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
	535042	A. BUILDING _____ B. WING _____	01/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(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 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the facility's policies and procedures, the facility failed to ensure restraints were not utilized unless required for two (#46, #65) of five sample residents with physical restraints. The findings were: 1. Periodic observations on 1/9/06, 1/10/06, 1/11/06 and 1/12/06 revealed resident #46 used a wheelchair with a lap tray attached. Interview on 1/12/06 at 8:10 AM with registered nurse (RN) #12 confirmed the resident was unable to remove the lap tray. Review of the 6/28/05 significant change Minimum Data Set (MDS) assessment showed the resident required limited assistance with bed mobility and transfers and utilized a trunk restraint. However, review of the 6/27/05 restorative nursing program note showed there was no change in the resident's status since the 2/22/05 review which revealed the resident used a lap tray (chair prevents rising restraint) in addition to the trunk restraint (seatbelt). Review of the facility's policy and procedure titled "Physical Restraint Use" showed: "A restraint will be utilized only after the Registered Nurse, Licensed Practical Nurse or Specialized Therapies Team Member ...has completed an assessment ...Restraints will be utilized only after consulting with the resident's responsible party, a review of contraindications for usage and possible adverse	F 221	F 221 The facility will ensure that residents are free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This will be accomplished by: A) Resident # 46 and #65 will receive the benefit of a comprehensive assessment with regards to the use of lap trays. The facility policy and procedure will be fully implemented during this assessment process to include physician involvement and direction. This will be performed by the Restorative Registered Nurse. B) All residents will be benefit from comprehensive assessments with regards to restraints. The facility policy and procedure will be adhered to during this process. C) The Director of Nursing will periodically review all residents with restraints to assure that the assessment is comprehensive and that the policy and procedure are properly implemented. In the event there are system or policy failures noted, the Director of Nursing will provide immediate inservice and remedy. D) The Director of Nursing will report findings of resident restraint review periodically to the Quality Assurance Committee.	2/27/06 2/27/06 2/27/06 2/27/06

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WYOMING DEPT OF HEALTH
HEALTH FACILITIES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jill Elliott RN	Assistant Administrator	2-3-06

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 accepted with changes made on 2/10/06 @ 1020 by Jill Elliott, RN, Assist. Admin. at Karen Howard, RN, Health Surveyor.

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F 221	Continued From page 1 affects of the restraint application are reviewed and discussed with the responsible party ...A physician's order is required to apply any type of restraint." The following concerns with the facility's failure to comprehensively assess the lap tray and to follow their policy and procedure were identified: a. According to section V of the 6/28/05 MDS assessment, the location of the assessment information was a RAP (no date indicated) and restorative nursing notes dated 6/05. Review of the medical record revealed there was no evidence of a physical restraint RAP for a lap tray. b. Review of the 6/27/05 restorative nursing note revealed no changes since the 2/22/05 review. However, review of the 2/22/05 restorative nursing note showed the resident used a lap tray and a seatbelt, but it failed to provide a comprehensive assessment of the lap tray. c. There was no evidence of a physician's order for the lap tray. 2. Review of the 10/25/05 quarterly MDS assessment showed resident #65 utilized a trunk restraint, was independent in bed mobility, and required limited assistance with transfers. Periodic observations on 1/9/06, 1/10/06, 1/11/06 and 1/12/06 revealed the resident used a wheelchair with a lap tray attached. Interview with certified nurse aide #21 on 1/10/06 at 5:25 PM confirmed the resident was not able to remove the lap tray without assistance. The following concerns with the use of a lap tray were identified: a. Review of the medical record revealed a comprehensive assessment for the lap tray was lacking. Review of a 5/10/05 restorative nursing program note confirmed the resident used a lap tray, and was "very adamant about not liking it." There was no evidence that any alternatives to	F 221		

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F 221	Continued From page 2 the restraint were tried. b. Review of a rehabilitation communication dated 5/17/05 revealed a request to restorative nursing to "please eval [evaluate] res [resident] for a "cross-over" seatbelt. Very agitated /c [with] use of tray table." Further review of the medical record revealed there was no evidence of any follow up to this request and no physician's order for a lap tray as required per facility policy and procedure. According to the 11/28/00 facility policy and procedure titled " Physical Restraint Use," a restraint "will be utilized only after the registered nurse, licensed practical nurse or specialized therapies (O.T., COTA, P.T., or P.T.A.) team member has completed an assessment...Restraints are any appliance or device that is attached to or adjacent to the resident's body or that prevents the resident from performing functions or actions...A physician's order is required to apply any type of restraint" 3. Interview with the director of nursing on 1/11/06 at 5 PM confirmed comprehensive assessments of the lap trays for residents #46 and #65 were not completed. She further confirmed there was no evidence of a physician's order for a lap tray for either resident #46 or #65. Additionally, she said it was her expectation that the facility policy and procedure would be followed for these physical restraints.	F 221		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and medical record review, the facility failed to ensure 7 (#3, #8, #10, #19, #29, #42, #167) of 43 residents seated in the south dining room were treated with dignity during the dining experience. In addition, one (#157) non-sample resident did not receive baths as scheduled, and two non-sample residents voiced concerns of not receiving scheduled baths. The findings were: 1. On 1/9/06 from 6:34 PM through 6:54 PM, observation revealed nurse aide (NA) #41 stood while he assisted residents #3, #8, #19, #29, #42, and #167 with their evening meal. Further observation revealed NA #46 stood from 6:40 PM to 6:44 PM while he assisted resident #10. Interview with certified nurse aide (CNA) #7 on 1/11/06 at 11:02 AM revealed staff should sit when assisting residents with their meals. She further stated the reason staff sometimes stood was because of the number of residents who required assistance. She stated, "Staff didn't [did not] have time to sit while assisting each resident." 2. Review of the care plan (review date 11/19/05) for non-sample resident #157 revealed the resident was to bathe or shower two to three times per week with staff assistance. Review of the 10/6/05 quarterly minimum data set assessment revealed the resident was able to understand and make his/her needs known, and required physical help in part of the bathing activity. The assessment also documented the resident retained both his/her short and long term memory and was moderately impaired for	F 241	F 241 The facility will ensure that each resident's dignity and respect is maintained or enhanced. This will be accomplished by: A) Resident' # 3, #8, #10, #19, #29, #42, #167 will benefit from assistance in the dining room without their caregivers standing over them during meals. B) All nursing staff will be inserviced to the deficient practice (not to stand over residents during assistance) so as to benefit all residents during the dining process. Inservice conducted by the D.O.N. C) Resident #157 will receive baths in accordance with the scheduled plan of care. D) All residents will receive baths in accordance with their plan of care. E) The Director of Nursing will establish a policy in which the charge nurse is notified of a missed bath (s). The nurse will then make provisions to reschedule the missed bath. F) The Charge Nurse may enlist the support of the Director of Nursing or Staffing Coordinator to alter care giver schedules in order to accommodate the missed baths. G) The Director of Nursing will perform periodic chart reviews to assure that the above system is properly executed making adjustments when necessary. H) The Director of Nursing will report review findings and effectiveness of above system to the Quality Assurance Committee.	2/27/06 2/27/06 2/27/06 2/27/06 2/27/06 2/27/06 2/27/06 2/27/06

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F 241	Continued From page 4 cognition. Interview with certified nurse aide (CNA) #6 on 1/11/06 at 10:55 AM revealed residents received baths twice a week and were weighed prior to their bath. The following concerns were identified with the timely provision of baths for this resident: a. Interview with the resident on 1/10/06 at 1400 revealed the resident did not always get his/her scheduled bath. b. Review of the resident's personal care record and weight record for December 2005 and January 2006 showed the resident missed at least one bath between 12/16/05 and 12/23/05. The resident received a bath on 12/23/05, then went 10 days without a bath until receiving another one on 1/3/06. Review of bath documentation with registered nurse #18 on 1/11/06 at 3:10 PM confirmed the resident was not bathed on 12/27/05 and 12/30/05 as scheduled. c. The last documented weight for the resident, which would have been obtained prior to bathing, was on 11/25/05. There was no evidence in the medical record that the resident was weighed during December 2005 and January 2006. Interview with CNA #6 on 1/11/06 at 3:00 PM revealed the dietary manager might have the weight sheets with missing documentation. Interview with the dietary manager on 1/11/06 at 5:05 PM revealed she did not have any weight information for the resident in December 2005 or January 2006. d. During the interview on 1/11/06 at 3:00 PM, CNA #6 stated the resident should received baths up to three times per week to maintain good personal hygiene. 3. Confidential interview on 1/11/06 revealed two non-sample resident's had concerns with consistently receiving their scheduled baths.	F 241		

