STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	04/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL MANOR	1108 BIRCH STREET DOUGLAS, WY 82633

MAY 10 2006

(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, and staff and resident interview, the facility failed to ensure two (#5, #45) of three residents with restraints, required the use of the restraint for medical reasons and/or the restraint was the least restrictive device. The findings were: 1. Review of the 4/15/05 at 5 PM nursing notes for resident #45 revealed the resident was assessed as able to ambulate without a walker. Interview with registered nurse (RN) #2 on 4/5/06 at 12:55 PM revealed the resident was capable of standing from his/her wheelchair. Observation on 4/5/06 at 5:10 PM revealed the resident was able to stand and transfer with minimal assistance. Observation on 4/3/06 at 6:32 PM revealed the resident had a buckled lap belt while in the wheelchair. During the observation, the resident approached the surveyor and requested that the surveyor release the lap belt. The following concerns with the use of a lap belt which restrained the resident's movement were identified: a. Interview with the resident on 4/3/06 at 6:32 PM revealed s/he was unable to release the belt. b. Interview with RN #2 revealed the resident had a history of falls and the lap belt prevented him/her from standing, "...that's why we use it." c. Review of the medical record revealed	F 221	This facility will ensure that residents have 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 will be accomplished by: 1&2. A new pre-restraint and fall risk assessment will be completed on residents #45 and #5 to determine the need for restraints. The assessment will include residents' mobility, cognitive status, medical need, and residents' ability to release the belt. A new care plan will be written to reflect the results of the assessments and will include a plan to try other alternatives. The least restrictive device will be identified and implemented to maintain residents' safety as well as dignity, independence, and comfort. PCPCs will be scheduled with family and residents to inform and involve them in new plan. Charge nurses will document the effectiveness of the plan. DON, Social Worker, and Administrator to monitor for compliance. Results will be reviewed at quarterly care plan meeting. QA committee will monitor for any trends.	6/2/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 221	Continued From page 1	F 221		

there was no assessment of the seatbelt as a restraint.

d. Review of the medical record revealed there was no evidence of a medical reason for utilization of the restraint.

e. Interview with the director of nursing (DON) on 4/5/06 at 5:10 PM revealed she was unaware if other devices were tried prior to using the lap belt.

2. Observation on 4/3/06 at 4:30 PM revealed resident #5 had a seat belt restraint on his/her wheelchair. Observation on 4/5/06 at 12:40 PM revealed the resident tried but was unable to physically release the seatbelt from the wheelchair. Observation on 4/5/06 at 12:30 PM revealed the resident was able to transfer with assistance from a chair to the wheelchair. Interview with the director of nursing and social worker on 4/6/06 at 9 AM confirmed the resident was able to stand and walk with assistance. They stated the seatbelt was placed on the resident to prevent him/her from standing because the resident was a fall risk. They were unable to provide a medical reason for the utilization of the seat belt restraint. Finally, they were unaware if less restrictive alternatives such as a pommel cushion or other cushion devices were attempted and found to be ineffective.

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F 226 SS=B	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy review, review of new employee personnel records, and staff interview, the facility did not consistently implement policies related to background checks prior to employment for three (#1, #3, #5) of five personnel records reviewed. In addition, the facility did not ensure their policies provided accurate information in regard to abuse investigations. The findings were: 1. Review of the personnel file for staff member #1 revealed she was hired on 1/2/06 and no background check was performed prior to employment. 2. Review of the personnel file for staff member #3 revealed she was hired on 1/25/06 and no background check was performed prior to employment. 3. Review of the personnel file for staff member #5 revealed she was hired on 2/22/06 and no background check was performed prior to employment. 4. Review of the facility policies and procedure on preventing resident abuse, undated, revealed the following instructions: 2. "Our abuse prevention/intervention program includes, but is not limited to:" (e) "Conducting back ground checks/investigations to prevent hiring people	F 226	This facility will ensure that policies and procedures are developed and implemented that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This will be accomplished by: 1,2,3. Background checks for employees #1,3, & 5 will be completed. 4. Although the facility had the understanding that background checks on licensed staff was previously completed upon licensure, the existing policy has been reviewed and implemented. All licensed staff will be in-serviced in the importance of background checks and the facility policy. Administrator will monitor for compliance. Any trends will be reviewed by QA committee. 6. The policy was reviewed and updated to reflect the actual procedure. All staff will be in-serviced on the correct abuse policy. Administrator to monitor for compliance. Any trends will be reviewed by QA committee.	6/2/06 6/2/06 6/2/06

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F 226	Continued From page 3 who have compromising records..." 5. Interview with the owner of the facility on 4/6/06 at 8:10 AM confirmed background checks should be performed on all employees prior to being offered employment. 6. Review of the facility's notice "Steps to follow When Suspected Abuse is Reported to any Staff" revealed step number six instructed: "Accused STAFF will be assigned to work with another STAFF, in another area away from the accuser, until the investigation is completed. If cleared of the abuse allegation, that STAFF will not be assigned to work with the accusing RESIDENT again." Interview with the administrator and facility owner on 4/6/06 at 8:10 AM revealed step six was inaccurate. They stated staff were suspended pending investigation in all cases of alleged abuse. They further stated the abuse policies and procedures were old and needed review and revision.	F 226		
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and resident interview, the facility failed to ensure resident dignity when providing eating assistance, addressing residents and providing continence	F 241	This facility will ensure that care is provided for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This will be accomplished by: 1. All staff will be in-serviced on the importance of maintaining residents' dignity and respect. "Bibs" will be referred to as clothing protectors. Staff will also be in-serviced on proper conduct while in the	6/2/06

