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

JR 4/20/05

PRINTED: 04/04/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	03/24/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST CASPER, WY 82601

APR 15 2005

(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 250 SS=D	483.15(g) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop a plan and make timely referrals for one of one sample resident (#69) with suicidal ideations. The findings were: Review of nursing notes dated 2/23/05 showed on 2/22/05 at 3:30 PM, the certified nurse aide (CNA) came to the registered nurse (RN) and stated resident #69 had a plastic bag around his/her pillow and stated he/she was going to use it to die. The note documented the resident was found lying in bed with a plastic bag over his/her head, stating he/she wanted to die. The physician was in the building and assessed the resident. Review of the physician's note dated 2/22/05 showed the resident was found by staff with a plastic sack over his/her head. The resident was transferred to the emergency room. Review of a 2/25/05 psychiatric consult showed the resident was talking about death, and had put a bag over his/her head. The plan was to admit the resident to a behavioral institute. Social service notes dated 2/25/05 showed that, due to continued anxiety and depression, the resident was sent to the behavioral institute. Review of the emergency room report dated 2/26/05 showed the resident was transferred from the behavioral institute to the hospital. Review of the re-admission orders dated 3/1/05 showed the resident had a diagnosis of depression/anxiety. Review of physician orders	F 250	1. The care plan was updated to reflect resident # 69's specific behaviors; the behaviors are not suicidal ideation. The GDS was completed on 3-23-05. The physician made aware and behavioral parameters were set for the resident. Physician verification was received that the resident is not suicidal. 2. Residents with specific behaviors and any type of indication or documentation of suicidal ideation will be reviewed and appropriate action will be taken. 3. The following measures will be completed in order to assure situation does not occur. A. In-service the staff on the reporting process for residents with behaviors done by SDC. B. The SSD will review assessments residents to insure they have or may need to receive a GDS. C. SSD will review the QI to identify monthly for further areas investigation. D. Care plans will be reviewed to insure specific behaviors are documented with effective interventions. E. Random audits will be done to insure care plans are accurate and reflect the resident and their needs to be completed by SSD/designee.	5/9/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Arlodajohnson | TITLE: NHA | (X6) DATE: 4-14-05

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.

Reviewed with Arlodajohnson & Brandie Daniels on 4/20/05

Accepted with Chron geo pg(s) 1, 4, 6, 8, 9, 16.

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F 250	Continued From page 1 showed the resident received Lexapro (antidepressant) 10 milligrams everyday. Review of nursing notes dated 3/14/05 at 4:00 PM, showed the resident voiced wanting to put a plastic bag over his/her head and to die. The note documented the plastic bags were removed from the room. The following concerns were identified: a. Review of the care plan showed no mention of the resident's history of suicidal ideations, and did not have interventions for mood other than to encourage the resident to be with other residents, eat in the dining room, and monitor for side effects of the antidepressant. b. Review of the medical record revealed no geriatric depression scale (GDS), or other evaluation for depression. c. During an interview on 3/23/05 at 3:25 PM, the social services director stated she was unaware the resident had voiced wanting to die since his/her return from the hospital. The social services director stated if she had been told of the comments the resident made on 3/14/05, she would have called the resident's physician and counselor. In addition, the social services director confirmed the care plan did not address the suicidal ideations. Furthermore, the social services director stated a GDS was not done, but should have been. d. During an interview on 3/23/05 at 3:50 PM, RN #9 stated she was the nurse the resident spoke to on 3/14/05. The RN stated she removed the plastic bags from the resident's room, but did not inform the DON, or call the physician or counselor. The RN stated the resident's counselor came for the regular weekly visit on 3/18/05 (four days after the resident voiced wanting to die by putting a plastic bag over his/her head). The RN stated she was unaware if the counselor had knowledge of the resident's	F 250	4. Random review of the care plans for accuracy will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	

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F 250	Continued From page 2 comments made on 3/14/05. e. During an interview on 3/23/05 at 4:04 PM, the DON and social services director stated they believed the resident's statements were more behavioral than suicidal. However, both stated statements like that should be taken seriously. They further stated there were no parameters from the resident's physician on what staff should do if the resident voiced wanting to die. f. Observation of the resident's room on 3/23/05 at 3:40 PM revealed there were at least three plastic bags in the room.	F 250		
F 278 SS=B	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		

