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	535029	A. BUILDING _____ B. WING _____	03/27/2008

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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 159 SS=B	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159	F159 The facility will ensure that all residents and/or representative with personal needs accounts receive a statement on their personal needs accounts at least quarterly and as requested. All residents with personal needs accounts have received a current updated statement. This will be evidenced by the Social Services Director obtaining statements monthly, and reviewing them with the residents. A quality indicator has been developed and will be monitored monthly for quarterly reporting at the quality improvement meeting.	4/11/08 monitoring compliance,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Doris Brown — TITLE: CEO/Administrator — (X6) DATE: 4/17/2008

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.

The POC was approved with corrections made by Connie Clous, RN DON and Kim Womack, RN Health Surveyor on 5/5/08 at 1030.

APR 21 2008
Wyoming Dept of Health
Licensing and Surveys

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F 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on confidential resident and family interviews and interview with staff, the facility failed to assure three of three residents with personal accounts received quarterly statements. The findings were: During a confidential interview on 3/26/08 at 1 PM, three residents reported they did not receive quarterly statements for personal accounts. As individual powers of attorney, family members of two of the three residents also stated quarterly statements were also not sent to them. The resident personally responsible for his/her account stated the balance was rendered only on request. An office assistant, employee #10, stated in interview on 3/27/08 at 1:20 PM that the business office did not routinely send an account summary of personal funds to residents. She also stated residents were encouraged to come to the business office if they had questions regarding their account status.	F 159		
F 164 SS=E	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	F 164		

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F 164	Continued From page 2 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to maintain privacy during provision of incontinence care for two (#3, #4) of five residents who were dependent on staff for that care. In addition, during confidential interviews, 9 residents stated staff failed to observe their right to privacy. The findings were: 1. Observation on 3/25/08 at 11:10 AM revealed resident #3 was incontinent of bowel and bladder and was transferred per manual lift to the toilet.	F 164	F164 The facility will ensure personal privacy will be maintained for each resident. #3 #4 and all residents This will be accomplished by: The charge nurse on duty will monitor ~~environmental aide (EA). She will knock and wait for a response to enter a resident's room with a closed door including resident #4.~~ all staff for resident privacy The Director of Nursing will inservice all staff on personal privacy for all residents including resident #4. and will monitor. A monthly monitoring tool will be implemented to ensure resident personal privacy. The monitor will be reported at the quarterly quality improvement meeting.	4/30/08

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F 164	Continued From page 3 During the transfer, environmental assistant (EA) #4 knocked on the door opening into the hallway and entered without waiting for permission. Although the resident was exposed from the waist down, the EA then stood in the bathroom doorway and watched the remainder of the transfer while she delivered a message to the certified nurse aides (CNAs) providing the resident's care. 2. Observation on 3/25/08 at 10:50 AM showed resident #4 was transferred to the toilet via manual lift. As one of the CNAs assisting with the transfer left the room, EA #4 entered the room without knocking. The EA did announce herself after entering, but did not receive permission to come further into the room. As the EA continued across the room, she passed in front of the open bathroom door and glanced inside where the resident was exposed from the waist down. 3. During confidential interviews between 3/24/08 and 3/27/08, nine residents stated the lack of privacy was a problem. They agreed staff walked around curtains when pulled, entered rooms as they knocked or knocked but did not wait for permission to enter, and walked into the bathrooms when residents were using them. 4. As EA #4 was unavailable, interview with the director of nursing (DON) on 3/27/08 at 11:15 AM revealed her expectation was that all staff knock and wait for permission before entering a resident's room. If the resident was hard of hearing, staff were to crack the door open and ask if they could come in before actually entering.	F 164		
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	F 170		

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F 170	Continued From page 4 promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to assure resident mail was delivered over the 2008 Easter weekend. The findings were: During confidential interviews between 3/24/08 and 3/27/08, 11 residents stated mail was not delivered over the previous weekend. Interview with the director of nursing on 3/26/08 at 5:30 PM revealed the social worker (SW) usually delivered the mail. When questioned immediately after the interview, the SW stated she was gone from 3/19/08 until 3/25/08. Upon her return, she reported finding resident mail mixed in with staff mail, and it was all placed in the social service's mail box. The time period when mail was not delivered to the nursing home included the Easter weekend	F 170	F170 All residents will receive their mail the day it is delivered from the post office. Social Services will monitor daily and develop a quality indicator for monthly monitoring for quarterly reporting at the quality improvement meetings. SS, activity personnel, office personnell Have all been directed of the correct process. from the SS. directed or activities.	4/11/08
F 176 SS=D	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, medical record review, and resident and staff interviews, the facility failed to assure documentation related to self-administration of medications was determined prior to administration for one (12) of two residents who self-administered medications	F 176		

