PRINTED: 10/18/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A043	A. BUILDING _____ B. WING _____	10/07/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING	201 14TH ST WHEATLAND, WY 82201

(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 176 SS=B	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and review of facility policy, the facility failed to evaluate two (#1 and #32) of two sample residents wishing to self-administer medications. The findings were: 1. Review of the 9/1/05 annual Minimum Data Set assessment (MDS) for resident #1 revealed diagnoses of multiple sclerosis and type II diabetes. Further review showed memory and cognitive skills for daily decision making were normal. Observation of the resident's room on 10/6/05 at 10:05 AM revealed 10 bottles of vitamins, minerals, and other dietary supplements on the shelf. In addition, the resident had a computer available for personal use. Interview on 10/6/05 at 10:10 AM revealed the resident had researched these two diagnoses through the Internet and believed the dietary supplements were of benefit. In addition, the resident also stated an interest in self-administering his/her own prescription medications. The resident was an early riser and stated a preference to self-administer his/her medications in the morning so that he/she could leave the room at his/her choosing rather than have to wait for staff to come to the room to administer the morning medications. Review of the medical record showed the facility had not	F 176	This Plan of Correction constitutes our allegation of compliance. **F 176** The facility will ensure an individual resident may self-administer drugs if the interdisciplinary team as defined by 483.20(d)(2)(ii), has determined that this practice is safe. 1. A mini-mental and functional assessment will be completed for Resident #1 by the RN and Occupational Therapist to assist in determining that resident #1 is safe for self-administration of medication. An interdisciplinary team consisting of members of the MDS team, Occupational Therapist and Pharmacist will meet to confirm Resident #1 is safe for self-administration of medication. If resident #1 is determined safe for self-administration of medication, the Resident Care Manager and Pharmacist will meet with Resident #1 to determine if the resident wants to self-administer, and outline the responsibility for storage, what & when medications will be self-administered and documentation of the administration. Appropriate notation of these determinations will be placed on the resident's Plan of Care. This will be completed by November 21, 2005. 2. A mini-mental and functional assessment will be completed for Resident #32 by the RN and Occupational Therapist to assist in determining that resident #32 is safe for self-administration of medications. An	11/21/05 11/21/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenneth Leibsle | TITLE: CEO | (X6) DATE: 10/28/05

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.

Adopted & Changes pg. 8

Reviewed with Ken Leibsle, CEO on 11/2/05 @ 4pm

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F 176	Continued From page 1 assessed the resident for self-administration of medications. 2. According to the 9/29/05 annual MDS assessment, resident #32 was alert, oriented, and cognitively intact. Observations on 10/4/05 at 9:15 AM and 10/5/05 at 8:27 AM showed the resident correctly self-administered an inhaled medication without instructions from the nurse who brought the inhaler and other prescribed medications. Review of the medical record failed to show an assessment for self-administration of medications. Interview on 10/5/05 at 4 PM revealed the resident knew what medications were prescribed and would like to take them independently. However, self-administration was not offered by the facility. 3. Review of the facility's 3/27/00 policy and procedure, "Self Administration of Medication," revealed, "All residents will be given the opportunity to self-administer medication if they so desire." However, on 10/5/05 at 2:55 PM, interview with registered nurse (RN) #21 revealed self-administration of medications was not routinely offered to the residents. The RN further stated the facility did not assess residents for self-administration of medications "until they see a need." The RN confirmed residents #1 and #32 had not been assessed for self-administration of medications and that the supplements and vitamins kept by resident #1 were classified as medications. 4. Interview with the interim director of nursing on 10/5/05 at 6:00 PM confirmed the facility did not routinely assess residents for self-administration of medications. The practice of the facility was to wait for a resident to initiate a request to	F 176	interdisciplinary team consisting of members of the MDS team, Occupational Therapist and Pharmacist will meet to confirm Resident #32 is safe for self-administration of medication. If resident #32 is determined safe for self-administration of medication, the Resident Care Manager and Pharmacist will meet with Resident #32 to determine if the resident wants to self-administer, and outline the responsibility for storage, what & when medications will be self-administered and documentation of the administration. Appropriate notation of these determinations will be placed on the resident's Plan of Care. This will be completed by November 21, 2005. 3. The "Self Administration of Medication" procedure will be reviewed by a multidisciplinary team to identify the gaps that prevented offering self-administration of medication to residents # 1, and # 32. All residents presently residing at the facility will have their mini-mental assessment reviewed by the RN and will receive a functional assessment by the Occupational Therapist to assist in determining that the resident is safe for self-administration of medications. An interdisciplinary team consisting of members of the MDS team, Occupational Therapist and Pharmacist will meet to confirm which Residents are safe for self-administration of medication. The Resident Care Manager and Pharmacist will meet with each Resident identified to determine their desire to self-administer; and outline the responsibility for storage, what & when	11/21/05

