MENT OF HEALTH AND H AN SERVICES
S FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2007
FORM APPROVED
OMB NO. 0938-0391

IF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/19/2007

F PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the physician for 1 (#13) of 2 sample residents with a demonstrated need to alter treatment. The	F 157	F157 NOTIFICATION OF CHANGES. This facility strives to notify physicians with needs to alter treatment. This is evidenced by the following: Resident #13 physician was notified on 8/13/07 of their high blood sugars. A policy on Notification of Significant Changes has been implemented. Nursing staff will be inserviced on this policy which included notification of physician for high blood sugars with documentation of the notification and any follow up orders from the physician. The DON will monitor the results and report them to the Administrator to be submitted to the quarterly QA meeting.	8/31/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Ann Mills — TITLE: RN — (X6) DATE: 8/13/07

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 157	Continued From page 1 findings were: Review of the admission face sheet and physician's orders showed resident #13 was an insulin dependent diabetic. According to the June 2007 recapitulation of orders sheet, staff were to notify the physician if the resident's blood sugar was above 400. Review of the June 2007 blood sugar tracking record showed the resident's blood sugar was 412 on 6/4/07. Review of the medical record showed no evidence the physician was notified of the elevated blood sugar. On 7/18/07 at 12:50 PM, the acting director of nursing (DON) verified the physician had not been notified.	F 157		
F 164	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information	F 164	F164 PRIVACY AND CONFIDENTIALITY This facility strives to provide personnal privacy as well as a secure confidential medical record for all residents. All nursing staff will be inserviced on the importance of assuring resident #44 and all other residents are completely covered to and from the	

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F 164	Continued From page 2 contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide personal privacy for one (#44) sample and one (#28) non-sample resident. In addition, observation at one of one nurses' stations revealed confidential medical records were not secure. The findings were: 1. Observation on 7/17/07 at 2 PM revealed resident #44 was being transported in a shower chair from the shower room to the resident's room by certified nurse aide (CNA) #4. The resident's upper body and legs were covered with blankets, but the resident's buttocks were exposed underneath the shower chair. Interview on 7/19/07 at 9:45 AM with the nursing home administrator revealed the facility's expectation was that when residents were transported to and from their rooms to the shower room, they would be completely clothed. 2. Observation on 07/18/07 at 8:15 AM revealed CNA #7 holding a dressing gown and standing next to resident #28 in the resident's room. The door to the room was open. The resident was seated in a wheelchair and partially unclothed, exposing private body parts. When the CNA noticed the surveyor walking past the room, the CNA closed the door. An attempt to interview the resident on 7/18/07 at 9:03 AM, revealed the resident was unable to communicate.	F 164	bathing areas. All nursing staff will be inserviced on the importance of protecting resident #28 and all other residents privacy and dignity by closing doors and pulling curtains during cares. The DON will monitor for compliance. Any non-compliance will be reported to the Administrator to be submitted to the quarterly QA meeting.	8/31/07

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F 174	Continued From page 4 private telephones were required to use a facility wall phone in a heavily traveled hallway opposite room #27. The majority of residents agreed their conversations could be heard by anyone walking down the hall at the time. Furthermore, interview with resident #39 on 7/18/07 at 4:48 PM revealed most residents' conversations were easily heard from his/her room which was directly opposite the wall phone. The resident further stated "I don't think I should be listening to those conversations." Interview with staff CNA #3 on 7/19/07 at 10:10 AM verified that the wall phone was the only phone available to residents unless the resident had a private phone.	F 174	F174 TELEPHONE This facility strives to ensure that all residents have a reasonable and private access and use of a telephone. This is evidenced by the following:	
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to assess 2 (#14, #23) of 3 sample residents who self-administered medications in order to determine whether or not it was safe. The findings were: 1. According to the 3/29/07 significant change Minimum Data Set (MDS) assessment, resident #23 was assessed as "modified independence (some difficulty in new situations)" with cognitive skills for daily decision-making tasks. Observation on 7/17/07 at 3:27 PM revealed the resident had a scabby area on the outside of his/her right ear. During the observation the resident stated s/he	F 176	Although residents had and still do have access to the social service office phone, the hall phone will be moved to a new location to ensure residents have privacy. The Administrator will review the success of the relocation of phone at the resident council monthly for three months then quarterly thereafter. The results will be submitted to the quarterly QA meetings 8/31/07	