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F 241	Continued From page 4 assistance. The facility census was 45. The findings were: 1. Observation on 4/3/06 at 5:48 PM revealed certified nurse aid (CNA) #11 refer to clothing protectors as "bibs". The CNA was standing next to non-sample resident #28 at the assisted dining table in the dining room when she asked another CNA, "Do you want to bib her?" At least 10 residents were present in the dining room at the time and could hear the exchange between the two CNAs. 2. Observation on 4/3/06 at 6:19 PM revealed CNA #1 and #11 assisting two of the four residents seated at the assisted dining table. A third resident #30 was observed eating her paper napkin for approximately four minutes before CNA #11 noticed and redirected the resident. 3. Observation on 4/3/06 at 5:53 PM revealed CNA #1 assisted resident #19 drink from his/her cup for approximately 20 seconds while at the same time she was looking over her right shoulder and talking to another CNA. 4. Observation of the evening meal on 4/3/06 from 5:50 PM through 6:35 PM revealed staff stood while assisting residents with eating. Observation revealed CNA #11 stood as she assisted non sample residents #23, #25, #30, and #19 from 5:50 PM until she left at 6 PM at which time CNA #1 replaced her and also stood to assist these residents until the surveyor left the dining room at 6:35 PM. Observation also revealed CNA #12 stood to assist non-sample residents #2, #14, #15, and #44 from 6 PM until 6:35 PM with the exception of one minute (from	F 241	F241 (Continued from page 4) residents' dining room. Charge nurses will be in-serviced on their role to monitor staff to resident interaction in dining room. Compliance will also be monitored by Resident Council meeting monthly. DON and Administrator to monitor for compliance and counsel staff as needed to ensure dignity and respect is maintained. QA committee to review for trends or need for change in policy and procedure. 2 & 3. Staff will be in-serviced on the need to focus on the residents' needs while assisting them at assisted tables. 4. All staff will be in-serviced on the reasons and importance of sitting while assisting residents at meal times. 5 & 6. Staff will be in-serviced on the importance of dignity and respect in caring for residents. Charge nurses will be in-serviced on their role to monitor staff to resident interaction in dining room. Compliance will also be monitored by Resident Council meeting monthly. DON and Administrator to monitor for compliance and counsel staff as needed to ensure dignity and respect is maintained.	6/2/06 6/2/06 6/2/06

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F 241	Continued From page 5 6:05 to 6:06 PM) when she sat. 5. Interviews with residents were done at 9:03 AM on 4/4/06, 10:19 AM on 4/4/06, and 1:45 PM on 4/4/06. Individual interviews revealed statements from two residents that staff were not always respectful. One resident was not able to give examples of disrespect. One resident stated that just this morning staff entered his/her room and addressed the resident by only the resident's last name. The resident stated it was "indignant" and staff should use either the first name or a title such as Mr./Ms. A third resident stated, "They don't care about us, they just care about the money." 6. On 4/4/06 at 3:38 PM record review was done by a member of the survey team in room #4 with the door closed. At that time, a staff member was heard as she called out in a loud voice to another staff member down the hall. The staff member asked "Has she peed today?" And, "Hey [staff member's name], has she pottied today?"	F 241		
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: 3. Observation on 4/4/06 at 8:56 AM of wheelchair for resident #43 revealed the washable surface of the chair arms were cracked and had exposed the interior upholstery. Further	F 253	This facility will ensure that housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior are provided. This will be accomplished by: 3. The cracked chair arms on the wheelchairs belonging to residents #43, #14, #32, & #8 were replaced by April 13, 2006. Staff will be in-serviced on the procedure to report damaged or non-working	4/12/06 4/13/06

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F 253	Continued From page 6 observations of resident wheelchairs on 4/6/06 revealed the following: a. Resident #14 was observed in his/her wheelchair at 8:33 AM as CNA #11 assisted the resident. The observation revealed one arm of the wheelchair was taped with dirty duct tape and the other arm taped with dirty silk medical tape. Interview with the CNA at that time revealed the washable surface of the arms were cracked and could cause a skin tear. The CNA stated she did not know how long the upholstery had been damaged. b. Observation at 8:34 AM of the wheelchair for resident #32 revealed the arms of the chair had cracked and missing sections of the washable surface and exposed the interior upholstery. c. Observation at 8:58 AM of the wheelchair for resident #8 revealed the washable surface of the right chair arm was broken and had missing sections. The left chair arm was cracked. Interview with the business office manager, who was also a CNA, at 8:44 AM on 4/6/06 revealed CNAs should report damaged wheelchair arms to the maintenance director so the chair arms can be repaired. The manager/CNA further stated the arms were taped with duct tape to prevent skin tears until the repairs could be made. Repairs were usually completed in one to two days. Based on observation and staff interview, the facility failed to ensure a safe, clean, comfortable and homelike environment for residents. The facility census was 45. The findings were: 1. Observation on 4/5/06 at 2:48 PM revealed 6 of 36 light bulbs burned out in four of the six	F 253	F253 (Continued from page 6) equipment. Maintenance will monitor for cracked wheelchair arms on daily rounds and will repair as needed. Safety and QA committees will monitor for compliance. This facility will ensure that a safe, clean, comfortable and homelike environment is maintained for residents. This will be accomplished by: 1. The dining room light bulbs were replaced on April 14, 2006.	4/14/06