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F 176	Continued From page 5 kept in the room. The findings were: Observation on 3/24/08 at 4:55 PM showed resident #12 had a bottle of Deep Sea Nasal Spray lying on the bed. When questioned, the resident stated s/he kept the nasal spray and used it independently whenever his/her nose became dry. Review of the medical record showed the resident was assessed as able to administer medications independently in his/her room. Interview with licensed practical nurse (LPN) #9 on 3/27/08 at 2:05 PM confirmed the resident frequently used the nasal spray. Review of the medication administration records showed no documentation for use of the spray or the other two self-administered medications. At 2:06 PM that day, the director of nursing confirmed the facility needed to track and document use of self-administered medications. Review of the facility's 9/2/04 policy and procedure entitled "Resident self administration/consumption of medication" showed documentation of self-administered medications was not addressed. In addition, safe storage of medications kept at the bedside was not discussed.	F 176	F176 The facility will ensure all self administered drugs that are kept at the bedside will be appropriately accounted for by the licensed nurse. This will be evidenced by all medications left at bedside, including resident #12, will be added to the MAR for the nurses to follow up with the resident for use and documentation. All residents with medication left at the bedside have been instructed to let the LPN know when they utilize the medications, including resident #12. A quality indicator has been developed and monitored by the DON for monthly completion for quarterly reporting at the quality improvement meeting.	4/11/08
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary and orderly environment for residents in one of one bathing rooms. Further, wallpaper was loose and peeling	F 253	1:1 training was done with all nurses regarding the facility Policy and a memo was posted for review	

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F 253	Continued From page 6 away from the wall in one of two hallways. The findings were: 1. Observation during the initial tour on 3/24/08 at 2:15 PM revealed the facility's only bathing room was not well maintained. The following areas were in disrepair: a. Numerous ceramic tiles lining the walls and ceiling in the shower and tub areas were cracked, broken, missing, discolored, and scratched. The corner molding at the entryway to the shower room was damaged, creating a surface that could not be easily cleaned. b. The plastic mop boards lining the bathing areas were cracked, broken, and loose from the wall and floor in several locations. Discoloration and accumulation of debris around loose mop boards showed the areas were not clean. c. An overhead beam above the whirlpool tub was missing several tiles, exposing the underlying wallboard. d. The wooden door leading to the bathing room was heavily scratched, marred, and gouged. In an interview on 3/27/08 at 10:25 AM, the maintenance supervisor acknowledged the bathing area was in need of repair and renovation. He indicated repair work was planned, but was not able to provide a timeline or overview of the work to be performed. 2. The wallpaper covering a half-wall separating the dining room from an adjacent hallway was observed on 3/25/07 at 2:25 PM. The outer surface of the half-wall, the side facing the hallway, had wall paper loose at the seam lines. Seven seams were peeling away from the wall, with up to an inch of the underlining wall exposed	F 253	F253 The facility will meet 483.5(h)(2) requirement. The tub and shower room will be repaired by replacing missing tiles in the tub area and overhead beam. Mop boards will be removed, wall and floor cleaned and replaced with new mop board. Shower room will be repaired with new class A fire rated material on all walls and corners. Doors will be repaired and refinished. Wall paper will be reglued and repaired with a high quality glue. Regular monthly inspections will be done by maintenance and nursing to maintain this requirement. Maintenance will report trends to QA for review.	5/15/08