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F 176	Continued From page 5 applied a cream to the ear, and pointed to a small jar on the bedside table. The cream was labeled "AdaptSkin." A second observation on 7/18/07 at 3:40 PM showed a container of AdaptSkin and an unlabeled jar of ointment, identified by registered nurse (RN) #10 as A&D ointment with Zinc, were on the resident's bedside table. At this time the resident stated, and the RN confirmed, that the resident personally applied the ointment. Review of the entire medical record failed to reveal an evaluation by the interdisciplinary team to determine that self-administration of any type of medication was a safe practice for this resident. On 7/18/07 at 3:33 PM, the acting director of nursing confirmed the lack of an evaluation. 2. Review of the 5/17/07 admission Minimum Data Set (MDS) assessment showed resident #14 was assessed as having "modified independence" with cognitive skills for daily decision-making tasks. Review of the physician's 6/13/07 orders showed the resident was receiving Fentanyl, Ativan, and Wellbutrin. Further review showed the physician also ordered Orajel for the resident to keep at the bedside and use as needed for oral pain. Review of the medical record showed no evidence the interdisciplinary team had evaluated the resident to determine if self-administration of medications was a safe practice for him/her. On 7/19/07 at 2:45 PM, the administrator verified there lacked evidence of the facility a self-medication evaluation for this resident.	F 176	F176 SELF ADMINISTRATION OF DRUGS This facility strives to ensure that all residents will be assessed for the possibility of self administration of medications in order to determine whether or not it is safe. This is evidenced by the following: Resident #23 and #14 will be assessed for their ability to safely administer drugs in order to determine resident ability to continue to keep ointment and oragel at bedside. Nurses will be inserviced on the procedure and importance of assuring all residents are assessed for self administration of drugs. Also the need to monitor daily and document usage and need for continuation of medication. The DON and medical records will audit all new admits and all other residents quarterly for presence of self	
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.	F 221		

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F 221	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure physical restraints were appropriately used for two (#25, #46) of four sample residents who were restrained. The findings were: 1. Observation on 7/17/07 at 1:40 PM revealed resident #46 was lying in bed with a full side rail in the raised position. The opposite side of the bed was pushed up against the wall. At 3:50 PM, CNA #4 lowered the side rail, in order to change the resident's disposable brief and then raised the rail back up. Review of the resident's significant change Minimum Data Set (MDS) assessment dated 3/9/07, showed the resident was restrained with a side rail daily. Further medical record review showed no evidence that an assessment for use of the side rail was done. Furthermore, the resident's care plan showed the side rail was supposed to have been discontinued on 5/10/06. Interview with the director of nursing on 7/18/07 at 1:28 PM confirmed the side rail restraint should not have been currently used. 2. Observation on 7/16/07 at 1:15 PM during the initial tour of the facility and on 7/16/07 at 7:45 PM revealed resident #25 had full side rails on his/her bed. A subsequent observation on 7/17/07 from 1:35 PM to 4:10 PM revealed the resident was in bed positioned on his/her back with full side rails raised on both sides of the bed. Review of the medical record face sheet showed the resident was admitted to the nursing home on 2/12/07. Further review showed the medical record did not contain any Minimum Data Set	F 221	administration of drugs assessments. The results will be presented to the Administrator to be submitted to the quarterly QA meeting. F221 PHYSICAL RESTRAINTS This facility strives to ensure all residents are assessed for the appropriate need for physical restraints. This will be evidenced by the following: Resident #46 will be have a comprehensive side rail assessment completed and added to the medical record. The full side rail will be removed and the recommendations of the assessment will determine need. Resident #25 will have a comprehensive side rail assessment and comprehensive restraint assessment to determine the least restrictive restraint required and added to the	8/31/07

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F 221	Continued From page 7 (MDS) assessments, or any other assessment to justify the use of the restraint for this resident. Interview with the director of nursing on 7/18/07 at 2:10 PM confirmed an assessment for the use of the side rails was not done.	F 221	medical record. The care plan will reflect the results and added to the medical record. The DON will monitor and the results will be presented to the Administrator to be submitted to the quarterly QA meetings.	8/31/07
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 and staff interview the facility failed to promote various aspects of dignity during three of four meal service observations. In addition, based on observation, facility staff failed to knock prior to entering 5 resident rooms. The findings were: 1. Observation on 7/17/07 at 5:45 PM showed the meal for non-sample resident #43 was on the table waiting for the resident. Two other residents were already at that same table, eating. At 6:10 PM the activity director guided resident #43 from the hallway to the table where his/her meal had been sitting, uncovered, for 25 minutes. When seated, staff did not offer to re-heat the resident's tomato soup. In addition, the two residents who were previously eating at the table were finished and were no longer in the dining room. However, the used plates, utensils, and cups remained on the table. The resident had to eat his/her meal at the dirty table with no effort from staff to bus the dirty dishes. 2. Observation of the evening meal on 7/16/07	F 241	F224 DIGNITY This facility strives to ensure that the they 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 is evidenced by the following. The LPN, SSD, and all staff will be inserviced on the importance of maintaining dignity and privacy for residents # 9, #22, #25, #32< and #42 as well as all other residents when entering these rooms by knocking and	