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F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to provide an activity program which met the assessed needs of 2 (#90, #91) of 26 sample residents. In addition, the facility failed to show evidence the scheduled 1:1 activities based on assessed needs, were provided on a weekly basis for 13 (#28, #46, #56, #65, #81, #87, #90, #91, #129, #138, #168, #169, #170) of 13 sample residents involved in those activities. Furthermore the facility failed to assure all residents who attended a group activity were involved or included in that activity. The findings were: 1. Review of the annual Minimum Data Set (MDS) assessment dated 12/29/05 revealed resident #90 was in a persistent vegetative state and had diagnoses including closed head injury and paraplegia. The assessment further documented the resident was involved in activities less than one-third of the time. Interview with registered nurse # 39 on 1/9/06 at 5:50 PM revealed the resident spoke Chinese and when his/her family would visit they spoke to the resident in his/her native language. Review of the "Resident Activity Assessment" dated 12/29/05 showed the resident's activity participation was passive and music was a general activity preference.	F 248	F 248 The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This will be accomplished by: A) Resident #90 will be provided Oriental music 3 x per week by Activity Department. Activity personnel will communicate with resident in native tongue simple messages (hello, how are you, good –bye) as well as provide 1:1 attention 3 x per week.	2/27/06
			B) Resident #91 will be provided large print books or offered talking books, This Resident will be offered the opportunity to play cards with weekly as well as 1:1 socialization and sensory stimulation by the activity personnel weekly.	2/27/06
			C) Residents # 28, #46, #56, #65, #81, #83, #87, #90, #91, #129, #138, (# 168, #169, #170 are closed records) will receive 1:1 activity contact by the Activity personnel.	2/27/06
			D) An Assessment tool developed and documented by the Activity personnel will reflect the participation and the resident's response to the activity for all above listed residents as well as all facility residents. Attendances will be documented weekly with responses documented monthly by activities.	
			E) The Activity Department personnel will be inserviced to the deficiency stating the need to attempt to include residents in unity activity.	2/27/06
			F) The Activity Coordinator will perform periodic audits of resident records to assure compliance with plan of correction. She will (re) educate the activity personnel as necessary.	2/27/06
			G) The Activity Coordinator will report to the Quality Assurance committee at least quarterly the results of above audits.	2/27/06

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F 248	Continued From page 6 Interview with the central activity assistant (employee #16) on 1/12/06 at 9:35 AM revealed the resident was scheduled to receive 1:1 activities three times per week and was supposed to listen to Asian music. She further stated she was unable to find a tape, so no Asian music had been provided to the resident since she started working on the unit five months ago. 2. Review of the 3/17/05 admission MDS assessment revealed resident #91 had no cognitive impairments; was awake morning, afternoon, and evening; and spent less than 1/3 of that time involved in activities. Activity preferences were listed as cards/other games, music, reading/writing, walking/wheeling outdoors, watching TV, talking/conversing, and helping others. Review of the 12/1/05 care plan showed goals included resident participation in one out of room activity per week" and participation in "1:1 contacts with the activity aide 2X/week [twice a week] for socialization." The approaches were listed as assist to activities of preference, reading club, walking/wheeling club, TV in room, and monitor need for antidepressant or in house counseling services. The following concerns were identified: a. Interview with the resident on 1/11/06 at 10:30 AM revealed the resident was alert and oriented. During the interview, the resident stated s/he watched TV because there was "nothing else to do." The resident stated s/he could read large print but did not have any books. The resident denied ever having books on tape and laughed at the idea that someone would read to him/her individually. In addition, the resident denied ever having anyone do 1:1 activities. b. Observation on 1/11/06 at 10:30 AM, 12:30 PM, and 1:40 PM and on 1/12/06 at 8 AM, 9:30	F 248		

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F 248	Continued From page 7 AM, and 10:30 AM showed the television was on while the resident remained in bed with his/her eyes closed. c. The facility was unable to provide information which explained how watching television continuously or attending one out of room activity per week met the resident's needs. In addition, they were unable to provide proof that the 1:1 visit for socialization occurred or was meaningful to the resident. 3. Review of the medical records for sample residents #28, #46, #56, #65, #81, #83, #87, #90, #91, 129, #138, #168, #169, and #170 revealed each was assessed as needing 1:1 activities. However, review of the activity records revealed there was no evidence 1:1 activities were provided weekly as recommended. Interview with the director of activities on 1/11/06 at 1:45 PM confirmed there was no documentation that provided evidence these resident received their recommended weekly 1:1 activities as scheduled. She further stated there were no notes written after the weekly 1:1 activities were provided that indicated when the 1:1 was provided, what the 1:1 activity was, what the resident's level of participation in the activity was, or what the resident's response was to that individual 1:1 activity. When asked how staff assessed residents on a quarterly basis without data, the activities director stated, staff "just know the residents." 4. On 1/11/06 at 10:20 AM observation showed 13 residents and activity staff member #16 seated in the central activity area while a program of gospel music was shown on television. The lights were off and 7 of the 13 residents were sleeping. The activity employee was seated on the floor in	F 248		

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F 248	Continued From page 8 front of the television until 11:07 AM. At that time the employee got up, spoke briefly with one resident, reseated herself in a chair in front of the television, and continued to watch the program until observations ceased at 11:15 AM. During the observation, the employee made no attempt to wake the sleeping residents or interact with the other residents and involve them in the music program.	F 248		
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 random observations, the facility failed to assure adequate housekeeping measures regarding ceiling air vents, the appearance of doors, walls and wall fixtures, and a dining room floor. In addition the facility failed to assure adequate maintenance and repair of a wheel chair for one non-sample resident #164 . Findings were: 1. Observation on 1/10/06 at 3 PM, 1/11/06 at 12:30 PM and 1/12/06 at 8:45 AM revealed a thick accumulation of dirt and grease on six ceiling mounted exhaust air vents located in several locations throughout the facility. Three vents were located in the shower room opposite resident room 201. The vents were located directly over the toilet, the whirlpool tub and the shower. Another dirty air vent was located in the ceiling of the soiled utility room near the south	F 253	F 253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This will be accomplished by: A) Three ceiling vents located in the shower room opposite resident room 201 (above the toilet, the whirlpool tub, and the shower), the ceiling of the soiled utility room near the south nurses station opposite room 28, and the ceiling mounted air exhaust vents located over the toilets in the bathrooms of resident rooms 41 and 34, will be thoroughly cleaned to remove the accumulation of dirt and grease. This task will be performed by the housekeeping department.	2/27/06
			B) The vent in resident room 34 will be secured to the ceiling by the maintenance department.	1/15/06
			C) The following areas identified as having scraped paint will be painted by the maintenance department: the east wall of the resident smoking room on the Central station, the doors on the clean utility room door near resident room 107, the dirty utility room door near resident room 106, the door to the storage room used by dietary in the east unit, the shower room door near resident room 102, the northeast facility exit doors, the shower room door near resident room 122, the soiled utility room door near room 120, the tub room door near room 112, the clean utility room door near resident room 119. The fire extinguisher enclosures outside resident rooms #5, 18, 231 and the accounting office.	2/27/06