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F 176	Continued From page 2 self-administer medications.	F 176	medications will be self-administered and documentation of the administration. Appropriate notation of these determinations will be placed on each Resident's Plan of Care. This will be completed by November 21, 2005.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and resident interview, the facility failed to assure adequate housekeeping and sanitation measures to maintain cleanliness of windows, an air vent, a refrigerator, and a baseboard heater. In addition, the facility failed to assure immediate access to a toilet in a shower room. The findings were: 1. Observations during the facility tour on 10/3/05 at 3:00 PM, on 10/4/05 at 9:55 AM, and again on 10/6/05 at 8:30 AM revealed the outside ledge of the window in the southwest corner of the dining room had an accumulation of dirt, grime and cobwebs. In addition, the outside ledge on the window opposite the door into the family lounge also had an accumulation of dirt, cobwebs and vegetative matter (leaves from cottonwood trees). Interview with resident #36 on 10/4/05 at 10:05 AM revealed the resident thought the window "should be hosed down from the outside so that we didn't need to look at the dirt." 2. Observation of the janitor's closet across the hall from resident room 102 on 10/3/05 at 3:15 PM and again on 10/06/05 at 8:35 AM revealed the exhaust air vent in the closet had a thick accumulation of dirt.	F 253	4. The "Self Administration of Medication" procedure will be reviewed by an interdisciplinary team consisting of the medical director, pharmacy, nursing, OT, and the Resident Care Manager. The process will be developed to include at least: administration of medication by a nurse until safe self-administration can be evaluated; assessment of safe self-administration of medication within seven days of admission, annually & with significant change; who will meet with and offer self-administration to the appropriate residents within seven days of admission; reassessment of self-administration; the responsibility for safe storage, documentation of self-administrated medication, options for storage of self-administered medication, medications excluded from self-administration, and the various options or types of self-administration. This process will be updated and implemented by November 21, 2005 by the Resident Care Manger. The process will be monitored by the MDS Coordinator monthly and reported to the Quality Management (IOP) Team quarterly.	11/21/05

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F 253	Continued From page 3 3. Observation of the refrigerator in the family lounge on 10/6/05 at 8:40 AM revealed a brown liquid spill on the floor of the refrigerator. 4. On 10/4/05 at 8:15 PM, observation showed the 24 foot long by 2 foot wide base board heater opposite the main entrance was streaked with black markings. In addition, paint was chipped in places and had faded in several other locations. 5. Observation on 10/6/05 at 9:56 AM revealed the toilet in the shower room opposite resident room 117 was inaccessible because four collapsed wheelchairs were placed in front of it.	F 253	**F 253** The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1. The dirt, grime and cobwebs from the outside ledge of the window in the southwest corner of the dining room was removed October 6, 2005. The dirt, cobwebs and vegetative matter was removed from the outside ledge on the window opposite the door into the family lounge on October 7, 2005. 2. The thick accumulation of dirt was removed for the exhaust air vent in the janitor's closest across the hall from resident room 102 on October 6, 2005. Housekeeping will develop a surveillance checklist and will inspect for cleanliness monthly. The list includes but is not limited to windows, air vents, and baseboards. This list will be developed and implemented by October 31, 2005 by the Housekeeping Manger. Inspections will be conducted monthly by housekeeping and results will be reported to Environment of Care Team by the Housekeeping Manager on a quarterly basis. 3. The refrigerator in the family lounge was cleaned by October 27, 2005. The LTC CNA cleaning schedule will be updated and reviewed with nursing staff by November 15, 2005 by the Resident Care Manager. Inspections of the refrigerators will be included in Nursing Safety rounds on a weekly basis. Results from the Nursing Safety rounds will be	11-21-05 10-07-05 10/31/05 11/15/05
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272		

