and that is even in our policy for this unit." 7. During observations of the facility on 6/27/05 at 3:30 PM, resident rooms 30 and 43 were found to have closets with outside bolt locks in use. The closets in both of these resident rooms were large	F 323	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from Page 42 egress to any person that may get locked inside the closet. 8. Chain lock closure on storage closet in hallway across from resident room #2 has been removed and replaced with a lock that requires a key to prevent any entrapment. 9. Staff will be educated to keep closet inside clean utility next to the back nurse's station closed to prevent access. New locks for treatment cart stored in the clean utility next to the back nurse's station have been installed. Staff will be educated to keep the door locked to prevent access. The facility will ensure continued compliance by: a. Housekeepers will list any potential accident hazards on a daily cleaning schedule form. b. Repair logs located at each nurse's station for staff to request repair or concern(s) to be checked daily. c. Maintenance and Housekeeping Supervisors will make random room rounds daily. d. Restorative C.N.A. will conduct random weekly audits to ensure	8/19/2005

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F 323	Continued From page 43 enough to allow a person to stand in the closet with the door closed. The closets measured approximately 2 feet by 5 feet by 1.5 feet. The bolt locks were only accessible on the outside of the door and were not accessible from inside the closet. The use of these locks would prevent egress to any person locked inside the closet. 8. During observations of the facility on 6/27/05 at 3:30 PM, a storage closet located in the hallway across from resident room 2 was observed to utilize a chain lock closure. The storage closet was large enough to allow a person to stand inside with the door closed. The chain closure prevented the door from being opened fully and also did not allow for the door to be unlocked from inside the closet. The use of the locks would prevent egress to any person locked inside the closet. 9. Observation was made of the clean utility room next to the back nurse's station at 8:35 AM on 6/28/05. A closet inside the room was observed to have a lock on the door knob. The door knob was locked, but was not shut to prevent access. The closet provided storage for the following items: Five tubes of Triple A antibiotic ointment, two bottles of Cara-Klenz wound cleaner, and three bottles of Aplicar antiseptic 62% ethyl alcohol hand cleaner. The clean utility room also contained a treatment cart that was not locked. The cart contained: one bottle of peroxide, one bottle of chlorhexidine gluconate oral rinse, one can of Granulex spray, one bottle of Calamine lotion, one tube each of: ketoconazole 2% cream, mupirocin 2% ointment, nystatin and triamcinolone acetonide cream, Xenaderm ointment, Triple A antibiotic ointment, one drawer with various sized syringes and	F 323	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from Page 43 mobility equipment is in good repair. He/she will notify maintenance staff of any concerns. e. Random audits of storage closets, medication carts and treatment carts will be conducted weekly by D.O.N. or designee. f. Maintenance staff or designee will make random outlet cover audits in the Special Care Unit weekly.	8/19/2005

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F 323	Continued From page 44 needles and one hemocult kit. During observation of the room the facility's Utilization Review Nurse stated that the cart should be locked and was not sure why it had not been locked prior to being placed in the clean utility room. At 8:45 AM in an interview with charge nurse for the back hall way, the charge nurse stated that the items on the cart were to be secured and the door to the closet in the clean utility room should have been closed and locked.	F 323	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 324 SS=E	483.25(h)(2) QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to ensure adequate staff supervision to minimize the potential for accidents for two of 17 sample residents (#9 and #14) and three supplemental residents (#20, #23, and #21). The findings included: 1. On 6/27/05 at 7:05 PM, sample resident #9 was observed in the back hallway seated in his/her wheelchair. There was a large box shaped fan plugged into a hall electrical outlet. This fan was turned on. The resident was observed playing with the electrical cord. The surveyor called a nurse to assist the resident. 2. On 6/29/05 at 5:00 AM, during the observation of personal care for supplemental resident #20,	F 324	F324 483.25(h)(2) Quality of Care This Requirement will be met as evidenced by: 1. The box fan has been removed from the back hallway. 2. The C.N.A. Care Plan for resident #20 has been updated to instruct staff to place mat beside bed when resident is in bed. 3. The C.N.A. Care Plan for resident #23 has been updated to notify staff to place mat beside the bed when the resident is in bed. 4. Resident #21 has a proper positioning device across the foot of his/her wheelchair. 5. Resident #14 has been assessed for possible neurological injury. No negative outcomes have been noted. Resident #14 was placed in a low bed with a mat beside the bed to decrease	8/19/2005

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F 324	Continued From page 46 the Certified Nurse Aide (CNA) placed the floor mat on the floor next to the resident's bed when the resident's care was completed. The floor mat was not observed to be on the floor when the staff entered the resident's room to begin providing care to the resident. The CNA verified that the mat had not been on the floor but that it should have been there. 3. On 6/29/05 at 5:15 AM, during the observation of personal care for supplemental resident #23, the CNA placed the floor mat on the floor next to the resident's bed when the resident's care was completed. The floor mat was observed to be standing up at the end of the resident's bed (not on the floor) when the staff and surveyor entered the resident's room. The resident was observed to have bolster pads on each side of his/her bed. The CNA stated that the bolsters were used to prevent the resident from rolling out of bed. 4. On 6/29/05 at 7:03 AM, in the purple sage dining room, supplemental resident #21 was observed by two surveyors. The resident was sliding down in his/her wheelchair which was located in the purple sage dining room. One surveyor put the purple sage dining room emergency light on and stayed with the resident to ensure that the resident did not slide out of the wheelchair. Three minutes later a CNA came to assist the resident; she yelled for another staff member but no one came. The CNA repositioned the resident and put the foot board across the foot pedals, commenting that it (the board) did not work. The board was not observed to be in place when the resident was sliding down in the wheelchair. The emergency call remained on for approximately seven minutes before other staff entered the dining area and turned the call light off.	F 324	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from Page 45 risk of injury. Resident #14 was provided with 2 patient protector alarms to alert staff of resident attempt to get up without assistance. Care plan will be updated to reflect safety measures in place. Staff will be educated related to fall prevention care plan accuracy, safety precautions to prevent injury. Nursing staff will also be educated regarding the need for proper response to emergency call lights. DNS or designee will observe and monitor for compliance. Results will be presented at the monthly Performance Improvement meetings.	8/19/2005