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F 253	Continued From page 9 nurse's station opposite resident room 28. Finally, dirty ceiling mounted air exhaust vents were located over the toilets in the bathrooms of resident rooms 41 and 34. In addition, the vent in resident room 34 mentioned above was partially separated from the ceiling and was only held to the ceiling by a single loose fitting drywall screw. 2. Observations from 1/10/06 at 3 PM through 1/12/06 at 10 AM revealed scraped paint on several doors, walls and on floor level wall-mounted fire extinguisher enclosures. All scrapes were located on the bottom third of the walls and doors. The east wall of the resident smoking room on the central unit had an approximate three foot scrape on it. The following doors were significantly scraped and missing paint at approximately three feet from the bottom: the "clean utility" room door near resident room 107; the "dirty utility room" door near resident room 106; the door to the storage room used by dietary in the east unit; the "shower room" door near resident room 102; the northeast facility exit doors; the "shower room" door near resident room 122; the "soiled utility room" door near resident room 120; the "tub room" door near resident room 112; the "clean utility" room door near resident room 119. The following fire extinguisher enclosures were all wall mounted at floor level protruding approximately four inches into the hallway. All were scraped and missing paint. The enclosures were outside resident room #5, resident room #18, resident room #321, and the accounting office. 3. Observation of resident #164 on 1/9/06 at 5:48 PM revealed the resident utilized a reclining wheeled chair. Closer inspection of the chair revealed split upholstery on the back of the chair	F 253	D) The chair utilized by resident #164 will be replaced with a chair that has intact upholstery. This will be accomplished by the Specialized Therapy department. E) The housekeeping department will clean the South dining room with an alternate cleaning solution that will prevent stickiness. F) The Director of Housekeeping will perform routine assessment/observations of ceiling vents to assure cleanliness. The Director of Housekeeping will also monitor dining room floors with special attention to the floor surface. Immediate (re)cleaning of any unacceptable findings will take place. G) The Maintenance department will perform routine rounds noting any walls, doors, alcoves or extinguisher enclosures needing repair or painting. H) The Restorative Nursing Assistants will be inserviced by the Director of Restorative Nursing on the need to assess and report and replace any w/c that have upholstery in need of repair and/or replacement. I) The Director of Housekeeping willl report observation findings regarding vent cleaning, painting, and dining room floor cleaning to the Quality Assurance committee no less frequently than every 3 months. J) The Assistant Administrator will monitor the Restorative Nursing Assistants with regards to upholstery chair assessments and report findings of above corrective action to the Quality Assurance Committee no less than every quarter, offering modifications to current programs when necessary.	2/27/06 2/27/06 2/27/06 2/27/06 2/27/06 2/27/06

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	01/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(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 253	Continued From page 10 near the head cushion. The exposed inner padding extended four inches by three inches on both sides of the resident's head, and resulted in a non-cleanable surface of the chair. Random observations on 1/10/06, 1/11/06 and 1/12/06 revealed the resident continued to use the chair when not in bed. Review of the resident's most recent quarterly minimum data set assessment dated 10/27/05 documented the facility was unable to assess the resident's short and long term memory, however the resident was severely impaired cognitively, could not make him/herself understood and could not understand others. Observation of the chair with staff on 1/12/06 and interview with registered nurse (RN) #11 and certified nurse aide (CNA) #14 at 8:23 AM revealed neither staff member were aware of the damaged upholstery nor when it occurred. The CNA stated the resident had been using the chair for about a month. 4. Observation on 1/9/06 at 6:41 PM showed the south dining room floor was sticky and the surveyor's shoes stuck to it. After standing for a time, shoes made sucking noises when pulled away from the floor.	F 253		
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:	F 272	F 272 The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. This will be accomplished by: A) Resident #28 will receive a comprehensive assessment for psychosocial well-being , and delirium, by the Director of Social Services. Resident #29 will be comprehensively assessed for delusions, cognitive loss, mood, and behaviors.	2/27/06

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F 272	Continued From page 11 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 resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to complete comprehensive assessments in various areas for 9 (#28, #29, #46, #56, #65, #81, #83, #87, #90) of 23 sample residents. The findings were: 1. Review of the 5/10/05 Resident Assessment Protocol summary (RAP) for resident #29 revealed he/she required comprehensive assessment for delirium, cognitive loss, mood, and behaviors. Further review of the RAP summary revealed the assessments for these areas were located in the 5/10/05 social services RAP. However, per interview with the director of nursing (DON) on 1/12/06 at 10:10 AM, staff were	F 272	B) Resident #46 will receive a comprehensive assessment regarding the w/c lap tray and urinary incontinence by the Restorative Nurse.	2/27/06
			C) Resident #56 will have a fall assessment addressing causative and contributing factors by the Restorative Nurse.	2/27/06
			D) Resident #56 will benefit from a comprehensive assessment including psychosocial well-being to be conducted by the Director of Social Services.	2/27/06
			E) Resident #56 will be comprehensively assessed by the Restorative Nurse addressing the use and effectiveness of safety devices, and lap tray.	2/27/06
			F) Resident #81 will receive a comprehensive assessment for cognitive decline by the Director of Social Services. A comprehensive assessment for bowel incontinence will be performed by the Restorative Nurse.	2/27/06
			G) Resident #83 will be comprehensively assessed by the Restorative Nurse for bowel incontinence. The assigned RN M.D.S Coordinator will comprehensively assess residents pressure sore and oral status.	2/27/06
			H) Resident #87 will be assessed comprehensively for cognitive decline and mood by the Director of Social Services.	2/27/06
			I) Resident #90 will be comprehensively assessed for bowel incontinence by the Restorative Nurse.	2/27/06
			J) All residents will be comprehensively assessed for psychosocial well being, delirium, safety devices, lap trays, bowel incontinence, cognitive decline. These assessments will be performed by the Director of Social Services, RN MDS Coordinator and/or Restorative Nurse.	2/27/06

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F 272	Continued From page 12 unable to locate a social services RAP for these areas. 2. Review of the 5/10/05 RAP summary for resident #28 revealed s/he required comprehensive assessment for psychosocial well-being. Review of the medical record revealed there was no psychosocial well-being assessment completed since 6/17/04. Interview with the DON on 1/12/06 at 10:10 AM revealed staff was unable to locate a more recent assessment. 3. Periodic observation on 1/9/06, 1/10/06, 1/11/06, and 1/12/06 revealed resident #46 was using a wheelchair with a lap tray attached. Interview on 1/12/06 at 8:10 AM with registered nurse (RN) #12 confirmed the resident was unable to remove the lap tray. Review of the 6/28/05 significant change MDS assessment revealed the resident had a trunk restraint used daily. According to section V of the MDS assessment, both physical restraints and urinary incontinence were triggered and required a comprehensive assessment. Review of the medical record revealed a physical restraint RAP for the lap tray was lacking. According to section V, the location of the urinary incontinence assessment was in the 6/05 restorative nursing notes. Review of the 6/05 restorative nursing notes revealed a comprehensive assessment was not completed. 4. Review of section V of the 9/13/05 significant change MDS for resident #56 showed falls was triggered. The location of the assessment information was listed as a 9/05 fall risk assessment. Review of the 9/12/05 fall risk assessment revealed the resident was at high risk for falls. However, the assessment did not	F 272	K) The Director of Nursing will monitor the Assessment process, offering inservice When deficits are noted. L) The Director of Nursing will report no less Than quarterly to the Quality Assurance Committee the results of the above audit.	2/27/06 2/27/06

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F 272	Continued From page 13 address the causative and contributing factors. 5. Review of section V of the 2/17/05 significant change MDS assessment for resident #65 revealed the triggered areas requiring a comprehensive assessment included delirium, psychosocial well-being, mood state, behavioral symptoms, and falls. All assessment information was listed in Section V of that MDS as located in the individual RAPs. Review of the medical record revealed the following concerns with assessments: a. The RAP for psychosocial well-being was dated 11/23/04, and there was no evidence of additional assessment information. b. The mood RAP showed summary dates of 11/23/04 and 2/17/05. The 2/17/05 summary note revealed the resident had "exhibited increased agitation." However, there was no evidence that a new assessment was done to address these changes in condition. c. The 2/17/05 behavior RAP was completed on 11/23/04, and a 2/17/05 summary note was added that indicated the resident had medication changes and "calls out and resists cares often." However, a new assessment was not done to address these changes. d. Review of the falls RAP revealed it was first completed on 12/13/04, and it was signed as updated on 1/17/05, 2/17/05, and 8/1/05. However, it did not indicate if there were any changes in the residents condition on any of these dates. Review of the 2/15/06 restorative nursing notes revealed the resident used a floor monitor, and a mobility monitor with a safety clip, but the assessment did not indicate why these devices were needed or if they were effective. e. There was no evidence of any assessment for the area of delirium. Interview with the social	F 272		