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F 241	Continued From page 8 from 5:50 PM to 6:15 PM revealed nurse aide #18, who was in training, stood, while she assisted residents #28 and #32 with their meal. During the observation, the administrator asked the nurse aide why she was standing instead of sitting on the inside of the horseshoe-shaped table. The aide's response was that it was easier. On 7/17/07 at 6 PM the administrator stated the facility's expectation was that staff would sit while assisting residents with their meals. 3. Observation showed certified nurse aide (CNA) #1 stood from 7:58 AM until 8:22 AM (24 minutes) while assisting resident #31 with his/her meal. The resident required total assistance. 4. Observation during the lunch meal on 7/16/07, the breakfast and evening meals on 7/17/07, and the evening meal on 7/18/07 revealed the meals served to all residents were left on serving trays. Their dishes, glasses, and silverware remained on the trays throughout the meal. 5. While making wound rounds on 7/16/07 from 7 PM to 8:10 PM, observation revealed licensed practical nurse (LPN) #6 walked into the rooms of five (#9, #22, #25, #32, #42) residents without first knocking or asking permission to enter. On 7/19/07 at 4:20 PM the administrator stated her expectation was that staff would knock and wait for permission before entering a resident's room. 6. Observation on 7/17/07 at 4:35 PM showed two CNAs closed the door, pulled the curtain at the foot of the bed, and changed the incontinence brief for resident #25. However, there was a gap between the end of the curtain and the closed door. During the procedure, the social service designee entered the room without knocking and	F 241	waiting for a response. The DON will monitor compliance. Any non-compliance will be reported to the Administrator for further action. All nursing staff will be inserviced on the importance of sitting while assisting residents to eat. The charge nurse and management team will audit the meal daily for one month then weekly thereafter. The results will be presented to the Administrator to be submitted to the quarterly QA meetings. A new dining room experience will be implemented and meals will be delivered to the table and removed from trays for those who do not request nursing staff will be inserviced on the need to cover trays when the residents are not in the dining room after an extended amount of time. Staff will offer to reheat the meals. Dietary will be inserviced on the need to professionally pus	8/31/07

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F 241	Continued From page 9 stated he was "counting concentrators." Upon entering, the SSD glanced through the gap and was able to observe the resident exposed from the waist down.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to honor the personal preferences for sleep schedules in for two (#18, #37) of nine sample residents scheduled to be gotten up in the early morning. The findings were: On 7/17/07 at 7:45 AM two certified nurse aides (CNAs) reported the night shift had a list of residents to get up before the day shift came on at 6 AM. Interview with the acting director of nursing (DON) on 7/18/07 at 1:32 PM confirmed the list. The acting DON stated the residents gotten up at 5 AM were usually those who were awake and wanted to get, up such as resident #18. The following concerns related to failure to follow resident preferences were identified : a. Observation on 7/17/07 at 5 AM revealed resident #18 was awakened by certified nurse aides (CNAs) #13 and #14, showered, dressed for the day, and then placed back in bed. The resident repeatedly stated throughout the	F 242	tables to ensure residents dignity and enhanced dining experience. The Dietary Manager and Administrator will monitor for compliance. The results will be submitted to the quarterly QA meetings. F242 SELF-DETERMINATION AND PARTICIPATION This facility strives to honor the personal preferences for sleep schedules in conjunction with the dining experience. This is evidenced by the following. Resident #18 and #37 will be asked their preferences for being assisted in getting ready in the morning for dining. All residents/family will be given the choice as to wake up times. These times will be put in the resident care plan and added to the medical record. All staff will be informed to these care plan times and inserviced on the	8/31/07