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F 324	Continued From page 46	F 324		

5. Resident # 14 medical record review revealed the resident was recently admitted to the facility from the hospital on 6/24/05 for skilled care. Resident diagnoses included: Right total knee replacement for severe degenerative arthritis, seizure disorder, COPD (chronic obstructive pulmonary disease), hypertension and history of falls.

a. Review of the "Interdisciplinary Progress Notes" included:
-6/28/05 described the resident as being confused at times, having oxygen on at 2 liters, having compiaints of constipation, dizziness and unsteady gait.
- 6/26/05 Resident found on floor beside the bed with patient alarm ringing."Dr. notified per fax
-Laceration over R (right) eye with steri strips no other injury noted additional pt. alarm and bed bolsters to bed."
There was no documentation to show the resident had a complete assessment following the fall with injury. There was no evidence that the facility policy and procedure was followed by starting a "Neurological Assessment Flowsheet" for the resident having had a head injury. The facility failed to provide necessary care by assessing and monitoring the resident for further injury.
-6/27/05 "Res fell x 2 this shift, [sign for no] apparent injury noted. Res with increased anxiety, crying couldn't find her purse or wallet, daughter had taken them home. Res has had numerous previous falls in res room beside bed/in bathroom after using toilet looking frantically for wallet purse which daughter had taken home... no injury noted."

b. Interview with the DON on 6/28/05

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F 324	Continued From page 47 confirmed there was no evidence that appropriate resident assessments and follow-up was done to ensure timely and appropriate interventions were put in place. c. Review of the "...Interim Plan of Care" had one issue addressed which was dated 6/27/05 (which was after the fall) Skin -"wound care, laceration upper eye brow steri stripes in place." There was no care plan to show the interventions staff was suppose to be using in an attempt to prevent further falls and injuries.	F 324	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 364 SS=E	483.35(d)(1)&(2) DIETARY SERVICES Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This Requirement is not met as evidenced by: Based on observation, record review, and resident interview, it was determined that the facility failed to provide food that conserved the nutritive value and flavor and was palatable and attractive. The findings included: 1. On 6/28/05 at 7:55 AM, during an interview with a resident, the resident stated that the hot foods were not hot and the cold foods were not really cold. Further, he/she commented that the ice cream was always melted. 2. Resident #13 medical record review revealed the resident was admitted to the facility from the hospital on 6/21/05. a. Review of the current MDS (minimum data	F 364	F364 483.35(d)(1)&(2) DIETARY SERVICES This Requirement will be met as evidence by: The Dietary Manager will do a tray temperature test at meals daily to ensure food is served at proper temperature. Food will be served attractively on plates with garnishes. Ice cream will be delivered to Dining Rooms 20 minutes after each dining room cart is served. The cook will prepare meat to be tender and palatable. Vegetables will not be overcooked. Meals will be served at appropriate temperatures; utilizing hot plates for hot food. Bedtime snacks will be offered. Vegetables will not be overcooked. Appropriate level of spices will be added to the vegetables. Meals will be appealing.	8/19/2005

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F 364	Continued From page 48 set) dated 6/11/05 identified the resident's cognitive skills as independent and identified by staff as being interviewable. b. Interview with Resident #13 on 6/29/05 at 1:40 PM the resident voiced concerns with the food which included: -"meat is tough hard to chew, -vegetables over cooked, -the last few weeks there has been a lot of carrots, -3/4's of the time the meals are cold that is the hot foods are served cold, -not offered bedtime snack." 3. A test tray meal was ordered for the noon meal on 6/29/05. The meal consisted of mashed potatoes/gravy, ground meat, pureed meat, cauliflower, sweet potatoes, milk, juice and applesauce. The temperature for the test tray was satisfactory, however, the cauliflower was mushy and overcooked, and highly spiced with pepper. The cauliflower was white in color and added no color or appealing appearance to the meal. Record review of the facility's Food Preparation and Presentation Policy (POL 608-02) stated under Policy that "food is prepared by methods that conserve nutritive value, flavor and appearance." 4. During the noon meal on 6/28/05, supplemental sample resident #27 was observed eating. During the meal the resident attempted to cut his/her main entree, a chicken fried steak, but was having difficulty. The resident took several bites, but stopped eating the steak and continued eating the rest of the meal.	F 364		

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F 364	Continued From page 49 The resident consumed most of the food presented on his/her plate, except the chicken fried steak. As a facility staff person passed by the table the resident stated he/she was finished. The staff person asked the resident why he/she had not eaten the steak. The resident replied, " It ' s too tough to eat " . The staff person asked the resident if he/she wanted the alternate, but the resident stated that he/she was done and didn ' t want to wait.	F 364	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 368 SS=E	483.35(f)(1)-(3) DIETARY SERVICES 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, record review, and resident and staff interviews, it was determined that the facility failed to serve the evening meal and morning meal no more than 14 hours apart. Additionally, the facility failed to offer bedtime snacks to each resident. The findings included:	F 368	F368 483.35(f)(1)-(3) This requirement will be met as evidenced by: The Dining Room schedules will be adjusted so that the breakfast cart will go out at 7:15a.m and the dinner cart will go out at 5:15p.m.	8/19/2005