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F 272	Continued From page 14 service director on 1/11/06 at 3:17 PM confirmed a comprehensive assessment for delirium was not done. f. According to a 10/25/05 quarterly MDS assessment, the resident was coded as utilizing a lap tray as a physical restraint daily. Review of the medical record revealed a comprehensive assessment for the restraint was not done. Interview with the director of nursing on 1/11/06 at 5 PM confirmed a comprehensive assessment for the lap tray was not done. 6. Review of the 10/20/05 admission MDS assessment showed resident #81 required comprehensive assessments for cognitive decline and bowel incontinence. According to Section V of that MDS, the comprehensive assessment for cognitive decline was the 10/19/05 social service RAP. Review of that RAP information revealed a comprehensive assessment was lacking. Interview with the social services director on 1/11/06 at 3:15 PM confirmed the assessment was incomplete. Further review of the medical record showed a bowel assessment was not available. When asked to provide their bowel assessment, the MDS coordinator, registered nurse (RN) #5, was unable to produce a comprehensive assessment. 7. According to the 11/10/05 significant change MDS assessment, comprehensive assessments were required for resident #83 in the areas of bowel incontinence, pressure sores, and oral status. The location of the assessment information itemized in Section V of that MDS was the 11/10/05 RAP for pressure sores. The 11/10/05 RAP and the dental hygienists's screen dated April 2005 was listed for the oral assessment. Review of that information, and	F 272		

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F 272	Continued From page 15 interview with the MDS coordinator, RN #5, on 1/11/06 at 3:40 PM, revealed comprehensive assessments were not completed. In addition, during the interview, the MDS coordinator stated bowel assessments were in the restorative notes. However, review of all restorative notes showed the facility failed to complete a comprehensive bowel assessment. 8. Review of the 5/26/05 admission MDS assessment showed resident #87 triggered for comprehensive assessments in cognitive decline and mood. According to Section V of that MDS, the compressive assessment information was in the 5/25/05 social service RAP. However, review of that information, and interview with the social service director on 1/11/06 at 3:20 PM, revealed comprehensive assessments were not completed. 9. Review of the annual MDS assessment dated 2/3/05 revealed resident #90 was incontinent of bowel all or almost all of the time and required a comprehensive assessment for the incontinence. Interview with the restorative nurse, RN #36, on 1/12/06 at 10:10 AM revealed bowel assessments were in the restorative notes. Review of the restorative notes revealed a comprehensive assessment of the resident's bowel incontinence was not conducted.	F 272		
F 278 SS=D	483.20(g) - (j) 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.	F 278	F 278 All assessments will accurately reflect the resident's status. This will be accomplished by: A) MDS assessment and appropriate RAP's for resident #90 will be completed by the Dietary manager, Director of Activities, and Director of Social Services.	2/27/06

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F 278	Continued From page 16 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. 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 all sections of the Minimum Data Set (MDS) assessment for one of 23 (#90) sample residents were complete prior to being signed and certified by a registered nurse (RN). The findings were: Review of the annual MDS assessment dated 12/29/05 for resident #90 revealed the following concerns: a. Section H (continence in the last 14 days), section K (oral and nutritional status), section N.4. (general activity preferences) and section Q.1. (discharge potential) were blank. Further review	F 278	B) All members of the Interdisciplinary team will be inserviced by the Assistant Administrator to the deficient practice noted in the survey report. C) All MDS's will be completed prior to the RN signature certifiying that the MDS and RAP's are complete. D) The Director of Nursing will monitor the above process for compliancy offering re-education or evaluation of the system in the event discrepancies are noted. E) A quality monitoring tool will be implemented and utilized by the D.O.N. to ensure the M.D.S. process is accurately completed. The D.O.N. will report no less than quarterly to the Quality Assurance Committee.	2/27/06 2/27/06 2/27/06 2/27/06

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F 278	Continued From page 17 of the assessment showed section R2a was signed by the RN coordinator and section R2b was filled in with a completion date of 12/29/05. b. Review of section V revealed the following resident assessment protocol (RAP) problem areas were checked as triggered: urinary incontinence and indwelling catheter, feeding tubes, and dehydration/fluid maintenance. Further review of this section showed the location and date of the RAP assessment and documentation for those triggered areas was blank; however, sections VB1 was signed by the RN coordinator and section VB2 was filled in with a completion date of 12/29/05 Interview with the MDS coordinator (employee #5) on 1/10/06 at 9:50 AM confirmed the sections were not filled in. The MDS coordinator further commented the sections should be complete before the document was signed and dated by the MDS coordinator. When asked if the blank areas were assessed, she said "I don't know." According to the December 2002 (revised December 2005), Centers for Medicare and Medicaid Services Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0, page 3-211, "Federal regulations at 42 CFR 483.20 (i) (1) and (2) require the RN Assessment Coordinator to sign, date and certify that the assessment is complete in Items R2a and R2b." Page 3-212 of the manual further specifies, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." In addition, page 3-238 of the manual states section VB1 is the signature of the RN coordinating the RAP assessment process and section VB2 is the date the RN coordinating the	F 278		

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F 278	Continued From page 18 RAP process certifies that the RAPs have been completed.	F 278		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, medical record review, and review of policies and procedures, the facility failed to assure staff maintained professional standards of practice related to medication administration for 3 of 23 sample residents (#83, #87, #93) and four non-sample residents (#13, #34, #37, #43). In addition, a medication cart on the south unit was left unlocked. The findings were: 1. Observation on 1/9/06 at 6:45 PM revealed registered nurse (RN) #20, left the following medications in a cup on the dining table for resident #13: Tylenol 650 mg and Ferro Sequel T/R (iron supplement) 1 tablet. In addition, observation on 1/10/06 at 8:30 AM revealed RN #35 left a cup of medications on the dining table for this resident which included Detrol LA (for bladder control) 4 mg, Vitamin E 400 international units, Magnesium oxide 250 mg, Calcium Citrate 600 mg, potassium chloride 20 mEq, and 1 multivitamin/iron tablet. The following concerns were identified: a. Observation revealed neither RN remained to ensure the resident took the medications. b. Review of the 7/26/05 annual Minimum Data Set (MDS) assessment for the resident	F 281	F 281 The services provided or arranged by the facility will meet professional standards. This will be accomplished by: A) Residents # 83, #87, #93, #13, #34, #37, #43 will receive medications in accordance with professional standards of practice. — 2/27/06 B) The Director of Nursing will inservice RN's and LPN's on the deficient practices noted in the certification survey ending 1/23/06. — 2/27/06 C) All residents will receive their medications to include oxygen therapy in accordance with professional standards of practice. — 2/27/06 D) The Director of Nursing will implement a quality monitoring tool to ensure compliance with professional standards to include medication administration observation, review of monthly physician order renewal (RECAPS), medication storage and security, implementation of physician orders. In the event deficient practice is identified the Director of Nursing will provide immediate (re)inservice/correction and/or policy evaluation and revision if warranted. — 2/27/06 E) The Director of Nursing will report the quality monitoring results to the Quality Assurance team no less than quarterly. — 2/27/06	