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F 253	Continued From page 7 small-bulb overhead chandeliers in the dining room. In addition, 2 of 15 light bulbs had burned out in 3 of the 3 large-bulb chandeliers. 2. Observation on 4/5/06 at 2:30 PM revealed a dirty laundry cart sitting in the hall opposite the shower room. The cart was still present at 3:48 PM at which time a CNA moved it. Interview with certified nurse aide (CNA) #3 on 4/6/06 at 8:19 AM revealed "dirty laundry carts are kept in the shower or tub rooms or in the hall when not in use. When they are full, nursing staff (primarily CNA ' s) take them downstairs to the laundry room."	F 253	F253 (Continued from page 7) Housekeeping and maintenance will monitor for burned out bulbs and replace as needed. Safety and QA committees will monitor for effectiveness. 2. Staff will be in-serviced on the need to follow proper infection control procedures to store the laundry carts when not in use. DON and charge nurses to monitor for compliance. Safety and QA committee to review for any trends.	6/2/06

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F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; 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 and resident interview, the facility failed to ensure three (#13, #34, #45) of 12 sample residents had comprehensive assessments in	F 272	This facility will ensure that a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity will be conducted initially and periodically. This will be accomplished by: 1. Although the trunk belt and chair are used for resident #13 as a positioning device opposed to restraint, a new pre-screening restraint and care plan will be completed to reflect what device is in use, what has been attempted as an alternative, and what is the least restrictive device. Physical Therapy to screen for recommendations. 2. Resident #34 will have a new comprehensive assessment and care plan for psychotropic drug use will be completed. 3. A new pre-restraint and fall risk assessment will be completed on resident #45 to determine the need for restraints. The assessment will include residents' mobility, cognitive status, medical need, and residents' ability to release the belt. A new care plan will be written to reflect the results of the assessments and will include a plan to try other alternatives. The least restrictive device will be identified and implemented to maintain residents' safety as well as dignity,	6/2/06 6/2/06 6/2/06

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F 272	Continued From page 9 areas which required further assessment. The facility failed to assess residents in the areas of psychotropic drug use and restraints. The findings were: 1. Review of the annual 9/24/04 Minimum Data Set (MDS) assessment for resident #13 revealed s/he had a trunk restraint and a chair that prevents rising. Observation of the resident at 5 PM on 4/3/06 revealed the resident had a seat belt on his/her chair. Review of the medical record, including the "Pre-restraining Assessment" form revealed there was no comprehensive assessment of restraints for the resident since the original assessment completed on 7/8/03. 2. Review of the 8/18/05 Resident Assessment Protocol (RAP) Summary Report for resident #34 revealed s/he triggered for comprehensive assessment of psychotropic drug utilization. Review of the 8/18/05 RAP module performed by the facility revealed there was no comprehensive assessment completed; only a list of medications the resident was receiving. Interview with the social worker on 4/6/05 at 8:30 AM revealed she thought it had been completed but stated she was unable to locate a complete assessment. 3. Review of the 4/15/05 at 5 PM nursing notes for resident #45 revealed the resident was assessed as able to ambulate without a walker. Interview with registered nurse (RN) #2 on 4/5/06 at 12:55 PM revealed the resident was capable of standing from his/her wheelchair. Observation on 4/5/06 at 5:10 PM revealed the resident was able to stand and transfer with minimal assistance. Observation on 4/3/06 at 6:32 PM revealed the	F 272	F272 (Continued from page 9) independence, and comfort. PCPCs will be scheduled with family and residents to inform and involve them in new plan. Charge nurses will document the effectiveness of the plan. DON, Social Worker, and Administrator to monitor for compliance. Results will be reviewed at quarterly care plan meeting. QA committee will monitor for any trends. The above steps will be followed for each individual resident to which a restraining/positioning device may be needed.	

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resident had a buckled lap belt while in the wheelchair. During the observation, the resident approached the surveyor and requested that the surveyor release the lap belt. The following concerns with the use of a lap belt which restrained the resident's movement were identified:

a. Interview with the resident on 4/3/06 at 6:32 PM revealed s/he was unable to release the belt.

b. Interview with RN #2 revealed the resident had a history of falls and the lap belt prevented him/her from standing, "...that's why we use it."

c. Review of the medical record revealed there was no assessment of the seatbelt as a restraint.

d. Review of the medical record revealed there was no evidence of a medical reason for utilization of the restraint.

e. Interview with the director of nursing (DON) on 4/5/06 at 5:10 PM revealed she was unaware if other devices were tried prior to using the lap belt. Further interview with the DON revealed the facility had not looked at the lap belt as a restraint, but had looked at the belt as a positioning device.

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F 278 SS=E	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. 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 ensure the accurate assessment for one (#18) of 12 sample residents in the area of nutrition. In addition, section VB4 on the Resident Assessment Protocol (RAP) summaries were not signed as completed for 6 (#5, #6, #13, #18, #26, #34) of 12 sample	F 278	This facility will ensure that the resident's assessment accurately reflects the resident's status and that all assessments are signed by each individual involved in its preparation, thereby certifying its accuracy. This will be accomplished by: The MDS nurse will be given refresher training on the MDS system and the importance of timely and accurate information, as well as the need to verify signatures and sign the appropriate sections. She will be going to another facility to train on May 31, 2006. All the disciplines responsible for MDS completion will be in-serviced on the importance of completing the MDS timely, accurately, and signing the appropriate signatures. Medical records supervisor will do a monthly audit on all charts on the recent assessments and check for signatures. The audit will be reviewed by DON and Administrator for compliance. QA committee will review quarterly for trends. 1a,b,c. A new nutritional RAP will be completed for resident #18 which will reflect the correct information including an assessment of the noted chewing problem. The Dietary Consultant will be reminded of the importance of completing all	6/2/06 6/2/06 6/2/06