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F 368	Continued From page 50 1. On 6/28/05 at 7:55 AM, during a resident interview, the resident revealed that they had to wait for the food. He/she commented that for breakfast, they were to be in the dining room by 7:00 AM. The resident said that today the food arrived at 7:40 AM. 2. Record review of the posted Dining Room Cart Hours (Revised 4-18-2005) indicated that the first dining cart (Vineyard Dining Room) was scheduled to be served at 5:05 PM. Breakfast the next morning for the same dining room was scheduled to be served at 7:25 AM. This leaves more than a 14 hour span between the evening meal and the breakfast meal. Observation of the breakfast meal delivery on 6/28/05 revealed that the first dining cart arrived in the Vineyard Dining Room at 7:30 AM. Record review of the facility's Meal Frequency Policy (POL 608-03) under Compliant Guidelines stated: "1. Meals are scheduled to be served such that there is no more than 14 hours between the evening meal and breakfast the following day. Up to 16 hours may elapse if: a. A nourishing snack is provided to all residents, and b. A resident group agrees to this meal plan." During an interview with the Dietary Manager on 6/30/05 at 10:15 AM, she said that dietary supplied evening snacks for the residents and nursing is responsible for distribution. She also stated that approval for a greater than 14-hour meal span has not been approved by a resident group.	F 368		

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F 358	Continued From page 51 3. During the Resident Group Interview conducted on 6/28/05 at 10:30 AM, the group was asked if they received snacks at or just before residents went to bed at night. The group of residents stated that they were not offered snacks at bedtime and the residents stated that they could not get a snack when they wanted one.	F 358	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 371 SS=F	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This Requirement is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to prepare and distribute food in a manner that minimized the potential for the spread of food borne illness. The findings included: 1. Observations during the initial tour on 6/27/05 at 3:45 PM revealed the following: a. In the walk-in refrigerator, frozen Health Shakes were observed thawing but were not dated as to when the thawing began. Each carton specifically stated "use within 14 days of thawing." During an interview with the Dietary Manager (DM) on 6/30/05 she stated that nursing keeps a supply of Health Shakes on the units, but the shakes are not dated when they leave the kitchen. b. Also in the walk-in refrigerator, observations revealed four cartons of nectar thickened water dated 6/22. Imprinted on the carton was "once open store up to 5 days." Observation on 6/28/05 at 5:10 PM revealed that the thickened water dated 6/22 was still in the refrigerator. During an	F 371	F371 483.35(h)(2) DIETARY SERVICES This Requirement will be met as evidenced by: Health shakes will be dated on outside of thaw tubs in the walk-in refrigerator. All health shakes taken out of the refrigerator for use will be dated before leaving the kitchen. Kitchen staff and nursing staff will be inserviced. All cartons of thickened liquid will be dated when opened by dietary staff members. Dietary staff will be inserviced. Hand washing sinks, and the surrounding areas will be cleaned daily by dietary staff. The eye wash station and hand sink will be cleaned daily by the dietary staff members. Oasis solution in the cook's sink and sanitation bucket will be at 200 PPM only. Dietary staff will check solution strength by using test strips when filling sanitizing sink and/or bucket.	8/19/2005

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F 371	Continued From page 52 interview with the DM on 6/30/05 at 9:00 AM, she stated that the date on each carton was the date received and not the date it was opened. c. The two handwashing sinks and the immediate areas (walls and floors) surrounding them were dirty. The eyewash station situated near one of the sinks was also dirty. 2. On 6/29/2005 at 7:00 AM, the surveyor asked the DM to test the solution that was being used for surface sanitation. It tested at 400 parts per million (PPM). The chemical in the solution was Oasis 144 Quaternary Ammonium Sanitizer. The DM stated that the recommended concentration was 200 PPM. Chemical concentrations above the manufacturer's recommended amount can pose a health problem for residents and staff. 3. Observation of the trayline service for the noon meal on 6/28/05 revealed the following: a. The cook, while serving at the steamtable and wearing the same pair of gloves, placed buttered bread on the trays, and then placed the tray card on the tray and then returned to trayline service. The cook proceeded to dish up the noon meal and then stopped and, using the same gloved hands, took two slices of bread out of the package and put it in the toaster. The cook returned to the steamtable and continued serving without washing hands/changing gloves. b. At 12:25 PM, the cook left the trayline, washed her hands and changed gloves, and proceeded to slice two oranges on the wooden shelf connected to the steamtable. After finishing this task, the cook did not wash her hands or change gloves. At 12:35 PM, she was observed	F 371	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from Page 52 Hand washing and glove change inservices will be given by Dietary Manager and Staff Development Coordinator. Dietary staff will be inserviced regarding dietary aides placing condiments and wrapped foods on trays. Health shakes will be placed on ice when stored on medication carts. Dietary Manager will complete random compliance checks. Any areas of concern will be reviewed at monthly Performance Improvement meeting for further action, if indicated.	8/19/2005