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F 281	Continued From page 19 revealed he/she had problems with short term memory, and his/her decision making ability was poor due to moderate cognitive impairment. c. The "Self Administration of Drugs" form signed 6/23/04 revealed the resident did not wish to self administer his/her medications. 2. Observation on 1/9/06 at 6:20 PM revealed registered nurse (RN) # 20 left the following medications in a cup on the dining table for resident #34: Lamictal (anticonvulsant) 100 milligrams (mg), verapamil HCL (antihypertensive and antianginal) 120 mg, Fiber lax (laxative) 500 mg, potassium chloride (electrolyte) 40 milliequivalents, and Coumadin (anticoagulant) 2.5 mg. The following concerns were identified: a. Observation revealed registered nurse (RN) #20 did not remain to ensure the resident took the medications. b. Review of the 3/8/05 significant change and the 11/15/05 quarterly Minimum Data Set (MDS) assessments for the resident revealed s/he had problems with short term and long term memory, and rarely made decisions due to severe cognitive impairment. c. The "Self Administration of Drugs" form signed 4/16/03 revealed the resident did not wish to self administer his/her medications. 3. Observation on 1/9/06 at 6:45 PM revealed RN # 20 left the following medications in a cup on the dining table for the resident: Requip (for Parkinson's Disease) 5 mg and Calcium Citrate (dietary supplement) 600 mg. The following concerns were identified: a. Observation revealed the RN did not remain to ensure the resident took the medications. b. Review of the 10/18/05 quarterly Minimum	F 281		

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F 281	Continued From page 20 Data Set (MDS) assessment for the resident revealed s/he had problems with short term memory, and his/her decision making ability was poor due to moderate cognitive impairment. c. The "Self Administration of Drugs" form signed 9/20/04 revealed the resident did not wish to self administer his/her medications. d. Interview with the resident on 1/9/06 at 8:50 AM confirmed nurses have at times left medications on the table and walked away without ensuring the medications were taken. 4. Observation on 1/9/06 at 6:34 PM revealed RN #20 left the following medications in a cup on the dining table for resident #43: Questran (to lower cholesterol) 4 gram (gm), Lopressor (antihypertensive) 100 mg, and lisinopril (antihypertensive) 20 mg . The following concerns were identified: a. Observation revealed the RN did not remain to ensure the resident took the medications. b. The "Self Administration of Drugs" form signed 12/22/03 revealed the resident did not wish to self administer his/her medications until seven to ten days prior to his/her discharge from the facility. 5. Observation on 1/9/06 at 6:41 PM showed registered nurse (RN) #20 dropped a white pill onto the floor in the south dining room. The RN picked up the contaminated medication, placed it in a medication cup, and administered it to resident #37. Interview with the RN immediately after the observation revealed the medication was Calcium Citrate. In addition, the RN confirmed she administered the same pill that was on the floor. The RN stated this was not the accepted procedure. Review of the facility's 11/14/2000	F 281		

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F 281	Continued From page 21 policy and procedure, "Medication Administration," showed administering contaminated medications was not addressed. However, interview with the director of nursing on 1/11/06 at 5 PM revealed her expectation was that medications dropped onto the floor would be discarded and new medications would be obtained and administered to the resident. According to the 3rd edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry and Potter, 2004, "asepsis" is the absence of disease-producing organisms and "medical asepsis" (clean technique) includes procedures to reduce the number of, and prevent the spread of, microorganisms. Cleansing, or discarding, contaminated objects is an example of medical asepsis and is an important aspect of infection control. 6. Interview with RN # 35 on 1/9/06 at 9:10 AM confirmed medications should not be left on the table for residents unless there was a physician's order for self administration. She further stated residents were not routinely evaluated for self administration of medications. 7. Review of the facility's policy on medication administration dated 11/14/2000 revealed the following: "Medication may not be placed in front of a resident and left for the resident to take without a nurses' witness unless the assessment for self-administration is completed and evaluated every 3 months." 8. Review of physician's orders showed resident #83 was to receive three laxatives daily, including Miralax 17 grams which was ordered on 11/1/05. However, according the December 2005 and January 2006 medication administration records	F 281		

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	535042	A. BUILDING _____ B. WING _____	01/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

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F 281	Continued From page 22 (MARs), the resident developed diarrhea and the Miralax was held from 12/10/05 to 12/25/05. It was restarted every other day on 12/26/05 and continued every other day through 1/12/06. However, a physician's order for the above change was not in the medical record. Interview with registered nurse (RN) #28 on 1/12/06 at 7:50 AM verified the MARs were accurate. The RN stated the physician was not notified of the resident's diarrhea and confirmed the absence of an order to restart the medication every other day. The RN stated that instead of "bothering the physician with every little thing," the nurses thought they would try the Miralax every other day. According to the July 2005 Wyoming Nurse Practice Act, nurses shall provide care according to the directions of a licensed physician. 9. According to the 5/14/05 admission orders, resident #87 was to receive Hydrocodone 5 milliliters (ml) at noon and HS (hour of sleep) and 10 ml in the morning and at HS, a total of 30 ml daily with 15 ml given at HS. That order remained in effect until 12/2/05 when the physician changed the order to Hydrocodone 5 ml in the morning, dropped the noon dose, and continued 15 ml at HS, a total of 20 ml daily. Review of a clarification request dated 12/2/05 at 10:30 AM showed "Continue all doses of Hydrocodone as previously ordered except - DC [discontinue] the noon dose." Review of the December 2005 recapitulation of orders (Recap) signed by the physician on 12/9/05 revealed the original admission orders for Hydrocodone were reordered. However, the unsigned January 2006 Recap was for Hydrocodone 5 ml at HS and 10 ml in the morning and at HS, a total of 25 ml daily. In addition, the resident had an order, originally written on 5/14/05 and continued on the monthly	F 281		

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F 281	Continued From page 23 Recaps through January 2006, for oxygen at 1 to 2 liters continually. The following concerns were identified: a. Both the December 2005 and the January 2006 Recaps were signed by a registered nurse as correct. However, neither agreed with the physician's 12/2/05 handwritten order for Hydrocodone. b. Review of the December 2005 and January 2006 MARs showed the resident received Hydrocodone 10 ml in the morning and at HS. On 12/2/05 the nurses stopped administering Hydrocodone 5 ml at noon and late afternoon and started administering Hydrocodone 5 ml at late afternoon, for a total of 25 ml daily. Per the facility's policy and procedure of block times for medications, late afternoon was between 3 PM and 5:30 PM. Per the 12/2/05 order clarification, the resident should have received 5 ml in the morning and 15 ml at HS, a total of 20 ml daily. Additionally, there was no order for a late afternoon dose. c. Interview with RN # 28 on 1/12/06 at 10:20 AM revealed he thought the physician meant to discontinue the order written on the morning of 12/2/05 and resume the previous 5/14/05 order for Hydrocodone after dropping the noon dose. However, he confirmed the requested order clarification dated 12/2/05 at 10:30 AM was not clearly written. The RN also confirmed no one had contacted the physician for orders which specified the physician's preferred dose and time. d. Observations on 1/9/06 at 5:45 PM, 1/10/06 at 7:47 AM and 1:30 PM, and 1/11/06 at 10:20 AM showed the resident did not use oxygen. Interview with RN # 28 on 1/11/06 at 9:20 AM revealed the resident never used oxygen. The RN stated he did not know why the order was on the December 2005 and January 2006 Recaps,	F 281		

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F 281	Continued From page 24 which were signed as correct by another RN . According to the July 2005 Wyoming Nurse Practice Act, nurses shall provide care according to the directions of a licensed physician. Furthermore, according to the 3rd edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry and Potter, 2004, the nurse "is responsible for verifying that the MAR is accurate...by comparing each medication to the original order, including...dose...and times to be given. If an order seems incorrect or inappropriate, the nurse needs to consult the prescriber." Review of "Clinical Nursing Skills Basic to Advanced Skills," sixth edition, by Smith, Duell, and Martin verified the physician must be contacted for clarification with an order that "is illegible or is questionable for any reason." 10. Resident #93 was admitted to the facility on 2/2/05 with diagnoses including chronic renal failure, hypertension, and peripheral vascular disease. Review of the 11/17/05 significant change MDS assessment showed the resident had no problems with short and long-term memory. According to the admission physician orders dated 2/2/05, the resident was to receive oxygen at 2 liters per nasal cannula. Review of the most current signed monthly physician's orders dated December 2005 showed a physician's order for oxygen at 2 liters per minute per nasal cannula on a continuous basis. The following concerns were identified . a. Observation of the resident on 1/9/06 at 5:55 PM and periodic observations on 1/10/06 and 1/11/06 showed oxygen was not in use. b. Interview with the resident on 1/11/06 at 3 PM revealed it was "months" since s/he used oxygen on a continuous basis. c. Review of the medication administration	F 281		