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	535040	A. BUILDING _____ B. WING _____	04/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 12 residents. Finally, the facility failed to ensure 9 (#5, #6, #11, #13, #34, #36, #40, #43, #46) of 12 sample resident records had signature attestations for accuracy (Section AA9) in all areas of the Minimum Date Set (MDS) assessments. The findings were: For findings related to the inaccurate nutrition assessment: 1. Medical record review of the Nutritional Status RAP review for resident #18 for the 11/11/05 annual MDS assessment revealed the following concerns: a. MS (Multiple Sclerosis) was listed as a complication and risk factor affecting the resident. The resident did not have a diagnosis of MS listed anywhere in the medical record. b. The resident was observed to be edentulous throughout the survey. This was confirmed in the section identifying the resident as having a chewing problem. However, this section also required additional information as to the cause of the chewing problem. None was provided. c. The Nutritional Status RAP module was included with the other 11/11/05 RAP modules in the medical record however it was dated 1/3/05. For findings related to the lack of signatures on the RAP summary reports: 1. Review of the 11/11/05 annual MDS assessment for resident #18 revealed three separate RAP summaries. Section VB4 was not signed on two of the three RAP summaries. 2. Review of the 4/1/05 significant change MDS	F 278	F278 (Continued from page 12) assessments and summaries accurately and timely. MDS nurse and DON to monitor for completion. As to findings related to the lack of signatures on the RAP summary reports: All assessments with missing signatures will be signed as they come due for the next review. These include residents #18, #6, #13, #34, #5, and #26. As to findings related to the lacking attestation signatures: All assessments with missing signatures will be signed as they come due for the next review. These include residents #6, #11, #36, #40, #43, #46, #5, #13, and #34.	6/2/06 6/2/06

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F 278	Continued From page 13 assessment for resident #6 revealed two RAP summaries. Section VB4 was not signed on either of them. 3. Review of the 9/9/05 annual MDS assessment for resident #13 revealed there were two RAP summary reports completed. Review further revealed one of the two RAP summaries was not signed by the RN assessment coordinator or the person completing the care planning decision. 4. Review of the 8/19/05 annual MDS assessment for resident #34 revealed there were two RAP summary reports completed. Review further revealed only one of the two was signed by the RN assessment coordinator and the person completing the care planning decision. 5. Review of the 2/3/06 significant change MDS assessment for resident #5 revealed there were three RAP summary reports. Review further revealed only one of the three was signed by the RN assessment coordinator and the person completing the care planning decision. 6. Review of the 1/27/06 annual MDS assessment for resident #26 revealed two RAP summaries. One summary listed only nutritional status as being triggered. The other summary listed all other areas triggered. Section VB4 of the nutritional status RAP summary was not signed. Interview with the DON on 4/6/06 at 10:20 AM confirmed the above. According to the Revised Long-Term Care Resident Assessment Instrument User's Manual (version 2.0, December 2002), section V contains the location and date of assessment	F 278		

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F 278	Continued From page 14	F 278		

documentation. In addition, section VB1 and VB2 is the signature of the registered nurse (RN) coordinating the assessment process, and the date the process was completed. Section VB3 and VB4 is the signature of the staff person facilitating the care planning decision-making and the date the care planning decision column was completed.

For findings related to the lacking attestation signatures:

1. Review of the 3/24/06 annual MDS . assessment for resident #6 revealed the signature of the person responsible for completing section "K" was missing from Section AA9. In addition, the communication module, the ADL physical function module, the urinary incontinence module, the falls module and the pressure ulcer module all were signed by the MDS coordinator with an inaccurate future date of 4/24/06 (review of the document was completed on 4/6/06).

2. Review of the admission MDS dated 01/17/06 for resident #11 revealed Section AD, Background (Face Sheet) Information at Admission, was not signed or dated. Further, this MDS did not indicate the identity of the individuals responsible for completing Sections D, K, and L.

3. The quarterly MDS dated 11/19/05 for resident #36 failed to identify of the individuals responsible for completing Sections D and L.

4. The most recent MDS assessment for resident #40 was a quarterly assessment dated 1/20/06. Review of section AA9 revealed no signature

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attestations for sections "K" and "L".

5. The most recent MDS assessment for resident #43 was a quarterly assessment dated 12/23/05. It lacked signature attestations for sections "A", "D", "K", and "L".

6. The most recent MDS assessment for resident #46 was a significant change RAI assessment dated 11/16/05. It lacked attestations for sections "A", "D", and "L".

7. Review of the 11/4/05 annual MDS assessment for resident #5 revealed section AA9 lacked signatures for the areas of A, B, D, E, F, K and L. In addition, review of the 2/3/06 significant change MDS assessment revealed sections A, D, and L were not signed.

8. Review of the 9/9/05 annual MDS assessment for resident #13 revealed section AA9 lacked signatures in the area of A, D, K, and L. In addition, review of the 12/9/05 quarterly MDS assessment revealed the areas of A, D, K, and L were not signed

9. Review of the 8/19/05 annual MDS assessment for resident #34 revealed section AA9 lacked signatures in the areas of A, D, K, and L. Review of the 11/18/05 quarterly MDS assessment revealed sections D and L lacked signatures, Finally, review of the 2/17/06 quarterly MDS assessment revealed sections D, K, and L were missing signatures.

10. Interview with the MDS coordinator on 4/4/06 at 4:30 PM revealed some sections did get missed when section AA9 was signed.