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F 371	Continued From page 53 cutting the chicken fried steak while holding it with her hand. She then proceeded to resuming serving from the steamtable. 4. Observation of the trayline service for the evening meal on 6/28/05 revealed that the cook, using the same pair of gloves she was using to plate meals, reached into a box of crackers and placed two packages of crackers on residents' plates that were receiving soup. The cook, using the same pair of gloves, proceeded to continue serving the meal and placing tray cards on each tray. Condiments, wrapped food items, and tray cards are normally placed on the trays by dietary personnel who do not come in direct contact with steamtable food items. 5. On 6/28/05 at 3:27 PM, there were three cartons of Health Shake Plus on sitting on top of the back hallway medication cart. These shakes did not have a thaw or open date on them. 6. On 6/29/05 at 8:10 AM, during a medication pass administration on the back hall unit, an undated Health Shake Plus, which was open, was observed sitting on the top of the medication cart. This carton was not sitting on ice to keep it cold.	F 371		
F 386 SS=B	483.40(b)(1)-(3) PHYSICIAN SERVICES The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders. This Requirement is not met as evidenced by: Based on record review, it was determined that	F 386		

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F 386	Continued From page 54 the facility failed to ensure that the physicians signed and/or dated the physician orders at the time he/she signed them for six of 17 sample residents (#3, #7, #12, #6, #10, and #2). The findings included:	F 386		

1. Review of physician orders for sample resident #3 revealed that telephone orders written on 2/3/05, 2/19/05, 4/1/05, and 6/2/05 were not signed and/or dated by the physician.

2. Review of physician orders for sample resident #7 revealed that telephone orders written on 5/9/05, 5/12/05 (x 2), 5/31/05, 6/14/05, 6/16/05, and 6/23/05 were not signed and/or dated by the physician.

3. During a review of the record for sample resident #2 it was found that the physician had not dated written orders regarding the care of resident #2.

a. Fifteen fax communications sheets were noted to have the physician's signature indicating a new order or change in an order. However, none of the signatures on the orders were dated by the physician. The dates for these communications sheets are as follows:

1/24/05 re: request changes in orders
2/4/05 re: request changes in orders
2/8/05 re: request changes in orders
2/11/05 re: request changes in orders
2/13/05 re: request changes in orders
2/15/05 re: request for order
2/17/05 re: changes in orders
2/18/05 re: request for order
2/25/05 re: changes in orders
3/2/05 re: request medication order
3/8/05 re: medication clarification

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F 386	Continued From: page 55 3/19/05 re: request for new orders 3/29/05 re: request for new orders 5/1/05 re: request for new orders b. The record for sample resident #2 also contained documents titled, " Emissary Pharmacy ACE Inhibitor Interchange Authorization Request " . Two of these requests for changes in medication orders, dated 1/18/05 and 1/18/05 were approved by the physician. In both instances the physician signed the order to change the medications, but did not date the signature. c. Further review of the record for sample resident #2 found a document titled, " Physician Action Report " . This document was a part of the facility ' s consultant pharmacist ' s report to the physician of monthly reviews. The Report dated 5/13/05 requested labs be drawn. The physician did sign the request and order for new labs, but did not date the order. 4. During a review of the record for sample resident #10 it was found that the physician had not dated written orders pertaining to the care of resident #10 a. During a review of the telephone orders for sample resident #10 it was found that the physician signature was not dated for the following dates: 5/10/05, 5/11/05, 4/12/05, 4/19/05, 4/29/05, 3/16/05, 3/25/05, 3/9/05, 3/11/05, 2/23/05, 2/25/05, 2/2/05, 1/25/05, and 1/31/05. b. Three fax communication sheets were noted to have the physician's signature indicating a new order or change in an order. However, none of the signatures on the orders were dated by the	F 386		

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F 386	Continued From page 56 physician. The dates for these communications sheets are as follows: 3/7/05 re: request for order 3/9/05 re: request for order 4/15/05 re: request for order c. Further review of the record for sample resident #10 found a document titled, " Physician Action Report " . This document was a part of the facility ' s consultant pharmacist ' s report to the physician of monthly reviews. The Report dated 2/10/05 requested a change in medication orders. The physician did sign new orders for the medication change, but did not date the order. 5. During a review of the record for sample resident #6 it was found that the physician had not dated written orders pertaining to the care of resident #6 a. During a review of the telephone orders for sample resident #6 it was found that the physician signature was not dated for the following dates: 5/17/05, 6/1/05, 5/4/05, 4/15/05, 4/20/05, 4/5/05, 4/5/05, 3/24/05, and 2/3/05. b. Eleven fax communication sheets were noted to have the physician's signature indicating a new order or change in an order. However, none of the signatures on the orders were dated by the physician. The dates for these communications sheets are as follows: 5/18/05 re: request for change in order 5/14/05 re: request for change in order 4/29/05 re: request for order 4/28/05 re: request for change in order 4/22/05 re: request for order 4/20/05 re: request for order	F 386		

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F 386	Continued From page 57 4/18/05 re: request for order 4/15/05 re: request for order 4/15/05 re: request for order 3/31/05 re: request for order 3/15/05 re: order 6. During a review of the record for sample resident #12 it was found that the physician had not dated written orders pertaining to the care of resident #12. a. During a review of the telephone orders for sample resident #12 it was found that the physician signature was not dated for the following dates: 2/3/05, 4/4/05 and 6/17/05. b. Three fax communication sheets were found in the noted to have the physician ' s signature indicating a new order or change in an order. However, none of the signatures on the orders were dated by the physician. The dates for these communications sheets are as follows: 6/22/05 re: request for change in order 5/2/05 re: request for change in order Undated re: request for change in order The undated fax sheet had a notation that indicated it was signed off by facility staff and noted for the chart on 4/6/05. c. Further review of the record for sample resident #12 found a document titled, " Physician Action Report ". This document was a part of the facility's consultant pharmacist's report to the physician of monthly reviews. The Report dated 5/13/05 requested a change in medication orders. The physician did sign new orders for the medication change, but did not date the order.	F 386		