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F 242	Continued From page 10 procedures, "I don't like this. I don't like this." When asked what s/he didn't like, the resident revealed s/he didn't like getting up so early. b. Observation on 7/17/07 at 5:30 AM revealed CNAs #13 and #14 awakened resident #37, got the resident dressed, and then up for the day. When asked if it was his/her choice to rise early, the resident responded, "No."	F 242	importance of the resident's right to wake up times. The administrator will review the morning schedules at resident counsel for three months and then quarterly thereafter. The results will be submitted to the quarterly QA committee.	8/31/07
F 254 SS=B	483.15(h)(3) ENVIRONMENT- LINENS The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation and family and staff interview, the facility failed to maintain a sufficient quantity of linen to provide an adequate supply for 1 (#44) of 11 sample residents who resided in the facility at the time of the survey. The findings were: During a confidential interview on 7/18/07 at 2 PM, a family member stated s/he often had to request clean towels, washcloths, and bed linen for his/her loved one, who was in the facility. Although the specified resident denied any concerns, observation on 7/17/07 at 7:27 AM showed there were no clean chair pads for another resident (#44). Interview with certified nurse aide (CNA) #3 at the time of the observation revealed laundry was not done after 2:30 PM, and the afternoon staff frequently ran out of clean linens until it was completed the next day. In addition, on 7/17/07 at 3:45 PM CNA #16 confirmed they "sometimes" ran out of linens.	F 254	F254 ENVIRONMEN-LINENS The facility strives to provide clean bed and bath linens that are in good condition. This is evidenced by the following. The facility has contracted with an outside contractor to do laundry and housekeeping services. New linen has been ordered on 8/3/07. The linen supervisor will monitor need for continues replacement of lost linen and notify Administrator in order to maintain adequate supply. Adequate staffing hours will be implemented in order to allow clean laundry be available to residents at all times. The DON or designee will monitor for any linen shortages and report findings to the Administrator for further action. QA will review quarterly	8/31/07
F 272 SS=F	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS	F 272		

PRINTED: 08/02/2007
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/19/2007

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

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F 272	Continued From page 11 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, staff interview, and review of policies and procedures, the facility failed to provide comprehensive assessments in various areas for 10 (#5, #13, #14, #23, #24, #25, #32, #41, #44,	F 272	F272 COMPREHENSIVE ASSESSMENTS This facility will ensure that each resident will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each residents functional capacity. This will be accomplished as follows: Resident #25 will have an MDS assessment completed and the nutritional assessment including the caloric and protein needs added to the resident's medical record. All charts will be audited to ensure that each resident has a completed MDS assessment in their medical record and that all residents at risk for skin breakdown and pressure ulcers have the caloric and protein needs documented on the nutritional assessment by a registered dietician. Five resident medical records will be audited by the DON or designee weekly times four weeks then monthly until three consecutive months of 100% compliance is achieved then quarterly thereafter. The audits will be presented to the Administrator to be submitted at the	

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F 272	Continued From page 12 #46) of 11 sample residents who resided in the facility at the time of the survey. The findings were: 1. Review of the medical record face sheet for resident #25 revealed s/he was admitted to the nursing home on 2/12/07 with diagnoses including right heel osteomyelitis, contractures of the joints at multiple sites, protein- calorie malnutrition, and diet controlled diabetes. In addition, physician admission orders dated 2/12/07 showed there was a Stage IV pressure ulcer on the resident's right heel. Further medical record review showed there were no Minimum Data Set (MDS) assessments included in the record. Interview with the acting director of nursing (DON) on 7/18/07 at 2:10 PM confirmed there were no MDS assessments completed for the resident. The most current skin assessment was dated 6/3/07 and showed the resident had three Stage II and one Stage I pressure ulcers. Observation on 7/16/07 at PM confirmed the resident still had a Stage II pressure ulcer on the coccyx area. In addition, the most current nutrition assessment, dated 2/19/07 and completed by the registered dietitian, did not indicate the resident's calorie or protein needs. Refer to F314 for further details regarding this resident's pressure ulcers. 2. Review of the medical record revealed resident #24 was admitted to the facility on 8/10/06 with diagnoses of dementia, renal insufficiency, and a history of a hip fracture. Review of the 9/5/06 admission MDS assessment revealed the presence of several stage I pressure ulcers on the resident's coccyx, buttocks and left heel. The admission MDS also revealed the resident was	F 272	quarterly QA meetings. Resident #24, #44, and #32 have had a current skin assessment completed and added to their medical record. The resident was added to the wound and skin care rounds list for weekly assessments by the wound and skin care committee. A "Skin and Wound Care Protocol" will be presented to the medical staff for approval then put into effect immediately. All resident's with wound and skin care have had a completed comprehensive skin assessment added to their medical record and will have one done periodically hereafter. The DON or designee will audit all medical records for residents with wound and skin care for timely assessment completion. for four weeks then five medical records monthly until three consecutive months of 100% compliance then quarterly thereafter. The audits will be presented to the Administrator to be submitted at the quarterly QA meetings. Resident #13 has had a comprehensive assessment for ADL's, bowel and bladder	8/31/07 5/31/07