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F 278	Continued From page 16 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."	F 278		
F 286 SS=D	483.20(d) RESIDENT ASSESSMENT - USE 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 ensure the previous fifteen months of Minimum Data Set (MDS) assessment information was in the active medical records for five (#11, #13, #36, #40, #43)) of 11 open sample residents. The findings were: 1. Review of the MDS assessments for resident #13 revealed the most recent quarterly assessment in the medical record was dated 12/9/05. The next required quarterly assessment, due on 3/3/06, was in an office that was not accessible to staff on a 24 hour basis. Interview with the MDS coordinator on 4/6/06 at 8:15 AM revealed she was in the process of moving all MDS information into the active records but was not yet finished.	F 286	This facility will ensure that all resident assessments completed within the previous 15 months are maintained in the resident's active record. This will be accomplished by: All assessments with missing sections will be evaluated. Missing sections will be placed in charts as they come due for review, or a new one will be completed. This will include residents #13, #40, #42, #36, and #11. MDS nurse will implement a procedure to move all records to the appropriate filing, i.e. chart, file cabinet at desk, or MDS office. All MDS disciplines will be re-inserviced of the MDS procedures to ensure timely and accurate completions and appropriate filing. DON, Administrator, Medical Records to monitor. QA to review quarterly for trends.	6/2/06

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2. Medical record review for resident #40 revealed the most recent resident assessment was a quarterly MDS assessment dated 10/21/05. No other quarterly assessments were found in the record. In addition, the most recent full assessment, a significant change resident assessment instrument (RAI), dated 4/23/05, was incomplete. The assessment lacked section "V" and additional assessment information for areas in this section which required further assessment. Interview and record review with the MDS coordinator on 4/4/06 at 4:30 PM revealed the information was not in the record and she believed it was in her desk.

3. Medical record review for resident #43 revealed the resident's most recent full assessment, a significant change RAI, was dated 9/23/05. Further review of the assessment revealed section "V" was missing, as well as, additional assessment information for this section. Interview with the MDS coordinator at 11:00 AM on 4/5/06 revealed the assessment information might be in her desk. At 2:00 PM on 4/5/06, the MDS coordinator located the assessment information and placed it in the record.

4. Review of the medical record for resident #36 on 04/04/06 at 11:30 AM revealed a required quarterly MDS was missing from the record. The director of nursing (DON) stated in an interview conducted 04/04/06 at 3:35 PM, the missing quarterly MDS was completed, just not yet posted in the record. Subsequent review of the resident ' s medical record on 04/05/06 at 8:56 AM revealed a quarterly MDS dated 02/17/06; the quarterly MDS was missing from the record for 47 days

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F 286	Continued From page 18 following completion. 5. Review of the medical record for resident #11 on 04/06/06 at 2:10 PM revealed a required quarterly MDS was missing from the record. The DON stated in an interview conducted 04/06/06 at 4:20 PM the missing MDS was completed within the required timeframe, but had not been added to the resident ' s medical record. Subsequent review of the resident ' s medical record on 04/07/06 at 8:15 AM revealed a quarterly MDS dated 02/10/06; the quarterly MDS was missing from the record for 54 days following completion.	F 286		
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, facility documentation, medical record review, and staff and resident interview, the facility failed to ensure seven (#5, #11, #13, #34, #36, #40, and #43) of 11 sample residents, who required assistance, received their baths as scheduled. The findings were: 1. Review of the bath schedule for resident #5 revealed s/he had baths scheduled twice per week on Tuesdays and Saturdays. Review of the bath documentation for March revealed the resident received a bath on 3/7/06 and not again	F 312	This facility will ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by: The facility has a policy that all residents will receive at least two (2) showers or baths per week or more per request of resident. All showers or baths are to be documented. Although the policy is in effect, documentation may be lacking or resident may refuse. Staff will be re-inserviced on the importance of personal hygiene and grooming. This inservice will include the procedure for documentation and the need to involve charge nurse when resident may refuse or a change in bath schedule occurs.	6/2/06

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F 312	Continued From page 19 until 7 days later on 3/14/06. Further review revealed the resident received a bath on 3/18/06 and then not again until 3/28/06, which was ten days later. 2 Review of the medical record for resident #11 revealed a care plan dated 12/28/05 (reviewed 01/13/06) documented a plan for three baths a week. Review of the resident's bath and skin assessment form revealed the resident received a bath on 03/14/06 and 03/28/06. 3. Review of the bath schedule for resident #13 revealed s/he only received two baths during the month of March 2006. 4. Review of the bath schedule for resident #34 revealed s/he had baths scheduled twice weekly on Wednesdays and Saturdays. Review of the bath documentation for March and April revealed the resident received a bath on 3/29/06 and as of 4/6/06 (8 days) had not received another one. Interview of the resident on 4/4/06 at 8:45 AM revealed s/he sometimes did not receive a bath because the facility was short-staffed. 5. Review of the medical record for resident #36 revealed a care plan dated 11/19/05 (reviewed 01/26/06) documented a plan for two baths a week. Review of the resident's bath and skin assessment form revealed the resident received baths on 03/02/06, 03/11/06, 03/13/06, 03/16/06, 03/27/06, and 03/30/06. 6. Interview with resident #40, on (Tuesday) 4/4/06 at 10:09 AM, revealed the resident did not receive all of his/her scheduled baths. The resident stated he/she should be bathed three	F 312	F312 (Continued from page 19) DON and charge nurse to monitor baths on a daily basis for completion. Bath schedules for residents #5, 11, #34, 13, 34, 40, and 43 will be reviewed and adjusted to ensure they receive baths. The care plan will reflect the accurate information and baths will be documented. For all Residents DON and Administrator to monitor compliance through daily audit for one month then weekly. Activity Director to review compliance at monthly resident council meeting for three months and then quarterly. QA committee to review trends	6/2/06