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F 272	Continued From page 4 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 staff interviews, medical record review, and review of policies and procedures, the facility failed to complete comprehensive bowel assessments for two (#4, #17) of the three residents in the facility with fecal impactions. The findings were: 1. Review of the 7/21/05 quarterly Minimum Data Set (MDS) assessment showed resident #17 had severe cognitive impairment, was incontinent of bowel two to three times a week with a history of fecal impactions, and required staff assistance to use the toilet. According to nurses' notes dated 7/12/05 at 7 AM and 7/16/05 at 7:30 AM, the resident was "disimpacted" of a large amount of feces. In addition, review of documentation dated 7/16/05 at 7:20 PM showed the resident was hospitalized that evening with continuing symptoms of a fecal impaction. However, review of the medical record failed to show the facility completed a bowel assessment. According to the	F 272	reported to Environment of Care Team by the Resident Care Manger quarterly. 4. Plant Operations has cleaned and repainted all hallway baseboard heater covers. Plant Operations will monitor and maintain the heater covers as needed to keep them looking in good repair. 5. The four collapsed wheelchairs in the shower room opposite resident room 117 were moved to storage making the toilet accessible to the residents on October 7, 2005. An interdisciplinary team consisting of maintenance, nursing and housekeeping will meet to identify opportunities to improve storage, and storage areas. Approaches will be identified, shared with nursing, housekeeping and maintenance staff, and implemented by November 21, 2005 by the Resident Care Manager. Inspections will be conducted by maintenance, housekeeping and nursing to include safety, comfort and sanitation. The results from these inspections will be reported to Environment of Care Team by maintenance, housekeeping and nursing quarterly. The inspections will be implemented by November 21, 2005. **F 272** The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 1. A bowel assessment was completed on resident #17 by the RN on	10/28/05 11/21/05 11/21/05 11-21-05 11/15/05

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F 272	Continued From page 5 facility's 3/27/00 policy and procedure entitled "Bowel Program," a bowel assessment which included any history of fecal impactions would be completed on all residents after admission. Interview with registered nurse (RN) #21 on 10/5/05 at 4:50 PM confirmed the lack of a comprehensive bowel assessment. 2. According to the 6/16/05 MDS assessment, resident #4 was continent of bowel, had a history of fecal impactions, and required limited staff assistance to use the toilet. Review of the physician's orders for September 2005 showed the resident received three different laxatives every day. During an interview on 10/5/05 at 12:50 PM, licensed practical nurse #15 stated the resident has a "terrible" problem with constipation without the medications. However, there was not a bowel assessment in the medical record. Interview with RN #21 on 10/6/05 at 9:15 AM confirmed the lack of a comprehensive bowel assessment.	F 272	October 20, 2005. The Plan of Care was updated to reflect the individual Bowel Program identified for Resident #17 on October 20, 2005. CNA staff will record negative or positive results of a bowel movement daily. The assigned nurse will review bowel movement record each shift. If no evidence of bowel movement in one day an oral laxative will be given. If no results from the oral laxative in three consecutive days a rectal suppository will be given. The Plan of Care with interventions will be shared at shift report, on report work sheet starting October 31, 2005 and reviewed at the November 15th staff meeting by the Resident Care Manager. 2. A bowel assessment was completed on resident #4 by the RN on October 25, 2005. The Plan of Care was updated to reflect the individual Bowel Program identified for Resident #4 on October 25, 2005. CNA staff will record negative or positive results of a bowel movement daily. The assigned nurse will review bowel movement record each shift.	10/25/05
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to assure staff followed the care plan for two (#2, #17) of nine sample	F 282	A review of all residents Bowel Program will be completed by the Resident Care Manager to ensure each resident's Plan of Care reflects the appropriate interventions based upon their bowel assessment. A team consisting of nursing, pharmacy, medical director and dietary will review the present Bowel Management Program to identify the gaps that lead to resident fecal impactions. This process will be	11/21/05 11/21/05