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F 281	Continued From page 25 record flow sheets for July through December 2005 (6 months) showed a monthly entry which documented the resident was "not using" oxygen. d. Interview with the Minimum Data Set (MDS) assessment Coordinator (RN #48) on 1/12/06 at 10:30 AM revealed the 2/2/05 admission order for oxygen was meant to be "prn" (as necessary) and was transcribed incorrectly onto the monthly summary orders. The MDS coordinator further commented the oxygen order was carried forward onto subsequent monthly orders without being corrected. e. Review of the monthly orders for July through December 2005 (6 months) revealed they were signed as correct by a licensed nurse. 11. Continuous observation on 1/10/06 from 5:55 PM to 6:01 PM revealed an unlocked medication cart in the south unit hallway between resident rooms #7 and #8. During this time nursing staff was not observed. However, three visitors were noted walking in the hallway past the medication cart. At 6:01 PM the nurse responsible for the cart was observed coming out of resident room #3 where she had been behind the resident ' s privacy curtain. Interview with registered nurse #2 on 1/11/06 at 4:35 PM stated unlocked medication carts should not be left unattended. According to the facility's 11/14/2000 policy, "Medication Administration," medications "must be secured, within the reach or visual field of the nurse at all times."	F 281		
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	F 282		

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F 282	Continued From page 26 care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed the care plan regarding ambulation for 1 (#2) of 23 sample residents. The findings were: Review of the 10/6/05 physical therapy communication revealed resident #2 should be ambulated by nursing staff 40 plus feet with a front wheel walker and assistance of one or two staff once daily. Review of the care plan updated on 12/13/05 revealed the resident should be ambulated using a front wheel walker and with the assistance of one or two certified nurse aides 40 feet or more daily. The following concerns were identified: a. Periodic observations on 1/9/06 and 1/10/06 revealed the resident was not ambulated. b. Review of the unit ambulation flowsheet revealed the resident was ambulated only 4 of 30 days in November 2005. c. Review of the medical record and confirmed by the director of nursing per interview on 1/12/06 at 10:10 AM revealed there was no evidence the resident was ambulated during December 2005 or January 2006. d. Interview with the restorative nurse aide on 1/11/06 at 1:25 PM revealed the resident was supposed to be ambulated, but staff had not ambulated him/her as directed.	F 282	F 282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each residents' written plan of care. This will be accomplished by: A) Resident #2 will be ambulated by nursing staff in accordance with established plan of care. — 2/27/06 B) All residents will be ambulated in accordance with their written plan of care. — 2/27/06 C) The Director of Nursing will inservice nursing staff to the deficient practice of failure to follow ambulation plan of care. — 2/27/06 D) Charge Nurses will monitor resident ambulation addressing deficient practices when noted. — 2/27/06 E) The Director of Nursing will develop a monitoring tool to assure that residents receive assigned ambulation and report to the Quality Assurance Committee no less than quarterly. — 2/27/06	
F 309 SS=D	483.25 QUALITY OF CARE	F 309		

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F 309	Continued From page 27 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assure staff provided timely care for one of 10 sample residents (#90) identified as incontinent of bowel. The findings were: According to the 10/6/05 quarterly Minimum Data Set (MDS) assessment, resident #90 was incontinent of bowel all or almost all of the time, utilized a urinary catheter, and was totally dependent for transfers. Review of the care plan showed staff were to use Attends (incontinence briefs) to manage the bowel incontinence. The following concerns with providing timely incontinence care were identified: a. Periodic observations on 1/10/06 between 10:05 AM and 4:20 PM (6 hours and 15 minutes) showed the resident sat in a recliner in the central activity area. Interview with registered nurse #39 on 1/10/06 at 4:06 PM revealed the resident's typical daily routine was to remain in the recliner "from after breakfast until about 4 PM." At 4:20 PM, observation showed certified nurse aides (CNAs) #2 and #9 transferred the resident from the recliner to a wheelchair and then transported the resident to his/her room. A fecal odor was present during the transfer. At 4:30 PM the CNAs transferred the resident into bed and found s/he was incontinent of soft to liquid feces. The old	F 309	F 309 Each resident will receive and the facility will 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 will be accomplished by: A) Resident #90 will receive timely incontinent care by the nursing staff as documented in the plan of care. B) All residents will benefit from timely incontinent care as determined by their plan of care. C) The Director of Nursing will inservice the nursing staff to the plan of care with regards to the management of bowel incontinence. D) The charge nurses will monitor resident care to assure that the plan of care is implemented. Swift inservice/direction will be delivered in the event a deficient practice is noted. E) The Assistant Director of Nursing will develop a quality monitoring tool to assess the compliance with this standard and report results to the Quality Assurance team no less than quarterly.	2/27/06 2/27/06 2/27/06 2/27/06 2/27/06

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
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F 309	Continued From page 28 incontinence brief, dated and timed 1/10/06 at 10 AM was removed and CNA #2 completed perineal care. Observation of the resident's skin during perineal care revealed it was intact but with multiple old scars on the buttocks and coccyx. The observation also showed the resident continued to have numerous expulsions of feces while the CNA provided care. During a previous interview on 1/10/06 at 9:10 AM, CNAs #17 and #40 stated all incontinence briefs were dated, timed, and initialed to show when they were last checked or changed and by whom. b. Periodic observations on 1/11/06 between 9:25 AM and 3 PM showed the resident sat in a recliner in the central activity area. Interview with CNA #23 at 3:35 PM confirmed the resident had remained in the recliner for 5 hours and 15 minutes before being transferred at 3:15 PM. The CNA further commented that when checked at 3:15 PM, the resident was incontinent of bowel. c. Interview with the restorative nurse, registered nurse #36, on 1/12/06 at 10:10 AM revealed the expectation was for the resident to be checked for bowel incontinence every two to three hours.	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F 314 The facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This will be accomplished by: A) Resident #90 will be repositioned every 2-3 hours and checked for incontinence.	2/27/06

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F 314	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide timely repositioning, incontinence care, and pressure-reducing devices for one of 16 sample residents (#90) who were at risk for developing pressure ulcers. The findings were: According to the 10/6/05 quarterly Minimum Data Set (MDS) assessment, resident #90 was incontinent of bowel all or almost all of the time, and was totally dependent for transfers. Review of the "Skin/Pressure Ulcer Risk Assessment" dated 12/29/05 showed the resident was assessed as being at "high risk" for the development of pressure ulcers. Review of the care plan revealed staff were to reposition the resident every two to three hours based on a turn clock, apply Spenco (pressure-reducing) booties to both feet, and use Attends (incontinence briefs) to manage the bowel incontinence. The following concerns were identified: a. Periodic observations on 1/10/06 between 10:05 AM and 4:20 PM (6 hours and 15 minutes) showed the resident sat in a recliner in the central activity area. Interview with registered nurse #39 on 1/10/06 at 4:06 PM revealed the resident's typical daily routine was to remain in the recliner "from after breakfast until about 4 PM." At 4:20 PM, observation showed certified nurse aides (CNAs) #2 and #9 transferred the resident from the recliner to a wheelchair and then transferred the resident to his/her room. A fecal odor was present during the transfer. At 4:30 PM the CNAs transferred the resident into bed and found s/he was incontinent of soft to liquid feces. The old incontinence brief, dated and timed 1/10/06 at 10 AM was removed and CNA #2 completed	F 314	B) All dependent residents will be repositioned and checked for incontinence every 2-3 hours. C) The Director of Nursing will inservice the nursing staff to the facility repositioning policy. D) The Charge nurses will assure that dependent residents are repositioned and checked for incontinence every 2-3 hours offering swift inservice/direction in the event that the task is not performed. E) The Assistant Director of Nursing will develop a monitoring tool to assure that dependent residents are repositioned and assessed for incontinence every 2-3 hours. The results will be reported to the Quality Assurance Committee.	2/27/06 2/27/06 2/27/06 2/27/06