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F 312	Continued From page 20 times a week, but would get baths every six to seven days. The resident stated his/her last bath was last Wednesday and further stated, "I smell and I don't like it." Review of the resident's bath and skin assessment form revealed the resident's last bath was 3/27/06, which was Monday, eight days since the resident's last bath. Further review revealed the resident did receive baths on 3/4/06, 3/8/06, 3/10/06, 3/14/06, 3/18/06, and, six days later, on 3/24/06. Review of skin problem identification sheets revealed the resident did receive an additional bath on 3/16/06 which was not documented on the other form. Review of the resident's medical record revealed a care plan (review date 3/22/06), which documented the resident's bath schedule as: shampoo and bathe two times a week; Century Tub (tub bath) one time a week. 7. Interview with resident #43 at 9:03 AM on (Tuesday) 4/4/06 revealed the resident received a bath about once per week. Review of the resident's medical record revealed a care plan (review date, 1/13/05) which documented a bath plan of twice a week. Review of the resident's bath and skin assessment form revealed the resident received a bath on 3/2/06, 3/7/06, 3/10/06, 3/13/06, seven days later on 3/20/06, seven days later on 3/27/06, and on 3/31/06. When interviewed on 4/5/06 at 1:15 PM, the director of nursing (DON) stated either the baths were not done or they were not documented. The DON stated bath documentation was on the bath and skin assessment form and the only additional information available were skin identification forms used by the certified nurse aides.	F 312		

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F 318 SS=E	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure restorative exercises were provided for six (#5, #11, #13, #18, #26, #34) of eleven sample residents. The findings were: Interview of the facility administrator, director of nursing (DON) and restorative aide on 4/6/06 at 9:50 AM revealed there was no designated restorative aide during the month of February 2006. Interview further revealed restorative services were provided by activities staff and other certified nurse aides when they had time. Interview with the DON on 4/6/06 at 10:30 AM revealed the activities staff did not have training in providing restorative exercises. Furthermore, review of restorative records revealed activities staff only provided residents with group exercise and not individualized range of motion, stretches or other prescribed restorative therapy. Interview with the facility administrator on 4/6/06 at 9:50 AM revealed a restorative aide had been hired the first of March. Review of the restorative program book for March 2006 revealed restorative exercises were provided only sporadically for some residents. Interview with the restorative aide at 9:50 AM on 4/6/06 revealed	F 318	This facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion through a comprehensive assessment of a resident. This will be accomplished by: The restorative program will be evaluated and the following changes made: 1. Restorative Aide will receive in-service training on restorative program. 2. Restorative Aide will be scheduled at least 4 times per week. 3. Physical Therapy contractor will be involved in weekly restorative meetings to include review of resident's care plan. 4. All referrals will be reviewed weekly by Administrator and DON. 5. Individual programs will be reviewed at PCPC meetings. 6. Restorative Aide and Activity Director will receive training for more effective exercise programs. All restorative programs including MDS, referral and restorative	6/2/06 6/2/06

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F 318	Continued From page 22 there was no list of residents who required restorative therapy. When the surveyor asked how the restorative aide knew who she was to provide restorative therapy for, she said she just knows and checks the restorative book. However, review of the restorative book revealed there was no planned days of therapy for residents. The following concerns with the restorative program were identified: a. Review of the 11/4/05 annual Minimum Data Set (MDS) assessment for resident #5 revealed s/he had partial loss of range of motion of the neck, arm, hand and leg on both sides. Review of the mobility assessment completed by physical therapy on 12/20/05 revealed s/he required range of motion exercises of the upper and lower extremities, sit to stand exercises, ambulation, walk and dine ambulation, and chair exercises to increase his/her strength and to prevent a decline in mobility. Review of the restorative referral revealed exercises were recommended 4 times per week. Review of the restorative nursing daily documentation for 1/06 revealed the resident received lower extremity range of motion exercises only twice (1/10/and 1/29), ambulation twice (1/10 and 1/20), and sit to stand exercises 7 times (1/3, 1/4, 1/5, 1/9, 1/10, 1/11, 1/13/06) in 31 days. Review revealed there was no documentation of restorative therapy during the month of February 2006. Finally, review of the 3/06 restorative documentation revealed the resident received lower extremity range of motion exercises four times, ambulated eight times, had sit to stand exercises 11 times, did walk and dine 9 times, and chair exercises 11 times in 31 days; not the recommended sixteen times per month. Finally, review of the medical record revealed as of 4/6/06 there was no	F 318	F318 (Continued from page 22) documentation will be reviewed for Residents #5, 11, 13, 18, 26, and 34. New or more appropriate plans will be implemented to reflect the needs of the resident. Restorative program will be reviewed weekly by DON, Administrator, and Physical Therapy Assistant. Any inconsistencies or areas of concern will be corrected. QA will review trends quarterly.	

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documentation of restorative therapy in April 2006.

b. Review of the restorative referral dated 2/3/06 for resident #11 revealed s/he required walk and dine daily. Review of the restorative nursing daily documentation form for January 2006 revealed the resident had walk and dine only twice (1/3, 1/17) during the 31 days. Review of the restorative records revealed there was no evidence of the walk and dine program during the month of February 2006. Review of the March 2006 restorative records revealed the resident was ambulated only four times during the 31 days. Finally, review of restorative records revealed as of 4/6/06, revealed there were no restorative exercises completed during the month of April, 2006.

c. Review of the 12/6/05 restorative referral for resident #13 revealed s/he required contracture management and strengthening exercises (active assisted range of motion to both lower and upper extremities) one to three times per week. Review of restorative records revealed there was no evidence exercises were completed during the month of February 2006. Review revealed during March 2006 exercises were completed only twice (3/15, 3/22). Review revealed as of 4/6/06, there was no evidence exercise were completed during April 2006.

d. Review of the 12/6/05 restorative referral for resident #18 revealed s/he required passive range of motion for both upper extremities for contracture management one to three times per week. Review of restorative records revealed exercises were provided only twice (3/10, 3/20) during the month of March 2006. Review revealed there was no evidence exercises were provided during the month of February 2006, and as of