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F 282	Continued From page 6 residents who required staff assistance. The findings were: 1. Review of the 7/21/05 quarterly Minimum Data Set (MDS) assessment showed resident #17 had severe cognitive impairment, required extensive staff assistance to use the toilet, was totally incontinent of bladder, and was on a scheduled toileting plan. According to that toileting plan, staff were to place the resident on the commode every two hours. Observation showed staff did not toilet the resident on 10/4/05 between 7:30 AM and 11 AM (3.5 hours) or between 11 AM and 2 PM (3 hours). In addition, the resident was not assisted to use the toilet; instead, staff checked the incontinence brief and changed it, if needed. Interview with certified nurse aide (CNA) #37 on 10/4/05 at 5:25 PM confirmed staff had not assisted the resident to use the toilet every two hours. 2. According to the 7/28/05 significant change MDS assessment, resident #2 had severe cognitive impairment, required extensive assistance from staff with bed mobility, and had a stage 4 pressure sore. Review of the current care plan showed staff were to turn and reposition the resident every two hours. Further review showed staff were to offer two ounces of fluids to the resident every hour. Observation on 10/3/05 showed the resident was not repositioned from 1:30 PM until 5:05 PM (3 hours and 35 minutes). In addition, staff did not offer fluids to the resident during that time period. Interview with CNAs #25, #28, and #32 on 10/4/05 at 2:25 PM revealed all three staff members were unaware the resident was to be offered fluids every hour.	F 282	revised to prevent resident fecal impactions. The process will include updated bowel assessment and protocols. This process will be developed and implemented by November 21, 2005. This process will be monitored by the Resident Care Manager monthly and reported to the Quality Management (IOP) Team quarterly. **F 282** The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 1. The toileting interventions outlined in the Plan of Care for Resident #17 was reviewed by the MDS team and updated on October 20, 2005. A Resident Care Worksheet was developed to include the toileting interventions reflected in resident #17's plan of care. This worksheet will be given to each CNA assigned to this resident starting October 31, 2005. 2. Resident #2's hydration and pressure ulcer prevention Plan of Care was updated October 27, 2005 A worksheet was developed October 27 to include the pressure ulcer prevention and hydration interventions reflected in resident #2's plan of care. This worksheet will be given to each CNA assigned to this resident starting October 31, 2005. A Resident Care Worksheet was developed October 27, 2005 reflecting	11-21-05 10/31/05 10/31/05 10/31/05
F 309	483.25 QUALITY OF CARE	F 309		