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F 426 SS=E	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This Requirement is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined that the facility failed to ensure that three of 17 sample residents (#11, #14, and #13) and one supplemental resident (#25) had their medications available to meet the needs of the residents. The findings included: On 6/29/05, during observations of medication passes, the following observations were made: 1. At 6:43 AM, when the nurse administered medicine to supplemental resident #25, the resident commented that his/her Xanax and Phenobarb were missed. He/she indicated that the medicine could have been obtained from ___ (local pharmacy) and was not sure why this did not happen. The nurse reviewed the resident's 6/05 Medication Administration Record (MAR) and confirmed that the resident had missed a dose of Phenobarb the evening before and that there was none for the resident's 8:00 AM dose on this date. She stated that the medication was ordered three or more days earlier (from the pharmacy used by the facility). Review of the resident's MAR revealed that the resident was to receive Phenobarb 100 mg (milligram) twice a day. No doses were charted	F 426	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F426 483.60(a) This requirement will be met as evidenced by: 1. Resident #25 has been discharged. 2. Residents #11 and #14 were assessed with no negative outcomes noted as a result of late administration of Tiazac and Protonix. Charge nurses will be inserviced regarding proper procedure for timely ordering, receiving and administration of medications. The facility pharmacy provider has been educated regarding response to medication orders. Medications will be ordered from a local pharmacy if needed to meet resident needs. DNS or designee will monitor for compliance and will report at the monthly Performance Improvement meetings.	8/19/2005

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F 425	Continued From page 59 on 6/24 and 6/28 at 8:00 PM. There was no explanation on the MAR or in the Daily Skilled Nursing Notes of why the medication was not given. Review of the resident's MAR evidenced that the resident was to receive Xanax 0.25 mg three times a day. The 9:00 PM doses on 6/16 and 6/17 and 6:00 AM dose on 6/29 were not charted. The 6:00 AM dose on 6/28 and the 9:00 PM doses on 6/23 and 6/28 were circled as withheld. There was no evidence to explain why these doses were not given and/or were not charted. On 6/29/05 at 9:10 AM, in an interview with the Resident Assessment Coordinator (RAC), she verified that there were intermittent problems with deliveries from the pharmacy. She stated that normally, if the medication does not come in, the local pharmacy is contacted and it supplies the medication. The RAC verified that there was no evidence that the resident received the Phenobarb doses. She was unaware that there was a problem with the resident receiving his/her Xanax. The nurse who was administering the medications stated that the 6:00 AM Xanax for this day was taken out of the emergency drug supply on the secure unit (by the night nurse). The RAC and the surveyor checked the medication sign out sheets for the emergency drugs. The RAC verified that the doses in question had been taken from the emergency supply. At 9:20 AM, the medication nurse reported to the surveyor that the resident's Phenobarb and Xanax were delivered by the pharmacy.	F 425		

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F 426	Continued From page 60 2. At 8:20 AM, the nurse administering medications stated that _____ (sample resident #11)'s Tiazac and _____ (sample resident #14)'s Protonix were missing. These were medications scheduled to be given at 8:00 AM. At 12:03 PM, the medication nurse reported to the surveyor that these residents' medications were received from the pharmacy. 3. During observation on 6/28/05 the evening charge nurse was observed looking through residents' medications stored in the front closet. The nurse reported that a couple of residents were short of medication. The nurse reported the medications in the closet were the replacement medication for the medication carts and that carts were to be changed out tonight. The pharmacist had been called and told staff to use from the resident cassettes or cards to replace the missing medications. Staff was unaware of how or why they were short of medication but would report it	F 426	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 432 SS=E	483.60(e) PHARMACY SERVICES In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 432	F432 483.60(e) PHARMACY SERVICES This requirement will be met as evidenced by: 1. Medications are delivered to allow for restocking of resident medications on the 27th or 28th of each month. 2. The lock on the door of the front hall closet used for medication storage has been changed. A new key has been placed on each set of nursing unit keys. The DNS also has a key to the medication closet. This is a total of 4	8/19/2005

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F 432	Continued From page 61 be readily detected. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to store all medications in a manner that prevented unauthorized personnel from accessing the storage area. The findings included: 1. During observation on 6/28/05 the evening charge nurse was observed going through a large box containing residents medications in the front hall closet. The nurse reported the box of medications was kept there and medications would be changed out with the medication carts that evening. The closet also had medications that were brought in by residents from home. 2. Observations during the general environment tour on 6/29/05 from 9:45 AM to 11:20 AM with the maintenance staff, housekeeping staff and the Administrator revealed unauthorized personnel having access to medications kept in the same front hall closet. During the tour the maintenance staff unlocked the front hall closet which had resident medications. The maintenance staff confirmed having the key and opening the door for housekeeping to clean. The maintenance staff was unaware that only authorized personnel responsible for administration or provision of medications were to have access to the medications. The Administrator rejoining the tour was unaware that maintenance had a key and access to the medications and instructed staff on getting the lock changed as soon as possible. The Administrator confirmed that maintenance staff having access to medication was a problem.	F 432	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from Page 61 keys for this closet. DNS or designee will monitor for compliance and will report any discrepancies immediately to the Maintenance Supervisor so that the locks may be changed, if needed.	8/19/2005