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F 318	Continued From page 24 4/6/06 none during the month of April 2006. e. Review of the 12/6/05 restorative referral for resident #26 revealed s/he required passive range of motion exercises to both upper and lower extremities one to three times per week. Review of the restorative record revealed there was no evidence any restorative exercises were provided during the months of February, March, or to date (4/6) in April 2006. f. Review of the 8/19/05 annual, and 11/18/05 and 2/17/06 quarterly MDS assessments for resident #34 revealed s/he had limitation with partial loss on both sides of the neck, arm, hand and foot. Review of the 12/20/05 mobility assessment revealed s/he required joint mobilization, range of motion, and warm water packs for contracture management. Review of the restorative records revealed there was no evidence restorative therapy was provided during the months of January, February, March, and to date in April 2006. Interview with the director of nursing administrator, and restorative aide on 4/6/06 at 9:50 AM confirmed no restorative therapy was provided.	F 318		
F 323 SS=E	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: Based on observation and staff interview, the facility failed to provide a hazard-free environment in one of three tub/ shower rooms. The findings	F 323	This facility will ensure that the resident environment remains as free of accident hazards as is possible. This will be accomplished by: Maintenance replaced the switch on April 14, 2006. Maintenance will monitor the switch for effectiveness on daily rounds. Safety and QA committees to review for any trends.	u/u/06 4/14/06

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F 323	Continued From page 25 were: Observations on 4/4/06 at 9:47 AM, on 4/5/06 at 1:48 PM and again on 4/6/06 at 8:49 AM revealed the wall mounted electric switch controlling the ceiling fan/ overhead space heater in the resident's tub room had loose electrical contact points in the interior of the switch. Interview with certified nurse aid #3 on 4/6/06 at 8:55 AM revealed she was unaware the loose switch constituted a faulty electrical connection.	F 323		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures during four of four survey days, the facility failed to maintain effective infection control measures intended to prevent the transmission of potentially infectious agents. The findings were: 1. Observation in the resident dining room on	F 441	This facility will ensure that an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection is established and maintained. This will be accomplished by: 1. Nurse #1, and all nursing staff. will be in-serviced on proper infection control procedures and the purpose of hand sanitizer. 1a & 1b. Although the documentation was intermittent, the facility has a policy for shower and tub cleaning in between residents. Staff will be re-inserviced on the importance of infection control and of cleaning and disinfecting the tub and shower rooms. A new documentation form has been implemented. DON, Charge nurse, and administrator to monitor by	6/2/06 6/2/06

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F 441	Continued From page 26 04/03/06 at 4:40 PM revealed licensed practical nurse (LPN)# 1 repeatedly coughed into her right hand while preparing resident medications for pass. The LPN did not sanitize his/her hand after coughing into it, but continued to handle medication cups, drinking cups, and open/pour/close Med Pass 2.0 supplement for residents. A bottle labeled "hand sanitizer" was available on the medication cart. The following concerns were noted with cleanliness and sanitation of bathing facilities: a. Observation on 04/05/06 at 9:10 AM revealed seven pieces of a dark brownish-black material on the floor and in the drain of the shower room adjacent to resident room 23. The observed matter had the physical characteristics (smell, texture, size, surface desiccation) of fecal material. Interview with certified nurse aide (CNA)# 4 on 04/05/06 at 9:25 AM confirmed the presence of fecal material in the shower. The CNA stated a lack of awareness as to when the shower was last used or last cleaned; it was discovered at this time that the facility did not document cleaning of the shower rooms. Interview with the director of nursing (DON) on 04/05/06 at 9:30 AM confirmed the presence of fecal material in the shower and confirmed a lack of documentation to indicate when the shower room was last cleaned. b. Observation on 04/06/06 at 9:35 AM revealed nine small fragments of a dark, crusty material in the bathing tub (Century Tub) located in the tub room adjacent to resident room 17. The observed debris was dry, hard to the touch, and brittle; it appeared to be nonmetallic. Interview	F 441	F441 (Continued from page 26) making shift rounds and checking the signature sheet to the tub and shower rooms. QA will review the outcome and address any trends. 1c. The facility policy is and has been that tubs and showers will be cleaned and disinfected after each use. However, the interview here was misunderstood as DON and administrator do not condone disinfecting tub only at and after the last use of the day. All nursing staff will be in-serviced on the policy. 2. The facility infection control policies will be reviewed and updated to reflect the facility's present procedures. The management team, QA committee, and Medical Director will sign off and date the review. DON and Administrator to monitor the yearly review or update procedure.	6/2/06 6/2/06

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with the CNA #1on 04/06/06 at 9:45 AM failed to reveal the last time the tub was cleaned. Documentation found in the tub room indicated the tub was last used and cleaned on 3/9/06. Review of the facility bathing log book showed multiple residents were bathed in the tub between 3/16/06 and 4/2/06; there was no documented evidence of tub cleaning during this interval.

c. Interview with the facility administrator and the DON on 04/05/06 at 3:10 PM revealed the facility policy was that all showers and tubs would be cleaned between residents and disinfected after the last use each day. A paper sign posted in the tub instructed staff to "Always clean and disinfect after each use."

2. Review of the facility policies and procedures for infection control revealed an in-service date of June 1995. Interview with the facility administrator on 4/07/06 at 10:50 AM revealed a lack of document reviews, revisions, or updates of these policies and procedures since their initial implementation in 1995. As such, there was no documentation to conclude the faculty's infection control plan incorporated current standards of practice found in the Centers for Disease Control & Prevention (CDC) Guideline for Hand Hygiene in Healthcare Settings, 2002 update, or the Occupational Health & Safety Administration 2000 revisions to the Occupational Exposure to Bloodborne Pathogens Standard (29 CFR 1910.1030). It was further noted the infection control plan did not document review and approval by the facility medical director.