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F 272	Continued From page 13 confined to a wheelchair and required total assistance for activities of daily living. The most current skin assessment was dated 12/2/06 and showed the resident's pressure ulcer was healed. However, according to the documentation, a pressure ulcer reappeared sometime in May 2007. A physician's order dated 5/31/07 for a consult with physical therapy in order to care for a "right gluteal stage two decubitus." Review of the most recent entry into the facility's "wound" book dated 6/23/07 confirmed the resident was being treated for a pressure ulcer; however, a skin assessment addressing the new pressure ulcer acquired in May was not found in the resident's medical record. On 7/19/07 at 2:50 PM the administrator stated she was also unable to locate any further information. Refer to F314 for details regarding the pressure ulcers. 3. Observation on 7/18/07 at 1:20 PM revealed resident #32 had two Stage II pressure ulcers on the buttocks. Review of the resident's medical record revealed the most current skin assessment was a Braden Scale pressure ulcer risk assessment completed on 3/15/07. This assessment showed the resident was at low risk for pressure ulcers. Interview with the nursing home director on 7/19/07 at 9:45 confirmed this was the most recent skin assessment. There was a nurses' note dated 7/9/07 at 10 PM which documented, "... stage II on each buttocks...." The facility was unable to provide evidence of an assessment related to the current pressure ulcers. Refer to F314 for additional information related to this resident's pressure ulcers. 4. Observation on 7/18/07 at 2:25 PM revealed resident #44 had two Stage II pressure ulcers on	F 272	incontinence and pain completed and added to their medical record. The ADL, Bowel and bladder incontinence, and pain assessment forms and policy and procedures for each have been reviewed and revised. The nursing department will be inserviced on these policies. All residents who trigger for these comprehensive assessments in these areas have had assessments completed and added to their medical record. The DON or designee will audit all appropriate resident medical records weekly for four weeks then monthly thereafter. The audits will be presented to the Administrator to be submitted to the quarterly QA meetings. Resident #14 has had a comprehensive assessment for urinary incontinence and pressure ulcers completed and added to their medical records. This resident will be included in the bowel and bladder, and skin care audits to monitor for completeness. Resident #23 has had all significant changes made to their comprehensive MDS assessment	8/31/07

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F 272	Continued From page 14 the sacral area. Review of the resident's medical record revealed the most current skin assessment was dated 12/8/06. The first documentation of the current pressure ulcer was a fax sent to the physician on 5/30/07. Interview with the nursing home administrator on 7/19/07 at 9:45 AM confirmed there were no other skin assessments found for this resident. Refer to F314 for further details related to this resident's pressure ulcers. 5. According to the 4/5/07 admission MDS assessment, resident #13 triggered for comprehensive assessments in the areas of activities of daily living (ADLs), bowel and bladder incontinence, and pain. Medical record review showed these assessments were lacking. Interview with the acting DON on 7/18/07 at 10 AM confirmed these assessments had not been completed. 6. Review of the 5/3/07 face sheet showed resident #14 was admitted with diagnoses which included cancer, general muscle weakness, malaise and fatigue, dysphagia), and malnutrition. Review of the 5/17/07 admission MDS assessment revealed resident #14 triggered for comprehensive assessment in the areas of pressure ulcers and urinary incontinence. Review of the Resident Assessment Protocol (RAP) module for pressure ulcers showed none of the aforementioned problems were considered as causative or contributing factors for the Stage II pressure ulcer on the resident's coccyx. Further review of the medical record showed an assessment for urinary incontinence was lacking. Interview with the acting DON on 7/18/07 at 9:50 AM confirmed there were no comprehensive assessments for pressure ulcers or urinary	F 272	with assessments on cognitive loss, communication, mood, ADLs pressure ulcers, and urinary incontinence completed and added to the medical record. All resident medical records have been audited to ensure that all residents with significant changes have had their comprehensive MDS assessments with all required assessments completed and added to their medical record. The DON will audit all resident medical records with significant changes for updated comprehensive MDS assessments for four weeks then monthly until 100% compliance for three consecutive months then quarterly thereafter. The audits will be presented to the Administrator to be submitted to the quarterly QA meetings. Resident #46 has had all significant changes made to their comprehensive MDS assessment with assessments on ADLs, dehydration, nutritional status, urinary incontinence, falls, pressure ulcers, visual function and communication completed and added to their medical record. This resident will be included in the audits	