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F 309 SS=D	Continued From page 7 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to implement a consistent bowel regimen for one (#17) of three sample residents with fecal impactions. The findings were: 1. Review of the 7/21/05 quarterly Minimum Data Set (MDS) assessment showed resident #17 had severe cognitive impairment, was incontinent of bowel two to three times a week with a history of fecal impactions, and required extensive staff assistance to use the toilet. According to nurses' notes dated 7/12/05 at 7 AM and 7/16/05 at 7:30 AM, the resident was "disimpacted" of a large amount of feces. Review of the medical record showed a comprehensive bowel assessment was lacking. Refer to F272 for additional information related to lack of a bowel assessment. Review of the care plan showed it was not revised after the resident's impactions. Review of the physician's orders and the medication administration record (MAR) revealed the resident received a liquid stool softener twice daily and had orders for 15 to 30 milliliters of Lactulose (laxative) daily, as needed, and a Dulcolax suppository every third day if no bowel movement.	F 309	the interventions outlined in the current residents' plan of care. These worksheets will be implemented by October 31, 2005 by the Resident Care Manger and MDS Coordinator. The Resident Care Manger and MDS team will develop a method for communicating the Resident's Plan of Care to all caregivers. This process will consider new staff, agency staff, updates, special needs, timelines and responsibilities. The method(s) will be developed and implemented by November 21, 2005 by the Resident Care Manager. The Resident Care Manager will monitor the process monthly, and report to the Quality Management (IOP) Team quarterly. **F 309** 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. 1. A team consisting of nursing, pharmacy, medical director and dietary will review the present Bowel Management Program for Res. #17 + All Residents to identify the gaps that lead to resident fecal impactions. This process will be revised to prevent resident fecal impactions and assist residents in reaching their highest practicable level of functioning and well-being. The process will include but is not limited to: bowel assessment and	11/21/05 11/21/05

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F 309	Continued From page 8 According to the documented bowel record, the resident did not have bowel movements between 9/3/05 and 9/7/05 (three days), 9/8/05 and 9/12/05(three days), and 10/1/05 and 10/6/05 at 8 AM (four days). Interview with certified nurse aide (CNA) #38 on 10/6/05 at 8:35 AM revealed the resident did have a bowel movement on 10/3/05, but staff forgot to document it. However, no one checked the record to determine if the documentation was correct. Review of the MAR for September and October 2005 revealed neither the physician's order for Lactulose nor the suppository were implemented. Interview with registered nurse (RN) #21 on 10/5/05 at 4:50 PM revealed the resident routinely received a suppository every third day until April 2005. Then it was changed to "prn [as needed]." The RN stated that when a suppository is administered "prn," staff do not always document bowel movements. The RN further stated that a resident can go "several days" without a bowel movement. In addition, interview with the chief nursing officer on 10/6/05 at 9 AM revealed that all the interventions itemized in the 3/27/00 policy and procedure, "Bowel Program," were not initiated for the resident. The itemized interventions included, but were not limited to, accurate intake and output, daily fruit bar, prune juice with the evening meal, belly massage and rectal stimulation every other day, and increased activity.	F 309	protocols. This process will be developed and implemented by November 21, 2005. This process will be monitored by the Resident Care Manager monthly and reported to the Quality Management (IOP) Team quarterly.	
F 323 SS=B	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible.	F 323	**F 323** The facility must ensure that the resident environment remains as free of accident hazards as is possible. The facility will provide a hazard-free environment by doing hazard	11/21/05

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	53A043	A. BUILDING _____ B. WING _____	10/07/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING	201 14TH ST WHEATLAND, WY 82201