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F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to handle and store soiled linens in a manner that prevented the cross contamination of dirty and clean linens and minimized the potential spread of infection. The findings were: 1. Observation on 04/05/06 at 9:05 AM revealed a linen cart stored in a shower room adjacent to resident room 23. The cart contained soiled resident linens and clothing. At least one of the items in the cart had a distinct smell of urine. Clean towels were also present on an open shelf in the shower room. 2. Observation on 04/06/06 at 9:25 AM revealed a covered soiled linen cart stored in a shower room adjacent to resident room #7. The cart contained soiled sheets, pajamas and linens, some of which were wet. Clean towels were also stored in the room. 3. The shower rooms were not maintained under negative air pressure to minimize aerosol dispersion out of the room. The rooms were equipped with an exhaust fan controlled with a wall switch, but the fans were switched off during the two observations. 4. Interview with the facility administrator and the DON on 04/06/06 at 1:30 PM revealed the facility was accustomed to using the shower rooms for	F 445	This facility will ensure that linens are handled, stored, processed, and transported so as to prevent the spread of infection. This will be accomplished by: The facility's soiled under cart storage procedure will be reviewed and changes made to prevent cross contamination by the following: 1. Carts will be appropriately stored in the dirty utility room. 2. Staff will be in-serviced on the need to maintain infection control and also on the storage of carts. They will be also in-serviced on the importance of emptying the cart frequently. DON and Administrator to monitor for compliance. Safety and ~~AQ~~ QA committees to review trends and need for any changes.	6/2/06 6/2/06

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F 445	Continued From page 29 temporary storage of soiled linen carts and had not fully considered the infection control implications of the practice.	F 445		
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS 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 on observation and staff interview, the facility failed to provide a safe and sanitary environment for residents and staff. The findings were: Observation on 4/5/06 at 11:22 AM revealed low voltage wires wrapped around and taped to a hot water pipe running near the ceiling in the boiler room. Interview with the facility administrator on 4/5/06 at 11:23 AM and the facility maintenance manager on 4/5/06 at 3:33 PM revealed neither was aware this represented a potential safety risk. Observation on 4/5/06 at 2:11 PM revealed a fan vent cover was missing from the ceiling mounted air vent in the oxygen storage closet in the main hallway. Interview with the facility manager on 4/6/06 at 12:33 PM revealed she was unaware the cover was missing.	F 465	This facility will ensure that a safe, functional, sanitary, and comfortable environment for residents, staff and the public is provided. This will be accomplished by: Maintenance and Administrator understood the wire to be a sensor wire connected to the pipe as part of the system. Upon further discussion, the wires were adjusted and fastened away from the pipe on the day of the survey. Maintenance will monitor for other wire placement. Safety committee will review for compliance. The oxygen closet vent cover was replaced on April 26, 2006. Maintenance will monitor on weekly rounds and repair or replace if needed. Safety Committee and QA committee to review for trend.	4/2/06 4/6/06 4/26/06

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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 staff interview and review of personnel files, the facility failed to ensure the two step tuberculin (TB) test was performed for three (#1, #3, #4) of five employees whose files were reviewed. The findings were: 1. Review of the personnel file for employee #1, hired on 1/2/06, revealed the employee had a TB test on 12/30/05. Further review revealed there was no evidence of a negative TB test within the past year and no second step follow-up test was performed. 2. Review of the personnel file for employee #3, hired on 1/25/06, revealed she had a TB test on 1/25/06. Further review revealed there was no evidence of a negative TB test within the past year and no second step follow-up test was performed. 3. Review of the personnel file for employee #4, hired on 1/19/06, revealed she had a TB test on 1/19/06. Further review revealed there was no evidence of a negative TB test within the past year and no second step follow-up test was performed. 4. Review of the facility's undated policy entitled	F 492	This facility will ensure that it is operated and services provided 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 this facility. This will be accomplished by: The tuberculin (TB) test for employees #1, 2, 3, and 4 will be reviewed and followed up as needed to reflect the facility policies. DON and Administrator to monitor all new employees to ensure TB testing is done correctly and timely. QA to monitor at quarterly meetings.	6/2/06 6/2/06

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F 492	Continued From page 31 "Associate PPD Skin Testing" revealed the following instructions: "Two-step testing is used for initial screening unless you provide documentation of a negative PPD test in the preceding 12 months." "Two-step testing means that if the first test is negative, a second test will be given 1-3 weeks later." Interview with the administrator on 4/5/06 at 2:30 PM confirmed this policy was current and the employees should have had a second TB test.	F 492		
F 513 SS=D	483.75(k)(2)(iv) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure results of an electrocardiogram (EKG) was in the medical record for one (#34) of twelve sample residents. The findings were: Review of the medical record revealed a physician's telephone order for an EKG on 3/25/06 for #34. Review of the entire medical record revealed the results of the EKG were not in the medical record. Interview with the director of nursing on 4/6/06 at 8:30 AM revealed the EKG was completed, but the results were not in the facility.	F 513	This facility will ensure that signed and dated reports of x-ray and other diagnostic services of residents are filed in the resident's clinical record. This will be accomplished by: Resident #34 had completed the EKG. The facility obtained the results from the hospital and placed in the chart. The facility will implement a follow-up policy to ensure all reports are received in a timely manner. Medical Records Supervisor, DON, and charge nurse will monitor for compliance. QA committee will review quarterly and address any trends.	5/22/06