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F 314	Continued From page 30 perineal care. Observation of the resident's skin during perineal care revealed it was intact but with multiple old scars on the buttocks and coccyx. The observation also showed the resident continued to have numerous expulsions of feces while the CNA provided care. During a previous interview with on 1/10/06 at 9:10 AM, CNAs #17 and #40 stated all incontinence briefs were dated, timed, and initialed to show when they were last checked or changed and by whom. b. Periodic observations on 1/11/06 between 9:25 AM and 3 PM showed the resident sat in a recliner in the central activity area. Interview with CNA #23 at 3:35 PM confirmed the resident had remained in the recliner for 5 hours and 15 minutes before being transferred at 3:15 PM. The CNA further commented that when checked at 3:15 PM, the resident was incontinent of bowel. c. Interview with restorative nurse, registered nurse #36, on 1/12/06 at 10:10 AM revealed nursing staff was expected to check the resident for incontinence every two to three hours. d. Interview with CNA #40 on 1/12/06 at 7:35 AM revealed the resident was only repositioned while in bed, based on a turn clock. Interview with the assistant administrator on 1/12/06 at 3 PM revealed the expectation was for the resident to be repositioned every two to three hours.	F 314		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by:	F 323	F 323 The facility must ensure that the resident environment remains free of accident hazards as is possible. This will be accomplished by: A) The South station tub room cabinet s will remain locked if not attended by personnel.	2/27/06

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F 323	Continued From page 31 Based on observation and staff interview, the facility failed to ensure the environment was safe and chemicals were not accessible to residents during three random observations. The findings were: 1. Observation of the south tub room on 1/10/06 at 6:10 PM revealed both doors leading into the room were open and no staff were in the vicinity. The following concerns were identified: a. There were two one-gallon containers of Classic Whirlpool Disinfectant Cleaner on the bottom shelf of an unlocked cabinet near the tub. One was full and the other one was 3/4 full. The label on the disinfectant cleaner instructed: "DANGER" "Keep out of reach of children. Corrosive. Causes irreversible eye damage and skin burns. Do not get in eyes, on skin or on clothing. Wear goggles, face shield, rubber gloves, and protective clothing. Harmful if absorbed through skin. Harmful if swallowed....Remove contaminated clothing and wash before reuse." b. There was a one gallon jar of barbicide labeled "POISON" on the bottom shelf of an unlocked cabinet near the tub. Observation revealed a notice on the wall above the tub and another one on the cabinet doors where the chemicals were located that said "Keep tub cleaner locked up at ALL times." Interview with certified nurse aides (CNAs) #22 and #50 on 1/11/06 at 3:08 PM confirmed the doors to the tub room and cabinet doors in the tub room should be locked at all times when staff were not in the room. 2. Continuous observation on 1/10/06 from 5:55 PM to 6:01 PM revealed an unlocked medication cart in the south unit hallway between resident	F 323	B) All tub room cabinets will be secured and locked when not in the attendance of a care staff member. C) All medication carts will remain locked when the nurse is not in attendance. D) The Director of Nursing will inservice nursing staff to the deficient practice. E) The Charge Nurses will monitor tub rooms for compliance with locking of cupboards when staff is not in attendance offering immediate inservice/direction if non-compliance is noted. F) The Director of Nursing, Assistant Director of Nursing will monitor the nursing staff to assure that medication carts are secure when the nurse is not in direct attendance of such cart. Immediate inservice/direction will ensue with the identification of deficient practice. G) The Director of Nursing will develop a quality monitoring tool to ensure environmental hazards are prevent ed reporting results to the Quality Assurance team no less than quarterly. H) The sharp edges on the hand rail support in the Special Secure Unit shall be repaired and/or replaced by the Maintenance Department. I) Housekeeping Department will be inserviced by the Director of Housekeeping and instructed to identify and monitor all handrails reporting those in need of repair/replacement to the Maintenance Department. J) The maintenance department will repair/replace handrails identified in poor repair. K) The Director of housekeeping will develop a quality monitoring tool to track handrail repairs and report results to the Quality Assurance Committee at least quarterly.	2/27/06 2/27/06 2/27/06 2/27/06 2/27/06 2/27/06 2/27/06 2/27/06 2/27/06

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F 323	Continued From page 32 rooms #7 and #8. During this time nursing staff was not observed. However, three visitors were noted walking in the hallway past the medication cart. At 6:01 PM the nurse responsible for the cart was observed coming out of resident room #3 where she had been behind the resident ' s privacy curtain. Interview with registered nurse #2 on 1/11/06 at 4:35 PM stated unlocked med carts should not be left unattended. According to the facility's 11/14/2000 policy, "Medication Administration," medications "must be secured, within the reach or visual field of the nurse at all times." 3. Observation on 1/10/06 at 3:30 PM, 1/11/06 at 1:30 PM and 1/12/06 at 9:15 AM revealed sharp edges on the hand rail support in the Special Care Unit around the corner from the nurses station, next to the water fountain.	F 323		
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on random observation, staff interview, and medical record review, the facility failed to assure certified nurse aides (CNAs) performed tasks for which they were qualified and which were within their scope of practice. Furthermore, the facility failed to assure licensed nurses	F 492	F 492 The facility will operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services. This will be accomplished by: A) Resident #104 will receive antifungal ointment application by a RN or LPN. — 2/27/06 B) No facility resident will receive inappropriately delegated care from a caregiver functioning outside of their practice scope. — 2/27/06 C) The Director of Nursing will inservice nursing staff to the proper scope of practice as it pertains to the application of prescription ointments. — 2/27/06	

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F 492	Continued From page 33 delegated tasks appropriately to CNAs. The findings were: 1. Observation on 1/10/06 at 10 AM showed CNA # 31 provided perineal care for resident #104. After cleansing the anterior groin and upper thighs, the CNA squeezed Clortrimazole (antifungal) ointment onto her gloved hand, applied it to the resident's groin, then turned the resident onto his/her side and completed perineal care. After completion of perineal care, the CNA stated she had washed the ointment off. Wearing the same gloves, the CNA re-opened the tube of ointment, squeezed some onto her gloved fingers, and applied it directly over the anal area. The resident requested more ointment to the genital area so the CNA squeezed additional ointment onto the same glove, replaced the tube in the drawer, and applied the ointment directly to the resident's genitalia. The following concerns were identified: a. The CNA contaminated the tube of Clortrimazole ointment three separate times by touching the tube to her gloves. b. The CNA went from a dirty (anal) area to a clean (genital) area when applying the ointment. According to the 2004 3rd edition of "Nursing Interventions & Clinical Skill" by Elkin, Perry, and Potter, moving from a clean area to a dirty area prevents transmission of pathogenic microorganisms. c. The CNA replaced the contaminated tube of medication in the resident's drawer for future use. d. According to the July 2005 Nursing Practice Act and Administrative Rules and Regulations November 2003, applying medicated ointments is not within the scope of practice for CNAs.	F 492	D) Charge nurses will monitor for proper delegation of tasks swiftly addressing and correcting any deficient practice. E) The Assistant Director of Nursing will develop a quality monitoring tool to ensure that proper delegation of scope of practice is in compliance and reporting results to the Quality Assurance committee no less than quarterly.	2/27/06 2/27/06

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F 492	Continued From page 34 2. Review of the physician's orders for resident #83 showed a request dated 10/26/05 for the physician to evaluate the resident's feet for a "possible fungus infection....If prescribing, please consider powder (OTC) [over the counter] aides can sprinkle on daily." Interview with the assistant administrator and director of nursing on 1/11/06 at 5:40 PM revealed the facility did not have a policy for CNAs to apply preventive OTC powders or ointments for skin care. However, both agreed the CNAs should not apply Clortrimazole ointment. When asked if this could be a delegation issue with the licensed nurses, the assistant administrator stated it was possible. Review of the July 2005 Nursing Practice Act and Administrative Rules and Regulations November 2003 revealed " 'delegation' decisions must be made by the licensed nurse on the basis of the skill levels of the care givers." Further review showed the delegating nurse must delegate only those tasks which are within the CNAs "area of responsibility and scope of practice."	F 492		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F 514 The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This will be accomplished by: A) Resident #46 will be comprehensively assessed for a physical restraint by the Director of Restorative Nursing. 2/27/06 B) Resident # 65 record will reflect documentation to support the use of lap tray by the Certified Occupational Therapist. 2/27/06 Residents #20, 23, 151 will have baths and/or weights documented when done. Refusals will be documented.	