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F 278	Continued From page 3 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the Minimum Data Set (MDS) assessments were complete and contained all signatures required for nine of 22 sample residents (#25, #33, #73, #78, #84, #92, #100, #114, #117). The findings were: 1. Review of the following MDS assessments revealed no section V (Resident Assessment Protocol Summary): a. The 8/31/04 significant change assessment for resident #25; b. The 6/4/04 annual assessment for resident #114; c. The 1/4/05 annual assessment for resident #78; During interviews on 3/22/04 at 2:10 PM and on 3/24/05 at 9:50 AM, the MDS coordinator stated she was unable to find the section V for the previously cited assessments. The MDS coordinator stated the section V forms were taken to care planning meetings, and must not have been put back in the medical records. 2. Review of the 6/3/04 annual MDS assessment showed Section V was missing for resident #84. Interview with the director of medical records on 3/23/05 at 2:30 PM revealed the form was not in the purged records. The director stated she was unable to locate the original form. According to the December 2002, CMS Revised Long-Term Care RAI User's Manual, Version 2.0, Section V provides the location of the assessment information and the care planning decision; it must be included in the assessment.	F 278	1. Resident #33 has been discharged. Residents #25, #73, #84, #92, #100, #114, #117 were not affected by the alleged deficient practice. (add) #78 2. A review of the signatures on section D will be reviewed and action will be taken as needed. and accessibility of section V 3. In-service the IDT on the signature process for the MDS done by SDC/designee. Random MDS reviews will be done to insure all sections of the MDS are signed, and accessible to staff. ~~Done~~ by the DON/ADON/Designee. 4. Random review of the care plans for accuracy will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	5/9/05

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F 278	Continued From page 4 3. Review of each resident's MDS assessments revealed signatures, titles, and dates for completion of Section D were missing from the attestation statement at Section AA9 for the following assessments: a. The 2/15/05 annual MDS assessment for resident #33, b. The 2/16/05 admission MDS assessment for resident #73, c. The 2/10/05 admission MDS assessment for resident #92, d. The 10/28/04 annual MDS assessment for resident #100. Interview with the MDS coordinator on 3/22/05 at 2 PM confirmed signatures for Section D were lacking. The coordinator stated she completed Section D, but she did not sign the attestation statement. She further stated she had not signed for Section D when required on any resident assessment. According to the December 2002, Centers for Medicare & Medicaid Services (CMS) Revised Long-Term Care Resident Assessment Instrument (RAI) User's Manual, Version 2.0, Section AA9, "All staff responsible for completing any part of the MDS...must enter their signatures, titles, sections they completed, and the date they completed those sections." 4. Closed medical record review of the 1/12/05 MDS annual assessment on resident #117 showed Section V was missing.	F 278		
F 280 SS=D	483.20(k)(2) RESIDENT ASSESSMENT A comprehensive care plan must be: Developed within 7 days after the completion of	F 280		

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F 280	Continued From page 5 the comprehensive assessment; Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and Periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interviews, the facility failed to assure care plans were reviewed and revised to reflect the current status for 2 (#33, #100) of 22 sample residents. The findings were: 1. Observation on 3/22/05 at 8:55 AM showed two certified nurse aides (CNAs #32 and #60) assisted resident #33 with morning care. During that time, the CNAs rolled the resident from side to side and held his/her legs apart to complete perineal (incontinence) care; sat the resident up, put an article of clothing on the right arm, removed it, and replaced it on the left arm before completely dressing the resident; laid the resident back down; and rolled him/her four times to properly place the sling for the mechanical lift. The resident cried and complained of pain during the entire process, which took 30 minutes to complete. When questioned, the resident stated s/he hurt "everywhere." After completion of morning care, the CNAs stated the resident always cried when moved. Interview with the	F 280	1. Resident #33 has been discharged. Resident #100's restorative care plan was discontinued on 3-22-05. 2. Care plans will be reviewed for all residents accuracy and to reflect the resident's current status. updated as 3. In-service done on the care planning process. Random reviews will be done of the care plan to ensure they reflect the residents' current status. 4. Random review of the care plans for accuracy will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	5-9-05