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F 253	Continued From page 7 along two of the seams. Interview with the maintenance supervisor on 3/27/08 at 10:40 AM revealed he was aware of the wall paper peeling from the wall. He stated previous attempts to glue the wall paper had not been effective.	F 253		
F 254 SS=D	483.15(h)(3) ENVIRONMENT- LINENS The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store linens in one of one shower rooms in a manner that preserved their cleanliness. The findings were: During the initial tour of the facility on 3/24/08 at 2:40 PM, towels stored on the bottom shelf of a four-shelf open unit were observed in the facility shower room. Towels on the bottom shelf were within half an inch of the floor. These were the only towels in the shower room. Interview with certified nurse assistant (CNA) #7 on 3/24/08 at 2:55 PM revealed all towels on the shelving unit were used to dry residents after their showers. Observation on 3/25/08 at 8:25 AM revealed the shower room floor was wet. The towels on the bottom shelf, closest to the floor, were damp. On 3/25/08 at 8:30 AM CNA #5 stated she mopped the floor after the morning showers. She acknowledged the towels on the lowest shelf were damp and stated she may have splashed water onto the clean towels while mopping the floor. Further observation on 3/25/08 at 4:50 PM	F 254	F254 The facility will provide clean bed and bath linens. This will be evidenced by no towels being stored on the bottom shelf in the resident shower area. All staff have been notified not to store towels on the bathroom shelf in the shower room. A quality indicator has been developed for monthly monitoring by the DON and will be reported quarterly at the quality improvement meeting.	4/11/08

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F 254	Continued From page 8 revealed the towels on the bottom shelf had not been replaced and remained available for use. The director of nursing stated in interview on 3/26/08 at 6:10 PM that clean bath towels should be stored on higher shelves, further from the floor. She also stated her expectation that staff should remove any towels possibly dirtied when the floor was mopped.	F 254		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the	F 272		

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F 272	Continued From page 9 resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide comprehensive assessments in various areas for three (#6, #9. #25) of nine sample residents. The findings were: 1. According to the Centers for Medicare and Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, version 2.0, revised August 2005, page 4-2, "It is helpful to think of the RAI (Resident Assessment Instrument) as a process. The MDS (Minimum Data Set) identifies actual or potential problem areas. The RAPS (Resident Assessment Protocols) provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPS to analyze assessment findings and then "chart your thinking." It is important that the RAP documentation include the causal or unique risk factors for decline or lack of improvement. A risk factor increases the chance of having a negative outcome, or complication. RAP guidelines may contain cues regarding risk factors and complications associated with the RAP condition." Failure to follow the above assessment guidelines were identified in the following instances: a. Review of the 12/22/07 annual Minimum Data Set (MDS) assessment showed resident #9 required comprehensive assessments for communication, mood, and activities. According to Section V of that assessment, all assessment	F 272	F272 The facility will provide accurate and comprehensive assessments on all residents including residents #6, #9 and #25. This will be evidenced by the RAP summaries on all residents and will contain casual and contributory factors. Resident #9 will have RAP's for communication, mood and activities completed correctly. Resident #25 will have RAP summaries for delirium and mood state completed. Resident #6 will have an updated bowel assessment completed to reflect her noted bowel maintenance. The MDS Coordinator will randomly monitor resident comprehensive assessments and RAP completion for completeness and accuracy. A quality indicator has been developed for monthly monitoring to be reported quarterly at the quality improvement meeting. All three nurses have recieved 1:1 train regarding MDS assessments.	4/30/08