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F 514	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility policy and procedure, the facility failed to assure staff maintained complete, accurate resident records. Documentation in the medical records for sample resident #46 was corrected inappropriately, and medical records for 5 (#20, #23, #65, #114, #151) of 23 sample residents were incomplete. The findings were: 1. Review of the 6/28/05 significant change Minimum Data Set (MDS) assessment revealed resident #46 was coded as using a trunk restraint, and a comprehensive assessment was required. Review of an undated physical restraint Resident Assessment Protocol (RAP) revealed it was incomplete. The RAP lacked the patient/ family signature as well as the physician's signature. Page two of the RAP was headed with the title summary; however, it was blank. On 1/10/06 at 1:10 PM the surveyor made a copy of this original document. Request by the surveyor for additional information resulted in the facility providing the original physical restraint RAP on 1/11/06 at 2:20 PM with new information added. Review of this version of the physical restraint RAP showed page two now included the following dates: 2/7/05, 2/22/05, 5/17/05, 6/27/05, 9/19/05, 12/12/05, and 12/13/05. Each date was listed on a separate line with "see rest [restorative] N.N. [nursing notes]" and the restorative nurse's signature. The new documentation did not include any statement of late entry. Interview with the restorative nurse, registered nurse #36, on 1/12/06 at 2:15 PM confirmed he added the signatures the previous day, but did not indicate	F 514	Resident #114 is no longer in the facility C) The Director of Nursing will inservice the Restorative Nursing Director and Certified Occupational Therapist to deficient practice noted. D) The Director of Nursing will inservice the nursing staff the proper method for documentation of resident refusals as well as proper documentation for care delivered (specifically bed baths and weight assessment and resident refusal with elaboration). E) The Assistant Director of Nursing will review weights monthly to assure proper documentation is in place. Deficient practices will be investigated and addressed by the ADON. F) The Director of Nursing will develop quality monitoring tools to address comprehensive assessments, documentation and weight assessment reporting no less than quarterly to the Quality Assurance Committee.	2/27/06 2/27/06 2/27/06 2/27/06

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they were late entries.

According to the March 2003 facility policy and procedure titled: "Documentation," section 4.5 "A late entry should reflect the date and time of the actual documentation but reference the date and time of the intended entry. I.e., 'late entry' March 15, 2003 10:10 AM for March 14, 2003 1600". According to "The Lippincott Manual of Nursing Practice," 7th edition, 2001, "Altering a medical record without noting it as a correction with signature, date, and time of change" is a departure from standards of care.

2. Review of the 10/25/05 quarterly MDS assessment showed resident #65 used a lap tray on his/her wheelchair. Included in the medical record was a rehabilitation communication dated 5/22/05 that showed a nurse was requesting a different positioning device because the resident was getting frequent skin tears on his/her elbow. Further review of the medical record revealed no evidence of any follow-up to this request. Interview on 1/12/06 at 12:30 PM with a certified occupational therapy assistant, employee #1, revealed she was aware of this request and had removed the Velcro from the lapboard (date unknown) that was causing the skin tears. She further stated she did not document this in the clinical record, and should have. According to "The Lippincott Manual of Nursing Practice," 7th edition, 2001, "failure to make prompt, accurate entries in a patient's medical record" is a departure from standards of care.

3. Interview with certified nurse aide (CNA) #6 on 1/11/06 at 10:55 AM revealed residents were weighed when they received their baths. The CNA stated all residents were bathed twice a week. The following concerns related to accuracy

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of documentation were identified.

a. Review of the personal care record for resident #20 revealed no bath documentation for January 2006. Review of documentation for December 2005 revealed the resident received five baths documented on 12/1/05, 12/4/05, 12/11/05, 12/18/05, and 12/25/05. Interview with the director of nursing on 1/12/06 at 12 noon, revealed weights, and therefore baths, were done on 12/8/05, 12/14/05, and 12/22/05. The baths were not documented as being done. Interview with CNA #3 on 1/12/06 at 9:39 AM revealed the resident received two baths a week. The CNA showed documentation of weights done on 1/1/06 and 1/8/06. Further interview with the CNA revealed that at least one bath was neither documented as done nor as refused. The CNA stated staff were trained to document each bath or the resident's refusal.

b. Review of the medical record for resident #23 revealed a "Vital Sign and Weight Record" and "Personal Care Record" (dated December 2005 and January 2006) which documented the resident received a bath on 12/27/05, and then went nine days until receiving another one on 1/6/06. Review of weight records revealed the resident was weighed on 12/30/05, but there was no documentation of any other care, such as a bath.

c. Review of bathing documentation for resident #114 revealed the resident received five baths during the month of December 2005 (on 12/7/05, 12/10/05, 12/17/05, 12/24/05, and 12/31/05). Yet weight documentation showed the resident was weighed on 12/7/05, 12/10/05, 12/13/05 (not listed above), and 12/16/05 (a bath day listed as 12/17/05 above). January documentation showed the resident received a bath on 1/4/06 and 1/10/06. No weights were

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F 514	Continued From page 38 recorded for January. Interview with CNA #6 on 1/11/05 at 10:55 AM revealed the resident was on "comfort care" and, for the past two weeks, received daily bed baths. When interviewed further, the aide stated the bed baths were not documented anywhere. d. Review of the medical record for resident #157 revealed a personal care record and weight record for December 2005 and January 2006. The documentation showed the resident missed at least one bath between 12/16/05 and 12/23/05. The resident received a bath on 12/23/05, then went 10 days without a bath until receiving one on 1/3/06. Review of the resident's care plan (review date 11/19/05) revealed the resident was to bathe or shower two to three times per week with staff assistance. The record failed to document the reason care was not completed. In addition, review of the weight record showed no weights were recorded for December 2005 or January 2006.	F 514		
F 520 SS=D	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of facility reports, and review of quality assurance information, the facility failed to correct identified deficiencies in the areas of assessment, accuracy of	F 520	F 520 The facility will maintain a quality assessment and assurance committee consisting of the Director of Nursing, A Physician and at least 3 other members of the facility's staff. This will be accomplished by: A) The Quality Assurance Committee will be revised to include methods in which to identify and monitor deficient practices and trends related to past and present certification surveys. B) The Quality Assurance Committee members will be inserviced by the Assistant Administrator to the new program modules as well as roles and responsibilities of each participant . C) The Assistant Administrator will (no less than quarterly) evaluate the effectiveness of the program and on-going compliance with the standard . The program will be revised when necessary.	2/27/06 2/27/06 2/27/06

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F 520	Continued From page 39 assessments, professional standards, following the care plan, care and services, and pressure sores. The findings were: Review of the facility OSCAR 3 report (a history of deficiencies cited on the previous 4 annual surveys) revealed the following concerns: a. Assessments were identified as deficient in the years 2001, 2002, and 2004. b. Accuracy of assessments was identified as deficient in the years 2001 and 2002. c. Professional standards was identified as deficient in the years 2001 and 2002. d. Following the plan of care was identified as deficient in the years 2001, 2002, and 2004. e. Care and services was identified as deficient in the years 2003 and 2004. f. Pressure sores was identified as deficient in the year 2004. During the annual survey for 2006, all these areas were again cited for deficient practice. Interview with the administrator and assistant administrator on 1/12/06 at 9:30 AM revealed these areas were not identified as problems or monitored through the quality assurance program.	F 520	D. The QA committee will develope a system to identify problems and set benchmarks. The teams will develope a process to re-evaluate the effectiveness of the system. The effectiveness and status of QA will be reported to the board of directors no less than quarterly.	