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F 323	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a hazard free environment in one of two shower rooms, the area around the nurses' station, one of two storage rooms, and in several locations in the hallway. The findings were: Observations on 10/3/05 at 4:00 PM and again on 10/6/05 at 8:48 AM revealed the exterior finish around the nurses' station sink was chipped in several locations revealing sharp edges. The chipped finish included 3 chips on the edge of the cabinet door under the sink, two chips in the edge of the sink cabinet and a 2 inch chip on the corner of the counter top just below the sink. This area was not secured; therefore, residents were able to access the area. Observation on 10/6/05 at 9:54 AM revealed the door to the shower/tub room opposite resident room 117 did not have a lock. A 16 ounce plastic bottle of CEN-KLEEN disinfectant was on the sink. Ingredients in CEN-KLEEN include ammonium chloride, which according to the Columbia Encyclopedia, 6th edition, is harmful if swallowed and causes skin and eye irritation. Observation on 10/4/05 at 10:13 AM revealed staples attached to the wall at several locations throughout the facility. This surveyor, upon brushing up against one of the staples, dislodged the staple and it fell to the floor, thus creating a hazard should someone without shoes step on it. The staples were located at the following locations: the wall between resident rooms 104 and 105; the wall outside resident room 116; the	F 323	surveillance rounds and correcting any problems as soon as they are encountered. Plant Operations will remodel the current nurse's desk and repair broken and damaged formica surfaces. The entrance to the nurses station will be widened to allow med carts through this area easier without damaging the counter surfaces. This will be completed by November 21, 2005. Plant Operations will monitor these areas regularly for any further damages. Nursing Service will orientate staff and monitor them on the use and storage of chemicals used in the tub/shower rooms. All chemicals will be secured in cabinets out of reach of any residents. Regular rounds by the Resident Care Manager and the Safety Officer will be made of these areas to look for any trends varying from this usage and storage of chemicals. All identified staples were removed by October 24, 2005. All staples used for holiday decorations will be removed by the Activity Staff when the decorations are removed. The facility will insure that Storage Room "A" is locked at all times. Plant Operations will install a keyed-style lock on the door which will prevent inadvertent resident access. Plant Operations on their daily rounds will check the door to make sure it is locked when not in use.	11/21/05 10/24/05 10/28/05

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F 323	Continued From page 10 wall next to resident room 120; the wall outside resident room 111, and the wall to the right of the announcement board opposite the main entrance. Observation on 10/6/05 at 9:48 AM revealed the door to storage room "A" was unlocked.six battery chargers were in the room, running on 120 volts of electricity. Six batteries were plugged into the chargers. Eight oxygen condensers, a gurney and other miscellaneous, small metallic items and supplies which could be inserted into the electric battery chargers were also in the room. Interview with CNA # 28 revealed the batteries were used for the mechanical lifts. In addition, the CNA stated the room was never locked in order to allow access by the staff. Furthermore, the door to the room was not visible from the nurses' station, and the facility did not provide constant supervision of the room or hallway to prevent inadvertent resident access.	F 323	Nursing will conduct "Safety Rounds" weekly to identify actual and potential safety hazards. These rounds will include visual inspections, interviews with staff, residents and families, and surveillance check list that is inclusive of safety goals, equipment, bathing facility, hazards and restraints. These inspections will be started by November 21, 2005. Results will be reported immediately to the Resident Care Manager and to the Environment of Care Team quarterly.	11/21/05
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of posted information, the facility failed to maintain a medication error rate below five percent (%). Observation revealed 4 non-significant medication errors out of 46 opportunities for error which resulted in an error rate of 8.69%. The findings were: 1. Observation showed the following medication	F 332	**F 332** The facility must ensure that it is free of medications error rates of five percent or greater. 1.Resident #23 and Resident #19 had their K-dur changed to Micro K so the capsules can be opened up and sprinkled on food, etc. The drug stores were notified on 10/13/05 and review of those resident's medications on 10/26/05 revealed that Micro K was in each resident's drawer. The MAR's were marked in red with "crush meds" at the top and the K-dur/Micro K orders on the MARs were marked in red with "Do Not Crush" by Pharmacy on 10/13/05.	11/21/05