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F 272	Continued From page 10 information was located in the RAP summaries. Review of the communication and mood summaries showed the assessments lacked causal and/or contributing factors. In addition, the "factors for consideration" were completed incorrectly. Furthermore, the activities RAP was not completed for that assessment. Interview with the activities director on 3/26/08 at 5:07 PM revealed she was gone in December and the assessment was not completed. b. According to the 3/3/08 annual MDS assessment, resident #25 triggered for comprehensive assessments for delirium and mood state. Further review of Section V of that assessment showed the information would be found in the RAP summary modules. However, both those summary modules were blank. On 3/26/08 at 5:40 PM the director of nursing (DON) verified the modules were not completed. 2. According to the 5/29/07 annual and 2/20/08 quarterly MDS assessments, resident #6 was continent of bowel. However, review of the certified nurse aide flow sheets and the nursing documentation showed the resident developed bowel incontinence in July 2007. Further review showed a comprehensive bowel assessment had not been completed since 5/29/07 when the resident was continent. On 3/26/08 at 11 AM the DON confirmed the resident was not assessed for known bowel incontinence.	F 272		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure staff provided appropriate incontinence care during one (#3) of five observations of residents dependent on staff for incontinence care. The findings were: Observation on 3/25/08 at 11:10 AM showed resident #3 was incontinent of bowel and bladder. Further observation showed the resident's buttocks and perineum were splattered with fecal material. While providing perineal care at 11:50 AM that day, certified nurse aide (CNA) #2 touched the wipe against the resident's buttocks, visibly contaminating the wipe with feces, while reaching to cleanse the anterior perineum. The CNA then wiped back and forth several times over the perineum with the same area of the contaminated wipe. When questioned on 3/26/08 at 4:40 PM the CNA stated she knew perineal care should be completed from front to back with a clean wipe or a clean area of a wipe. She further stated she was trying to hurry and get the resident out of the sling to the manual lift as s/he was complaining of pain.	F 312	F312 Staff will provide appropriate incontinence care to all dependent residents, including resident #3. This will be evidenced by: All staff will be inserviced on appropriate incontinence care. The charge nurse, unit coordinator, and DON will monitor the staff. A quality indicator will be developed for monthly monitoring. This will be reported quarterly at the quality improvement meeting.	4/30/08
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of medical records, the facility failed to exercise precautions to prevent residents from entering one of four rooms with wet floors. The facility further failed to ensure a concentrated disinfectant solution was securely stored in one of one bathing areas. The findings were: 1. During the 3/25/08 breakfast meal, housekeeping staff were observed mopping floors in four resident rooms across from the dining room, including the room of resident #6. Observation at 8:25 AM that day revealed the resident entered his/her room after the breakfast meal. The resident walked with a shuffling gait, sliding his/her feet along the floor. There was no signage or barricades in place to restrict movement in those areas with wet floors. A surveyor entered the room to interview resident #6 at 8:27 AM and confirmed the floor was wet. Certified nursing assistant (CNA) #4 acknowledged in interview on 3/25/08 at 8:30 AM the floor in the resident's room was wet and "...could have been slippery." Subsequent interview with the housekeeping supervisor on 3/27/08 at 9:40 AM revealed his expectation that staff use signs and brightly-colored cones to restrict resident traffic until floors dried after mopping. 2. During the initial tour of the facility on 3/24/08 at 2:35 PM, the door to the bathing room was observed to be open. A storage closet inside the room was found opened about 2 inches. The inner closet door did not have a locking handle or dead bolt. The bathing room was accessible from the main hallway, a high-traffic area adjacent to	F 323	F323 The facility will ensure all hazardous materials, including disinfectants, are stored in a locked closet in the bathing room and not accessible to the residents. The facility will ensure appropriate precautions are utilized when mopping resident rooms and common areas. Cones or wet floor signs will be utilized. A quality indicator has been developed by maintenance for monthly monitoring for quarterly reporting at the quality improvement meetings.	4/11/08

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F 323	Continued From page 13 the beauty salon and dining room. This situation revealed the following accident hazard: a. On the floor inside the closet were four containers of concentrated disinfectant (Cen-Kleen IV solution); each container was labeled "Danger - Avoid Contact." Three of the four containers were labeled with an expiration date of 07/01/2004; the expiration date on the fourth container was not legible. b. Review, on 3/26/08 at 8:45 PM, of the material safety data sheet for the commercial disinfectant revealed the presence of didecyl dimethyl ammonium chloride. This chemical is noted as "highly toxic" by the environmental protection agency, with acute toxicity for humans. c. Subsequent observations revealed the door to the bathing area was left opened on 3/24/08 (5:40 PM), 3/25/08 (7:20 AM, 9:45 AM, 1:10 PM, 3:05 PM, 6:15 PM), and 3/26/08 (8:55 AM, 11:20 AM, 2:50 PM, 4:30 PM). d. Interview with the director of nursing on 3/26/08 at 6:30 PM revealed the chemical cleaner was no longer used at the facility; she further acknowledged the door to the bathing area was generally open when not in use. e. Interview with the housekeeping supervisor on 3/27/08 at 10 AM confirmed the cleaning concentrate was no longer in use. He further stated the chemical solution should be stored in another area, one "...out of the way..." of residents and visitors.	F 323		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 14 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the medication regimen for two (#6, #25) of nine sample residents was free of unnecessary drugs. The findings were: 1. According to the physician's orders and the medication administration records (MARs), resident #6 received Restoril (a hypnotic) 15 milligrams (mg) every night since 8/29/06. Review of the physician's history and physical dated 7/17/07 showed the resident took the medication on a "chronic outpatient basis. "We did try going without it when [the resident] first arrived [05/26/05] at long-term care but [his/her] sleep pattern became quite disruptive to the other residents..." Review of the medical record	F 329	F329 The facility will ensure that all residents are free of unnecessary drugs. This will be evidenced by: A noted dose reduction trial on any resident utilizing a psychoactive medication including resident #6 and #25 with appropriate documentation by physician is in the resident's medical record. The Director of Nursing will assist the doctors in identifying residents who may need or could benefit from a medication dose reduction. A quality indicator has been developed for monthly monitoring by the DON for quarterly reporting at the quality improvement meeting. All residents have been reviewed for appropriate medications.	4/30/08