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F 280	Continued From page 6 resident's roommate on 3/22/05 at 12:50 PM revealed resident #33 "cries a lot" during perineal care. According to the face sheet, the resident was admitted with diagnoses which included rheumatoid arthritis. Review of the care plan showed interventions to decrease pain with movement and activities of daily living (ADLs) were not addressed. Interview with the director of nursing (DON) on 3/23/05 at 2:15 PM confirmed the facility failed to revise the care plan to include interventions which could limit or minimize pain for the resident during ADLs. 2. Review of the care plan showed resident #100 was to receive bilateral upper and lower extremity exercises, or use the bike for three minutes, five times a week. On 3/22/05 at 12:50 PM, interview with the resident revealed s/he did perform the exercises and utilize the bike. However, interview with the restorative aide (RA: CNA #21) on 3/23/05 at 11:05 AM revealed the formal restorative program was discontinued approximately one month ago and the resident was now exercising independently. The RA stated she forgot to revise the care plan to reflect the resident's current status.	F 280		
F 286 SS=B	483.20(d) Resident Assessment A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain 15 months of assessments in the active medical record for nine of 20 sample residents (#7, #26, #33. #35,	F 286		

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F 286	Continued From page 7 #58, #62, #69, #78. #84). The findings were: 1. Medical record review revealed the following assessment information was not contained in the active medical record: a. The 1/12/04 annual Minimum Data Set (MDS) assessment for resident #78; b. Section V for the 1/18/05 significant change MDS for resident #69; c. Section V for the 1/18/05 significant change MDS for resident #7. During interviews on 3/22/05 at 2:10 PM and on 3/24/05 at 9:50 AM, the MDS coordinator stated the above mentioned assessment information was found in the purged medical records. 2. Review of medical records showed the following assessment information was missing from each resident's active record: a. The 4/2/04 significant change Minimum Data Set (MDS) assessment was not readily available for resident #33. b. Section V of the 11/11/04 annual MDS assessment was not in the current record for resident #58. c. Section V of the 1/10/05 annual MDS assessment for resident #62 was not in the current record. d. The 6/18/04 significant change MDS assessment for resident #84 was not readily available. 3. Medical record review revealed the following assessment information was not contained in the active medical record: a. Section V for the 1/19/05 MDS annual assessment for resident #26; b. Section V for the 12/21/04 MDS annual assessment for resident #35.	F 286	1. Resident #33 has been discharged. Resident(s) #7, #26, #35, #58, #62, #69, #84 ~~were not affected by the alleged deficient practice~~. Resident #78 assessment was placed in the chart, no negative affects from the alleged deficient practice. 2. Review of the charts to insure All appropriate documents were placed back into the chart.s. 3. In-service in medical records on the policy and procedure of thinning charts to be done by SDC/Designee. Random reviews of charts to ensure MR are thinning charts as per protocol to be done by NHA/Designee. 4. Random review of the care plans for accuracy will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	5/9/05

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F 286	Continued From page 8 4. During an interview on 3/24/05 at 9:50 AM, the MDS coordinator stated only the administrator and medical records director had keys to access the purged medical records.	F 286		
F 311 SS=E	483.25(a)(2) QUALITY OF CARE A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and medical record review, the facility failed to assure five (#7, #29, #40, #66, #102) of five sample residents received restorative services as planned to maintain ambulation. The findings were: 1. During a confidential interview, a resident stated that residents who were supposed to be walked everyday, were not getting walked. 2. During an interview on 3/23/05 at 10:11 AM, the director of nursing (DON) stated the certified nurse aides (CNAs) were not documenting the walk and dine restorative services like they should. The DON stated since it was not documented, there was no evidence the services were done. The following concerns were identified with residents on the walk and dine program: a. Review of a 2/24/05 restorative note showed resident #40 was put on the maintenance walk and dine program for ambulation. Review of the care plan showed the walk and dine program was added on 3/1/05. The resident was to be	F 311	1. Resident #7, #29, #40, #~~66~~ #isle, #102 were reevaluated for appropriateness of the walk and dine program. 2. Review of residents that could benefit from a walk and dine program and follow up with action taken. Restorative nursing designee by the 3. In-service on the documentation process of the walk and dine program to be completed by SDC/Designee. The DON/Designee will do random review of the RFPR's. List of residents on the walk and dine program to be placed in the RFPR. 4. Random review of the care plans for accuracy will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	