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F 441 SS=F	483.65(a)(1)-(3) INFECTION CONTROL The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This Requirement is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility failed to investigate, control, and prevent the spread of infections in the facility and to maintain an accurate record of the infections and the corrective actions taken. The findings included: Review of the "Infection Control Program" and interview with Staff (Infection Control Coordinator) on 6/30/05 revealed; the monthly tracking logs for March 2005, April 2005, May 2005 had been done. However the logs were not a concurrent surveillance of residents having signs and symptoms of infections. The log did not address interventions put in place to prevent reoccurrence or spread of infections. The logs did not address if and when isolation precautions were put in place. An example was the report dated April 2005 which included: UTI (urinary tract infection) 1 new MRSA (methicillin resistant staphylococcus aureus) and Skin - 1 new MRSA. However there was no documentation to show interventions to address these current issues. It listed "Education: had Infection Control Inservice 12/30/04 and Inservice scheduled for May 5, 2005". There was no documentation of what was being done to address the infections as they were occurring in	F 441	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F441 483.65(a)(1)-(3) INFECTION CONTROL This requirement will be met as evidenced by: The Infection Control Coordinator will include interventions used to prevent spread or re-occurrence of infections on monthly infection control reports. Notation will also be made regarding if and when isolation precautions are used. Monthly infection control reports will also be modified to include staff training related to infections. Documentation will also include monitoring of staff for infection control techniques. Resident #44 has been discharged. Resident #11's UTI has been resolved with use of IV antibiotics. Diarrhea has been resolved. All nursing staff will receive re-education for all infection control policies, including proper pericare, hand washing and linen handling.	8/19/2005

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F 441	Continued From page 63	F 441		

the facility. Review of the reports found all the reports to lack substantial completion in regards to precautions to prevent cross contamination. The infection control forms did not indicate how the facility would provide appropriate in-servicing of staff related to identified infections and patterns.

During an interview with the Infection Control Coordinator and the MDS Coordinator on 6/30/05 at 9:00 AM, they stated that the procedure used for tracking infections was supposed to be done as infections were identified. There was no follow-up for residents identified with antibiotic resistant infections or multiple infections to show monitoring and interventions done to prevent the spread or reoccurrence of those infections. These examples included the residents who had MRSA of urine, skin and sputum. The Infection Control Coordinator reported that monitoring of staff providing cares for proper infection control techniques was done but it was not documented.

Observation and record review which identified infection control issues during the survey were reviewed with Staff (Interview with the Infection Control Coordinator and the MDS Coordinator) which included:

-Resident # 4 with a history of MRSA infection in the sputum. Staff was unaware if any precautions were done and none were documented. Staff stated, "I found out it was MRSA when you asked about it 6/29/05." The resident was admitted to the facility on 3/14/05 after being treated for MRSA for 4 days in the hospital. There was no care plan to guide this resident's care for having recent respiratory infection (MRSA). MDS Coordinator reported that any isolation precautions put in place should be addressed in

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 441	Continued From page 64 the resident's care plan. The Infection Control Coordinator reported that she does not identify resident's having MRSA in their care plans. -Resident # 11 medical record review revealed the resident was readmitted to the facility from the hospital on 4/5/05. Resident # 11's diagnoses included: UTI (urinary tract infection) with MRSA (methicillin-resistant Staphylococcus aureus) infection of the urinary tract. The resident was currently on IV (intravenous) antibiotics for Pseudomonas Aeruginosa infection in the urine and had an indwelling Foley catheter in place. The resident also had diarrhea in the hospital and was set up to have a Clostridium difficile antibody but diarrhea stopped and the test was not completed before return to the facility. The resident had been having intermittent episodes of diarrhea in the facility but no follow-up had been done with Clostridium difficile antibody. The DON had been asked about this issue and reported on 6/29/05 that the resident had had diarrhea and staff was to be checking with the resident's physician about checking for Clostridium difficile infection. The Infection Control Coordinator was not aware of the resident's episodes of diarrhea and follow-up for Clostridium difficile. Review of laboratory reports revealed the following infections (resident #, specimen, date, and organism): Resident #9 Urine - 9/15/04 - Pseudomonas Aeruginosa (Pseudo A) Urine - 10/15/04 - Staph Aureus, Methicillin Resistant (MRSA) Sputum - 12/8/04 - Escherichia Coli (E. Coli), Streptococcus Alpha Hemolytic (Strep A), Neisseria Species	F 441		

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F 441	Continued From page 68 Urine - 12/22/04 - Pseudomonas Aeruginosa Sputum - 1/7/05 - MRSA, Strep A, Neisseria Sputum - 1/13/05 - Staphylococcus Coagulase Neg Urine - 4/15/05 - Pseudo A, MRSA Urine - 5/10/05 - Enterococcus Faecium Resident #3 Urine - 11/30/04 - Escherichia Coli (E. Coli) Urine - 1/6/05 - E. Coli Urine - 1/24/05 - Staphylococcus Epidermidis (Staph E) Urine - 1/30/05 - Staph E and Lactobacillus Species (Lacto S) Urine - 2/1/05 - Staph E Urine - 2/17/05 - Staph E Urine - 3/22/05 - Klebsiella Pneumoniae. Resident #17 Urine - 5/19/05 - E. Coli Urine - 6/4/05 - Lactobacillus Species Resident #16 Sputum - 2/11/05 - Strep A, Neisseria The facility failed to provide residents with adequate perineal care and catheter care to minimize the potential for UTI. (cross refer to F-316) The facility failed to ensure staff followed proper handwashing after direct resident contact. (cross refer to F-444) The facility failed to ensure that personnel handled linens in a manner which would prevent the potential spread of infections. (cross refer to F 445) The facility failed to establish an effective	F 441		