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F 329	Continued From page 15 revealed there was no evidence another dose reduction was ever attempted. Interview with the director of nursing (DON) on 3/27/08 at 4:45 PM confirmed the facility had not attempted another dose reduction so there was no evidence the resident still required the medication on a nightly basis. 2. Review of the physician's orders and the MARs showed resident #25 received Zoloft (an antidepressant) 150 mg every evening since 4/27/05. Further review of the medical record showed no evidence a gradual dose reduction was ever attempted. Interview with the DON on 3/26/08 at 10:42 AM confirmed a dose reduction was never attempted and there was no evidence tapering the dosage was clinically contraindicated.	F 329		
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, and staff interview, the facility failed to assure the medication error rate remained at or below 5 percent. Observation revealed 3 errors occurred out of 49 opportunities for error, resulting in an error rate of 6.12 percent. The findings were: 1. Observation on 3/25/08 at 7:50 AM showed licensed practical nurse (LPN) #6 prepared and administered medications for non-sample resident #29. While preparing the medications, the LPN stated Aricept probably would not be	F 332	F332 The facility will ensure that the medication error rate will be five percent or less. This will be evidenced by the Director of Nursing performing random audits during medication passes. A quality indicator has been developed for monthly monitoring to be reported quarterly at the quality improvement meeting. All nurses receive 1:1 training related to med pass.	4/30/08

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F 332	Continued From page 16 given as it was not available. She checked the medication room to ensure the medication had not arrived (it had not) and stated it was ordered two weeks ago. Reconciliation of the medications confirmed the resident was to have Aricept daily. Review of the medication administration record on 3/26/08 showed the medication was not given the previous day. 2. Observation on 3/25/08 at approximately 7:55 AM showed LPN #6 prepared a second dose of Metformin gram (Gm) 1 for resident #10 (a total of 2 Gms) and then continued setting up medications. At 7:57 AM the LPN confirmed she was finished preparing the resident's medications. Upon request of the surveyor, the LPN checked the medications and confirmed she had set up two doses of Metformin. She stated the second pill should have been potassium. She then removed the extra pill, prepared Klor-Con 20 mEq (meq), and administered all the medications to the resident. Reconciliation of the medications with the physician's orders revealed the resident was to receive Metformin Gm 1 and Klor-Con 20 meq. Two errors occurred with this resident's medications.	F 332		
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		

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F 356	Continued From page 17 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the Benefits Improvement and Protection Act staff posting requirements were met. The findings were: Observation on 3/26/08 at 2:14 PM revealed the nursing staff information was already posted for all three shifts. In addition the posted format lacked the name of the facility, the census, and the actual hours worked by each category of staff. Interview with the director of nursing (DON) on 3/26/08 at 2:16 PM revealed the information was posted at night for all the upcoming shifts and the hours might not be correct if someone called off. The DON further stated the facility did not keep the posted information for 18 months.	F 356	F356 The facility will ensure the Benefits Improvement and Protection Act staff posting requirements will be met. A staffing sheet has been developed to include: - Facility name; - Current date; - Total number of actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care, registered nurses, licensed practical nurses and certified nurses aides. - Current census. This sheet is being placed in a prominent place and is clear and readable. This sheet will be retained for 18 months. The Unit Coordinator and Charge Nurse will ensure the staffing sheets are accurate and will post them at the beginning of each shift. A quality indicator has been developed by the unit coordinator for monthly monitoring to be reported quarterly at the quality improvement meeting.	4/11/08
F 371	483.35(i)(2) SANITARY CONDITIONS - FOOD	F 371		