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F 311	Continued From page 9 walked to one meal per day. However, review of the March 2005 Resident Functional Performance Record (RFPR) showed the resident was ambulated to a meal only six times (through 3/22/05). There was only one documented refusal. b. Review of a 2/25/05 restorative note showed resident #7 was being referred to the walk and dine program for ambulation. Review of the care plan showed on 3/1/05 the walk and dine program was added. The resident was to be walked to one meal per day. However, review of the March 2005 RFPR showed the resident was only walked three times (through 3/22/05). There were only three documented refusals. c. Review of the care plan for resident #29 showed on 3/1/05 the walk and dine program was added. The resident was to be ambulated to one meal per day. However, review of the March 2005 RFPR showed the resident was only ambulated four times, with seven refusals (through 3/23/05). d. Review of the care plan (revised 3/1/05) showed resident #102 was supposed to be ambulated to at least one meal per day. However, review of the March 2005 RFPR showed the resident was ambulated two times, with nine refusals (through 3/23/05). 3. On 3/23/05 at 3:25 PM interview with resident #66 revealed s/he walked from his/her room to the nurses' station daily, a distance not equal to the distance to the dining room. When questioned, the resident denied walking in the hallway more than once per day. Review of the 7/14/04 Minimum Data Set (MDS) assessment revealed the resident was alert and oriented and was admitted with diagnoses which included a pathological bone fracture. Review of the occupational therapy note dated 9/17/04 showed the resident was discharged from therapy to the	F 311		

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F 311	Continued From page 10 restorative program. Interview with the restorative therapist, CNA #21, on 3/24/05 at 8:30 AM revealed the resident was on a maintenance program for ambulation called "walk & dine." According to the 3/10/05 care plan, the resident was to walk to all meals. However, review of the documentation for the walk & dine program showed the certified nurse aides (CNAs) documented the resident actually walked to only four meals in February 2005 and to 7 meals by March 15, 2005. On 3/24/05 at 9:25 AM, interview with the person responsible for the restorative maintenance program (CNA #23) confirmed the resident should, but did not, walk to all meals. The employee stated sometimes the resident was "not asked" by the CNAs and sometimes staff were "very busy." The employee also confirmed there was no other documentation for completion of the walk and dine program.	F 311		
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, staff interview, medical record review, and review of policies and procedures, the facility failed to assure four (#58, #62, #78, #100) of seven sample residents with urinary catheters received treatment and services to prevent urinary tract infections (UTIs). The findings were: 1. On 3/22/05 at 8 AM observation showed two	F 316		