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F 441	Continued From page 66 infection control program to identify and investigate all infections within the facility which prevents the facility from controlling cross contamination and the spread of infections.	F 441	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 444 SS=E	483.65(b)(3) INFECTION CONTROL The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This Requirement is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to ensure that staff washed their hands after providing personal cares to one of 17 sample residents (#11) and one supplemental resident (#20). The findings included: 1. On 6/29/05 at 4:45 AM, during an observation of two Certified Nurse Aides (CNAs), supplemental resident #20 was lying crosswise in the his/her low bed. The staff assisted the resident to ambulate to the bathroom. The resident's gown was wet, as were the incontinent pads on the bed. One of the CNAs, who while wearing gloves, verified that the pads were wet and then removed the incontinent pads from the bed. The CNA placed these pads and the resident's wet gown in an "isolation" container which was in the room. Without changing the gloves and washing her hands, she touched the clean laundry in the laundry basket, in the resident's dresser drawers, and closet while trying to find a gown for the resident. 2. Resident # 11 medical record review revealed the resident was readmitted to the facility from the	F 444	F444 483.65(b)(3)INFECTION CONTROL This requirement will be met as evidenced by: 1. Resident #20 had clothing and linens thoroughly washed and replaced in his/her closet and drawers. 2. Resident #11 has resolved infection. Nursing staff has been in-serviced related to proper use of gloves and hand washing technique. Staff will be observed and monitored for compliance and the results will be presented with the infection control report at monthly Performance Improvement meetings. Staff will be re-educated annually as needed.	08/19/05.

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F 444	Continued From page 67 hospital on 4/5/05. Resident # 11's diagnoses included: Alzheimer's disease, BPH (benign prostatic hypertrophy) UTI (urinary tract infection) with MRSA and decubitus on right heel, weakness and falls. a. Record review revealed the resident was readmitted to the facility with a MRSA (methicillin-resistant Staphylococcus aureus) infection of the urinary tract. The resident was currently on IV (intravenous) antibiotics for Pseudomonas Aeruginosa infection in the urine had an indwelling Foley catheter in place. The resident also had diarrhea in the hospital and was set up to have a Clostridium difficile antibody but diarrhea stopped and test not completed before return to the facility. b. Observations on 6/29/05 at 4:35 AM the resident was observed with Staff #1 providing care. Staff #1 was observed coming out of the resident's room wearing gloves. The staff went back into the room after getting linens from the linen closet with gloves on. The resident was resting in bed on left side with feces on soaker pad and brief. Staff #1 continued with cares with same gloves. Staff #1 then removed the gloves, washed hands, pick up soiled linens with bare hands and placed them in linen barrel in the hallway. Staff #1 then went to clean linen closet to look for a bottom sheet touching doors and clean linens with soiled hands. Staff #1 returned to room and was observed to close clamp on Foley catheter to stop urine leaking on the floor with bare hands. Staff #1 did not wear gloves to close the clamp and did touch other items in the room before washing hands. Staff #1 failed to ensure proper hand washing and gloving technique during the provision of care	F 444	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F444 483.65(b)(3) INFECTION CONTROL Continued from page 67	

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F 444	Continued From page 68 and handling of soiled linen for a resident having a known infection. This failure also placed other residents, staff and public at risk for the cross contamination and spread of infection.	F 444	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 445 SS=E	483.65(c) INFECTION CONTROL 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, it was determined that the facility failed to handle and transport soiled linen in a manner which would prevent or minimize the spread of infection. The findings included: 1. On 6/28/05 at 7:45 AM, two laundry barrels with unbagged linens stacked at least one foot above the top of the barrels were observed in the back hallway. The Certified Nurse Aide (CNA) was observed to push the barrels to the door of the dirty utility room. In the hallway, she pulled plastic bags up around the dirty linens. The linens were observed to be against her clothing. 2. On 6/29/05 at 4:45 AM, staff were observed to place several plastic bags of trash on top of the soiled linen barrel which was located outside room 32. A CNA was observed to bring a trash barrel down the hall and place the trash in it. 3. Observations on 6/29/05 at 4:35 AM Staff #1 was observed providing resident care. Staff #1 was observed handling soiled linens with bare hands. The resident was identified as having an infection however linen was not bagged before taking it out	F 445	F467 483.65(c) INFECTION CONTROL This requirement will be met as evidenced by: Nursing staff will be instructed regarding proper technique for bagging and transport of soiled linens and trash. Staff will also be educated related to proper use of gloves to handle soiled linen. DNS or designee will monitor staff for compliance. Re-education will be provided as indicated	08/19/05