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F 371 SS=E	Continued From page 18 PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure appropriate food sanitation techniques were practiced during one of two food service observations. The findings were: 1. Observation of food preparation and service on 3/25/08 from 4:50 PM to 5:27 PM (37 minutes) revealed a lack of appropriate sanitation. The following deficient practices were observed: a. Cook #3 washed her hands and donned gloves at 4:50 PM but then proceeded to touch several contaminated environmental surfaces prior to handling the residents' food. She retrieved a pen dropped to the floor and, in the process, stepped on the power cord from the heating cart. She then unplugged the power cord and coiled it for storage under the cart, handling about three feet of the cord, a portion of which had been lying on the floor. b. The cook loaded food pans onto the heating cart and pushed the cart to an area adjacent to the dining room, touching two door knobs and the hand rail in the hallway while moving the food cart. c. Meal service required the cook to handle bread slices and bread sticks with her gloved hands. On two occasions when using a divided plate, the cook moved vegetables on the plate with her gloved hand when they spilled over from	F 371	F371 The facility will ensure appropriate food sanitation techniques are practiced during food preparation and service to residents. Staff will be inserviced on appropriate food sanitation techniques. A quality indicator will be developed for monthly monitoring by the dining room manager and reported at the quality improvement meeting.	4/30/08

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F 371	Continued From page 19 an adjacent compartment. d. The cook's hair covering was not effectively positioned and several six to eight inch strands of hair were exposed from under the covering. On three occasion, the cook used her gloved hands to push her hair from her face while serving food. e. When pulling plates from a warmer, the cook placed her gloved thumb or fingers on the eating surface for 12 of 22 plates used during service. f. At no time during the 37 minute observation did the cook wash her hands or change her contaminated gloves. Interview with the dietary manager on 3/26/08 at 4:20 PM revealed her expectation that kitchen staff practice appropriate hand washing and sanitation. The manager further stated these practices included hand washing prior to handling and serving food, as well as anytime the hands or gloves could have become contaminated.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425		

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F 425	Continued From page 20 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to establish an effective system for obtaining medications for 1 (#12) of 10 residents observed during medication passes. The findings were: 1. Observation on 3/25/08 at 7:50 AM showed licensed practical nurse (LPN) #6 prepared and administered medications for non-sample resident #29. While preparing the medications, the LPN stated Aricept probably would not be given as it was not available. The LPN checked the medication room to ensure the medication had not arrived (it had not) and stated it was ordered two weeks ago. Review of the physician's orders confirmed the resident was to have Aricept daily. Interview with the director of nursing (DON) on 3/27/08 at 2:05 PM revealed the resident's medications were ordered from a non-local supplier and the facility frequently had trouble obtaining them in a timely fashion.	F 425	F425 The facility will establish an effective system for obtaining medications for all residents. Have medications been obtained for resident #12 A letter will be sent to all residents and their designated family contacts that in the event we are not able to obtain the residents medications from their out of town pharmacy, the needed medications will be obtained from the local pharmacy. A quality indicator will be developed for monthly monitoring by the DON and reported quarterly at the quality improvement meeting.	4/30/08
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and interview with a pharmacist, the facility failed to assure irregularities were reported for two (#6, #25) of nine sample residents. The findings were: 1. According to the physician's orders and the medication administration records (MARs), resident #6 received Restoril (an hypnotic) 15 milligrams (mg) nightly since 8/29/06. Review of the monthly medication regimen reviews (MRRs) from 1/25/07 through 3/23/08 showed they all indicated "No irregularities." The only documentation the pharmacist included was a separate, undated note which read "The lowest dose of temazepam [Restoril] is given." The note was signed by the director of nursing (DON) on 6/1/07. There was no evidence the physician saw the pharmacist's note or the MRRs. On 3/27/08 at 11:10 AM the DON stated the pharmacist was presently on vacation, but she agreed there was no evidence the irregularity was recognized and reported. During an interview on 4/2/08 at 1:30 PM, the pharmacist stated the note was written just before the DON signed and dated it. He acknowledged there was no evidence the medication was identified and reported as an irregularity. 2. Review of the physician's orders and the MARs showed resident #25 received Zoloft (an antidepressant) 150 mg every evening since 4/27/05 and Ambien (a hypnotic) 10 mg nightly since 8/22/06. Review of the monthly MRRs from	F 428	F428 The facility in conjunction with the pharmacist will ensure that all medication irregularities, including those on resident #25 and #6, will be reported. The DON will monitor monthly pharmacy reviews with the pharmacist for quarterly reporting at the quality improvement meeting.	4/30/08