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F 316	Continued From page 11 certified nurse aides (CNAs, CNAs #32 and #48) assisted resident #58 from bed into a wheelchair per mechanical lift. CNA #48 first lifted the resident's indwelling catheter bag to the level of her (the CNA's) shoulder and then hooked it to the crossbar of the lift, which was above the level of the resident's bladder. When the lift was elevated, the catheter bag was at the level of the resident's head. Urine flowed backwards in the catheter tubing into the resident. Review of the 3/15/05 laboratory report showed the resident's urine contained three different organisms, and review of the physician's orders showed the resident was started on an antibiotic for a UTI. Review of the 2/8/05 care plan and the facility's 11/15/02 policy and procedure, Urinary Catheters, IC 0507.00, showed the catheter bag should be kept below the level of the resident's bladder. Interview with the staff development coordinator, who was also the infection control nurse, on 3/23/05 at 4:40 PM confirmed the catheter bag and tubing should always be below the level of the resident's bladder. 2. Observation on 3/21/05 at 4 PM showed CNA #32 provided catheter care for resident #62 by cleansing the catheter with a wash cloth and Betadine wipe while using a back and forth motion. When questioned after completion of care, the CNA stated she was taught to wipe away from the resident's body when providing catheter care. Review of the 2/16/05 laboratory report showed the resident had a UTI, and review of the orders showed the physician ordered an antibiotic on 2/18/05. Interview with the staff development coordinator and infection control nurse on 3/23/05 at 4:40 PM confirmed staff were to taught, and expected, to cleanse away from the urinary meatus with Betadine and alcohol wipes,	F 316	1. Resident #58 catheter has not been higher then the bladder since the incident. Resident #62 catheter is now being cleaned per protocol. Resident #100 catheter is no longer lifted above the bladder since the incident. Resident #78 catheter spigot is cleaned per policy. 2. Review residents with catheter for the following a.) placement b.) cleansing the catheter c.) cleaning the catheter spigot 3. In-service staff, to be done by SDC/Designee on the policy and procedure for a.) placement b.) cleaning with pericare c.) cleaning the spigot Return demonstration, by staff to the SDC/Designee, of the procedures to insure a.) placement b.) cleaning with pericare c.) cleansing the spigot Random reviews for appropriate placement and adequate cleansing with pericare and the cleaning of the spigot. 4. Random review of the care plans for accuracy will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	5/9/05

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F 316	Continued From page 12 using only one stroke with each wipe. 3. On 3/22/05 at 8:40 AM observation showed CNAs #32 and #60 transferred resident #100 from bed to a wheelchair per mechanical lift. During the transfer, CNA #60 raised the resident's indwelling urinary catheter bag and tubing above the level of the resident's bladder, and urine flowed back up the tubing. According to the 7/6/04 laboratory report faxed to and from the physician, the resident had a urinary tract infection and was started on an antibiotic. Review the facility's 11/15/02 policy and procedure, Urinary Catheters, IC 0507.00, showed the catheter bag should be kept below the level of the resident's bladder. Interview confirmed the catheter bag and tubing should always be below the level of the resident's bladder. 4. Observation on 3/22/05 at 7:22 AM revealed CNA #57 emptied the urinary catheter drainage bag for resident #78 into a urinal. The CNA did not clean the spigot of the drainage bag prior to, or after, draining the urine into the urinal. Review of the results of a 3/18/05 catheter culture showed the organisms pseudomonas aeruginosa and enterococcus faecalis were present. Review of the facility's policy and procedure showed cleansing an indwelling catheter drainage spigot was not addressed. However, interview with the staff development coordinator (SDC) and infection control nurse on 3/23/05 at 4:40 PM revealed she taught staff to cleanse the drainage spigots with Betadine and alcohol each time the catheter bag was emptied. The SDC further stated it was her expectation that the spigots be cleansed after the bag was emptied and before the spigot was replaced in the cover.	F 316		

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F 329 F 329 SS=D	Continued From page 13 483.25(l)(1) QUALITY OF CARE 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 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the drug regimen was free of unnecessary drugs for one of four (#78) sample residents who received antipsychotic and/or antianxiety medication. The findings were: Review of the March 2005 physician's order sheet showed resident #78 was ordered the following medications: Buspar (antianxiety medication) 10 milligrams (mg) twice per day since 5/26/00, Seroquel 50 mg twice per day since 5/26/00, and Seroquel 50 mg at bedtime. The following concerns were noted regarding the Seroquel: a. Review of physician orders and pharmacy-physician communication forms showed the last dose reduction of the Seroquel was on 8/23/03 (the bedtime dose was decreased from 100 mg to 50 mg). b. Further review of the medical record showed a pharmacy-physician communication form dated 2/17/04. The pharmacy communication was "Lethargy noted on	F 329 F 329	1. A request was sent to resident #78's physician requesting a decrease of Seroquel and/or Buspar were sent to the MD for a decrease. On 3/23/05 the MD signed a statement of the benefits out weighing the risks. 2. Review of the residents on antipsychotic, antianxiety and hypnotics for appropriateness of the medication and last recommended decrease. Appropriate action will be taken. 3. In-service on the psych medications for a.) appropriateness b.) last dosage reduction c.) diagnosis d.) evaluation e.) consent f.) care plan g.) physician response h.) all other interventions initiated before medication use. Random review of psych medications by the DON/ADON/Designee t be completed weekly. Pharmacy to review psyche medications. 4. Random review of the care plans for accuracy will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	5/9/05