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F 445	Continued From page 69 of the resident's room. (cross refer to F-444).	F 445	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 467 SS=E	483.70(h)(2) PHYSICAL ENVIROMENT The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide adequate ventilation in resident room bathrooms and public restrooms and the physical therapy area in order to minimize odors. The findings included: Observation during the initial facility tour on 6/27/05 at 3:20 PM revealed resident bathroom vents were not working in the front hall. Observations during the general environment tour on 6/29/05 from 9:45 AM to 11:20 AM with the maintenance staff, housekeeping staff and the Administrator present revealed that not all mechanical ventilation in resident bathrooms were working. Some of the resident bathrooms in the front hall did not have windows and were dependent on mechanical ventilation for air flow. The vents identified at the time of the tour as not working were located in the bathrooms in resident rooms which included rooms 1, 16, 24, 26, and 28. The maintenance staff confirmed the above observations. Room 28 was noted to have lingering urine odors present. It was also identified that the public restrooms and the physical therapy restroom in the front hall	F 467	F467 483.70(h)(2) PHYSICAL ENVIROMNET This requirement will be met as evidenced by: Bids have been obtained by contractors to fix the resident and public bathrooms that do not have adequate ventilation. The vents will be fixed so as to have adequate outside ventilation. The urine odor in resident room #28 has been eradicated. The maintenance supervisor or designee will keep a log to indicate that the ventilation system is functional and routinely being monitored and/ or follow-up with any necessary maintenance issues	08/19/05.

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F 467	Continued From page 70 had mechanical ventilation for air flow which was not working. Interview with the maintenance staff and Administrator during the tour reported that the mechanical ventilation in resident bathrooms had been working and had been recently checked when a life safety code survey was conducted. The maintenance staff confirmed there were no logs or other documentation to show that the functional status of the ventilation system was routinely monitored or checked. Interview with the maintenance staff on 6/30/05 at 9:30 AM related that ventilation units were checked. It was reported that the ventilation units on the roof and were not working on the front hall. There was something tripping the breaker so a service person was called and was coming to check on the problem.	F 467	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 468 SS=E	483.70(h)(3) PHYSICAL ENVIRONMENT 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, it was determined that the facility failed to provide handrails in all sections of the hallways utilized by residents. The findings included: 1. On 6/27/05 at 5:01 PM, during the initial tour of the facility, it was observed that there were no handrails under the windows on the outside wall of the main dining room. The missing sections of handrail were approximately six to seven feet long.	F 468	F468 483.65(h)(3) INFECTION CONTROL This requirement will be met as evidenced by: Handrails will be installed in the main hall and main dining room in all "gap areas" to provide handrail support for resident access and maneuverability.	08/19/05.

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F 468	Continued From page 71 2. Observations during the general environment tour on 6/29/05 from 9:45 AM to 11:20 AM with the maintenance staff, housekeeping staff and the Administrator present verified that no handrails were present in this area of the main dining room under the windows. This wall had the only handrails available for residents to hold on to when going into and out of the main dining area. The missing sections of handrails from this area can limit resident access for residents who used handrails for support.	F 468	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Continued from page 71	08/19/05.
F 492 SS=B	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to provide the mandatory written notice of the denial of Medicare payment for any residents. The findings included: On 6/29/05 at 8:55 AM, in an interview with the Business Office Manager, she revealed that when a resident is admitted on Medicare, the admission coordinator discusses the number of days that Medicare may cover for the facility stay. Then the Utilization Coordinator and Social Service staff with the input of the facility team plan for the resident's discharge. When the determination for discharge from Medicare is made, the family is notified of the impending discharge. On 6/29/05 at 9:05 AM, in an interview with the	F 492		

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F 492	Continued From page 72 Utilization Coordinator, she stated that the admission packet contains a notice (form) about the demand bill/denial process. She indicated that once a resident is to be discharged from Medicare, a discharge planning meeting occurs. At least two weeks before discharge, she notifies the family of the exact date for discharge. The Coordinator said that no written form is given to the family. She revealed to the surveyor that the notification of the family is documented but that the family decision is not documented. She confirmed that no written notification is given to the family (or resident). At the exit conference on 6/30/05, the Utilization Coordinator verified that the written notification letters had just arrived.	F 492	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 516	483.75(l)(3) ADMINISTRATION The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This Requirement is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to safeguard medical records from unauthorized access and to protect the residents' privacy. The findings included: Observation during the environment tour on 6/29/05 from 9:45 AM to 11:20 AM revealed issues with storage of residents medical records. Observation of a basement room, which was reported as the maintenance/housekeeping work room and an office area for other staff, contained unlocked file cabinets and boxes. These boxes were identified as resident over flow records. A	F 516	F516 483.75(1)(3) ADMINISTRATION This requirement will be met as evidenced by: 1. All financial files identified as overflow have been moved to a locked offsite storage location. 2. All loose papers have been removed and appropriately destroyed, discarded for filed.	08/19/05.

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F 516	Continued From page 73 stack of loose papers containing resident information was noted laying on top of one of the boxes. Maintenance staff reported the room was locked but other staff did have keys including maintenance and housekeeping. During an interview on 6/30/05 with the staff member responsible for medical records (Medical Records Coordinator), she stated that she was unaware that residents' medical records were being stored in the maintenance room. This Staff person then accompanied the surveyor to the room. Staff confirmed the file cabinets contained resident financial records. Staff then reviewed the stack of loose papers and confirmed them to be resident medical records from different residents. The staff reported that any over flow papers from resident charts was to be given to her and she would file them in their appropriate record. This Staff person then showed the surveyor the locked room where resident medical records were suppose to be kept to ensure confidentiality of resident records.	F 516	*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 the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F516 483.75(1)(3) ADMINISTRATION Continued from page 73 3. Personnel files will remain in filing cabinets but will have locks placed on them with the key to remain with Human Resources. 4. Medical Records personnel will check maintenance area weekly to assure there are no improperly stored files	08/19/05.