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F 332	Continued From page 11 errors related to administration of potassium: a. On 10/3/05 at 5:46 PM licensed practical nurse (LPN) #18 crushed Potassium Chloride SA (sustained action), mixed it with applesauce, and administered it to resident #23. b. On 10/5/05 at 8:22 AM, LPN #14 crushed K-Dur (potassium), mixed it with applesauce, and administered it to resident #19. Interview with the pharmacy technician on 10/5/05 at 9:30 AM revealed K-Dur and Potassium Chloride SA cannot be crushed. The technician stated SA stood for "sustained action" which meant the form of the medication could not be altered. The technician further stated she personally posted in the nursing home a list of medications which could not be crushed. Observation of the medication room on 10/5/05 at 9:37 AM revealed the posted list of medications which could not be crushed included K-Dur and all sustained action medications. Interview with LPN #14 revealed the information had been posted for "a while." Review of the 2005 edition of the "PDR Nurse's Drug Handbook" confirmed K-Dur and sustained action medications should not be crushed. 2. Observation on 10/4/05 at 8:22 AM showed LPN #12 administered Zaroxolyn, and other medications including Lasix, to resident #32. On 10/5/05 at 8:28 AM, LPN #15 also administered Zaroxolyn and Lasix to the resident. Reconciliation of the medications showed the physician's order, from 4/28/05 through September 2005, was for Zaroxolyn to be given 30 minutes before Lasix. Review of the medication administration record (MAR) showed Zaroxolyn was scheduled at 7:30 AM with Lasix scheduled at 8 AM. Interview with LPN #12 on 10/4/05 at 9:10 AM revealed she was unaware	F 332	Pharmacy will review the meds of residents requiring crushed med to identify potential problems. Meds that can not be crushed will be marked in red on the MAR "Do Not Crush". Medication will be changed when possible to medications that can be crushed. This will be done by pharmacy with the monthly MAR reviews. 2. Resident #32 has "Give 30 min before Lasix" highlighted in pink on MAR. This was completed by approximately 10/21/05. a memo reminding nurses why Zaroxolyn is given 30 min. before Lasix was posted in the med room 10/27/05. Education related to Zaroxolyn, other medications, and medication administration techniques as deemed necessary by pharmacy and/or nursing, will be placed in the nursing newsletter and posted on memos in the med room. The plan to educate will be completed by 11/21/05. Upon hire new facility and agency staff are oriented by pharmacy to medication administration and safety protocols.	11/21/05 11/21/05

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F 332	Continued From page 12 Zaroxolyn was supposed to be given 30 minutes before Lasix. The LPN stated she thought she had an hour to give the medications, so she gave them together at the 8 AM medication pass.	F 332		
F 432 SS=D	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to maintain the internal temperature of one of one medication refrigerators within a range which provided proper storage for thermolabile medications. The findings were: Observation with the chief nursing officer (CNO) on 10/6/05 at 8:40 AM showed the internal temperature of the refrigerator in the medication	F 432	**F 432** In accordance to the 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 key. The pharmacist and maintenance were contacted immediately when the refrigerator in the LTC medication room was discovered to be 54 degrees Fahrenheit. The pharmacist reviewed the medications. All medications were found to still be viable since they did not require refrigeration but just room temperature for storage. Insulin stable 3 months at room temperature. The temperature control was adjusted and the refrigerator temperature returned to 42F degrees by 11 AM on October 6, 2005. The CNO instructed staff through memoranda to check the refrigerator temperature daily all shifts starting October 6, 2005. The Med Use team reviewed the identified problem on October 11, 2005 and developed a process for consistently checking the refrigerator temperature during the shift narcotic count daily. The process was implemented October 11, 2005. The thermometer in the	10/11/05 11-2(-05

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F 432	Continued From page 13 room was 54 degrees Fahrenheit (F). Review of the temperature log showed the temperature was last recorded on 9/28/05. During the observation, the CNO verified the temperature reading and stated no one had checked the temperatures. The CNA further stated on 10/6/05 at 8:53 AM that nursing staff was responsible for checking the temperature of the refrigerator. According to the facility's December 1995 policy and procedure, "Monitoring Refrigerator Temperatures," the internal temperatures of medication refrigerators would be "monitored and recorded on a daily basis to insure the proper temperature for storage of thermolabile medications from 35 degrees to 46 degrees F." The refrigerator contained various types of Insulins, Miacalcin Nasal Spray, and Interferon, all of which, according to the 2005 edition of the "PDR Nurse's Drug Handbook," should be stored in the refrigerator between 36 degrees and 46 degrees F.	F 432	refrigerator was replaced with an alarming thermometer on October 10, 2005. This new thermometer will alert staff when the temperature is above 46F or below 32F.	