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F 329	Continued From page 14 Physician's record of 1/27/04. (1) Would Dr. like to try a reduction of his morning dose of Seroquel from 50 mg to 25 mg?" The form showed no response from the physician. During an interview on 3/23/05 at 10:05 AM, the director of nursing (DON) confirmed the physician had not responded to the pharmacist's report. c. Review of the quarterly psychoactive medication evaluation for Seroquel, dated 2/3/05, showed the resident was experiencing sedation, an adverse reaction. The evaluation documented the resident's behaviors had decreased, so the facility was requesting a dosage decrease from the physician. Review of the 1/4/05 Minimum Data Set (MDS) assessment showed the resident did not exhibit any behaviors. d. During interviews on 3/22/05 at 3:55 PM and 4:15 PM, and on 3/23/05 at 10:05 AM, the DON confirmed the last dose reduction of the Seroquel was in August of 2003. The DON stated there was no documentation that would show why a dose reduction would be contraindicated. The DON stated the facility mailed the physician last month (2/05) regarding an evaluation of the medication, but did not get a response. The DON further stated when the facility called the physician's office, they were told the office had not received anything on the resident since 1999. The following concerns were noted regarding the Buspar: a. Medical record review showed no attempts at a dose reduction of the Buspar. b. Review of the psychoactive medication quarterly evaluation for Buspar, dated 2/3/05, showed the resident experienced sedation, an adverse reaction. The evaluation documented the facility was requesting an evaluation of a dosage decrease by the physician.	F 329		

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F 329	Continued From page 15 c. During interviews on 3/22/05 at 3:55 PM and 4:15 PM, and on 3/23/05 at 10:05 AM, the DON confirmed there had been no attempt at dose reduction of the Buspar. The DON stated there was no documentation that would show why a dose reduction would be contraindicated. The DON stated the facility mailed the physician last month (2/05) regarding an evaluation of the medication, but did not get a response. The DON further stated when the facility called the physician's office, they were told the office had not received anything on the resident since 1999.	F 329		
F 430 SS=D	483.60(d)(2) PHARMACY SERVICES The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to assure that drug irregularities reported to a physician for 2 (#33, #78) of 22 sample residents were acted upon by the physician. The findings were: 1. Review of the drug regimen reviews showed the pharmacist wrote a note on 8/27/04 which notified the physician of a drug irregularity for resident #33 and requested a response. Further review showed the note was faxed to the physician and re-faxed on 9/17/04. However, there was no response from the physician. Interview with a registered nurse (RN, RN #15) on 3/21/05 at 5:10 PM revealed no one followed up on the lack of a response to the faxed irregularity. On 3/24/05 at 12:05 PM, the director of nursing (DON) stated she was notified by the physician's	F 430	1. Resident #33 has been discharged. The physician was requested to reduce the dose of resident #78's Seroquel and Buspar. On 3/23/05 the MD signed a statement of the benefits out weighing the risks. 2. All Psyche medications will be reviewed by the pharmacist and necessary recommendations to be followed up on by DON/ADON/Designee. 3. In-service the medical director on the federal tag ~~329~~ 430. Pharmacy recommendations will be reviewed by the DON/Designee for completeness and response from the physician. Each consult to be faxed three times to the physician. If there is no physician response, the consult will be given to the medical director for further evaluation.	5/9/05