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F 428	Continued From page 22 1/25/07 through 3/23/08 showed all were checked as "No irregularities." There was an undated note signed by the pharmacist which indicated Ambien was appropriate, but the Zoloft was not addressed. The DON signed the note on 6/1/07, but there was no evidence the physician saw the note or the MRRs. On 3/26/08 at 10:42 AM, the DON stated there was no evidence the medications were reported as irregularities. During an interview on 4/2/08 at 1:30 PM, the pharmacist stated he wrote the note just before the DON signed and dated it. He further acknowledged there was no evidence the medications were identified and reported as irregularities.	F 428		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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.	F 431		

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F 431	Continued From page 23 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 and staff interview, the facility failed to assure medications were properly labeled for 1 (#12) of 10 residents observed during medication passes. The findings were: Observation on 3/24/08 at 4:55 PM revealed licensed practical nurse (LPN) #9 prepared an unlabeled, small, round, green tablet for administration to resident #12. When questioned, the LPN removed a rectangular package containing approximately 24 individual packets with a small, round, green, tablet in each. The middle of the rectangular package was labeled "Iron 65 mg [milligrams]" over a few of the individual packets, but the remainder of the packets were not labeled. At that time the LPN confirmed the outside individual packets were not labeled. She then administered the unlabeled medication to the resident.	F 431	F431 The facility will ensure all medications are properly labeled. This will be evidenced by: any unit dose medication without adequate labeling will remain in its assigned properly labeled container. All medications utilized during medication pass will be in properly labeled containers. The Director of Nursing will randomly check the medication cart for unlabeled medications. A monthly quality monitoring tool will be implemented for quarterly reporting at the quality improvement meetings. A memo was posted for all nurses notifying them of the need for all over the counter medications, not individually labeled, must stay in original container. Nurses received 1:1 training.	4/11/08
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted	F 444		

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F 444	Continued From page 24 professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff followed appropriate hand hygiene practices during two of three meal observations. The findings were: Observation of staff while serving and assisting residents during meals revealed several deficient hand hygiene practices: a. On 3/25/08 from 8:15 AM to 8:38 AM certified nurses aid (CNA) #4 assisted resident #3 with his/her breakfast meal. The resident was served a meal tray in his/her room. CNA #4 entered the room and without washing or sanitizing her hands proceeded to reposition the resident, a process that involved touching several environmental surfaces as well as the resident's skin. The CNA then handled the resident's food and tableware while assisting him/her to eat. The CNA picked up pieces of toast with her hands, repeatedly lifted a drinking glass with her hand and fingers over the rim of the glass, and twice coughed with her hand over her mouth. The resident ate at a slow pace and the CNA rested her hands on the resident's bed and siderail when waiting. At no time during the 23 minute observation did the CNA wash her hands. b. On 3/26/08 from 7:30 AM to 7:49 AM CNA #5 served food to residents and assisted resident #11 with his/her breakfast meal. The CNA carried plates to five residents, placing her thumbs onto the eating surface of the plates. On one of these occasions, the CNA's thumb went into the food of resident #11 while she carried the plate to the table. While assisting resident #11 to eat	F 444	F444 The facility will ensure proper hand hygiene practices during meal times. This will be evidenced by all CNA's being inserviced on proper hand hygiene and proper hand hygiene during meals. The charge nurse, unit coordinator, and DON will monitor during meal times for proper hand hygiene. A quality monitoring tool will be implemented and a monthly quality indicator reported quarterly at the quality improvement meetings.	4/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	03/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 444	Continued From page 25 breakfast, the CNA scratched her head and arm. At 7:40 AM, the CNA took a spoon from the table, walked to the sink by the nurse's station and rinsed the spoon; she turned the cold water faucet handle with her right hand while resting her left hand on the front edge of the sink. She stated in interview on 3/26/08 at 7:50 that the spoon "looked dirty." At no time during the 19 minute observation did the CNA wash her hands.	F 444		