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F 430	Continued From page 16 office that the physician discarded the fax. The DON confirmed the physician did not act upon the irregularity. 2. Review of the medical record for resident #78 showed a pharmacy-physician communication form dated 2/17/04. The pharmacy communication was "Lethargy noted on Physician's record of 1/27/04. (1) Would Dr. like to try a reduction of his morning dose of Seroquel from 50 mg to 25 mg?" The form showed no response from the physician. During an interview on 3/23/05 at 10:05 AM, the director of nursing (DON) confirmed the pharmacist's report was not acted upon by the physician. The DON stated she called the physician's office and was told they had not received any faxes since 1999 regarding this resident.	F 430	4. Random review of the pharmacy consults for accuracy will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	
F 465 SS=D	483.70(h) PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based upon observations and staff and family interviews, the facility failed to assure a safe and sanitary environment in the kitchen, the special care unit, and in shower rooms for residents, staff and visitors. The findings were: Observation of the kitchen on 3/21/05 at 1:05 PM and again on 3/22/05 at 11:30 AM revealed an interior wall window between the resident dining area and the kitchen. A computer monitor with keyboard was accessible from the main dining	F 465		

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F 465	Continued From page 17 room where staff could input resident dietary requests. The back of the monitor was inside the kitchen and directly exposed to the working area of the kitchen. Cords from the back of the computer and monitor were hanging loose and unprotected. Additionally, the air circulation vent cover on the back of the computer was covered with dirt. The computer was located directly next to the milk dispenser. Observation of the dining area in the special care unit on 3/23/05 at 9:30 AM and again on 3/24/05 at 10:30 AM revealed the vertical covering of the baseboard heater had pulled away from the heater exposing the interior heater fins. Interview with the director of maintenance on 3/24/05 at 10:45 AM revealed he was unaware the situation existed. Observation of three doorways leading into resident shower rooms on 3/21/05 at 4 PM and again on 3/24/05 at 11 AM revealed the kick plates attached to the doorways were frayed around the edges exposing sharp edges. During a confidential interview, a family member stated the facility needed to pay more attention to the upkeep of the building. The family member stated there were some sharp edges where wheelchairs have scratched/banged into the kick plates at the bottom of the doors. The three rooms identified were rooms #201, the shower room in hall #4 (door not labeled) and the shower room in hall #1 (door labeled hydrotherapy). In addition, a battery charger in the hydrotherapy room in hall #1 was barely attached to the wall with a sheetrock screw, and a cord coming from the charger had frayed edges. Interview with the director of maintenance on 3/24/05 at 11:10 AM revealed he was aware of the dangers posed by these	F 465	1. The Maintenance Supervisor (MS) immediately secured the computer cables in a manner as to eliminate the cables from hanging loose. The battery charger in W-1 shower room was immediately reattached. 2. The MS will repair the vertical heat covering in the SCU common area by 5-9-05 and the MS will repair and/or replace the kick plates to room 201, W-1 and W-4 shower rooms. 3. In-service of the proper way to clean the cleaning air vent on the back of the computer will be completed by MS/Designee. The MS supervisor will monitor all above and report his findings to the QA&A committee for three months. 4. Random review of the environmental service audit will be reviewed for accuracy and will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	5/9/05

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F 465	Continued From page 18 conditions and confirmed the battery cord was frayed.	F 465		
F 502 SS=D	483.75(j) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide laboratory testing in accordance with physician's orders for one of one sample resident (#29) who received the anticoagulant Coumadin. The findings were: Review of the 3/05 physician's orders revealed resident #29 received Coumadin 1.5 milligrams (mg) everyday on Saturday, Sunday, Tuesday, Wednesday and Friday. The resident received Coumadin 2 mg on Monday and Thursday. The 1/27/05 admission orders and the 3/05 physician's orders showed an order for a PT/INR (prothrombin time/international normalized ratio) laboratory test every two weeks. Review of the medical record on 3/23/05 showed the last PT/INR laboratory result was on 2/23/05. During an interview on 3/23/05 at 6:25 PM, the director of nursing (DON) confirmed the last PT/INR for this resident was done on 2/23/05.	F 502	1. Resident #29 PT/INR was immediately drawn and the results were within normal limits. 2. Residents on anticoagulant therapy will be reviewed for timely, drawing of labs and action will be taken as needed. 3. In-service on the lab process to be done by SDC/Designee. The lab care coordinator will monitor labs daily for completion. New orders will be reviewed by the IDT for new lab orders and appropriate action will be taken. The 24-hour report will be reviewed daily for any changes in lab orders. The lab care coordinator is to update the lab book weekly. 4. Random review of the lab book for accuracy will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance for three months.	5/9/05