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F 272	Continued From page 15 incontinence. 7. Review of the 3/29/07 significant change MDS assessment revealed the facility determined resident #23 required comprehensive assessments for cognitive loss, communication, mood, ADLs, urinary incontinence, pain, and pressure ulcers. Review of the assessment information for cognitive loss, ADLs, pressure ulcers, and urinary incontinence showed it was continued from the previous admission and significant change assessments of 7/24/06 and 9/19/06, respectively. During those time periods the resident was admitted for recovery from a hip fracture and later hospitalized for another surgery. Although the current information had changed, no changes were made to the original answers of 7/24/06 for both the 9/19/06 and 3/29/07 significant change assessments. Furthermore, assessments for communication and mood were lacking. At 2:20 PM on 7/19/07, the administrator confirmed the facility was unable to locate assessments for communication and mood status. 8. Review of the 3/9/07 significant change MDS assessment for resident #46 showed triggered areas that required further assessments included: activities of daily living, dehydration, nutritional status, urinary incontinence, falls, pressure ulcers, visual function and communication. Medical record review showed there was no evidence of further assessments completed for the above mentioned areas. On 7/19/07 at 2:50 PM the nursing home administrator verified there were no assessments to be found. 9. As determined by the facility in the 4/8/07 significant change MDS assessment, resident	F 272	f comprehensive MDS assessments for significant changes. Resident #41 has had all significant changes made to their comprehensive MDS assessment with assessments on cognitive loss/delirium, mood, bowel and bladder incontinence, and activities completed and added to their medical record. This resident will be included in the audits of comprehensive MDS assessments for significant changes. Resident #5 has had further assessments on cognitive loss, mood state, ADLs, dehydration, nutritional status, urinary incontinence and psychotropic drug use completed and added to their medical record. All resident medical records will be audited for completion of all MDS triggered assessments. The MDS coordinator or designee will audit all resident medical records with quarterly MDS assessment for completion of all triggered assessments for one year. The audit will be presented to the Administrator to be submitted to the quarterly QA meetings.	8/31/07

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F 272	Continued From page 16 #41 required comprehensive assessments for cognitive loss/delirium, mood, bowel and bladder incontinence, and activities. Review of the medical record revealed comprehensive assessments in these areas were lacking. 10. Review of the 6/2/07 admission MDS assessment for resident #5 showed triggered areas that required further assessments included: cognitive loss, mood state, activities of daily living, dehydration, nutritional status, urinary incontinence and psychotropic drug use. Medical record review showed there was no evidence of further assessments completed for the above mentioned areas.	F 272		
F 274 SS=E	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility	F 274	F274 RESIDENT ASSESSMENT-WHEN REQUIRED This facility strives to ensure a comprehensive assessment of each resident within 14 days after the facility determines that there has been a significant change in the resident's physical or mental condition. This will be accomplished by the following: Resident's #44, #24 will have their MDS assessments updated to reflect all significant changes and added to their medical records. All triggered assessments have been completed and added to the medical record.. This resident will be included in the	

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F 274	Continued From page 17 failed to conduct significant change assessments for 2 (#44, #24) of 6 sample residents who experienced significant changes of condition. The findings were: According to the "Revised Long Term Care Facility Resident Assessment Instrument User's Manual" version 2.0, revised March 2007, "...Any decline in an ADL [activity of daily living] physical functioning area where the resident is newly coded as a 3 [extensive assist], 4 [total dependence], or 8 [activity did not occur] for item G1A [physical functioning and structural problems, self - performance]....Resident's incontinence pattern changes from 0 [continent] or 1 [usually continent] to 2 [occasionally incontinent], 3 [frequently incontinent], 4 [incontinent]...Emergence of a pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher..." A decline in two or more areas would constitute a significant change. The following concerns with failure to complete required significant change assessments were noted: a. Review of the quarterly Minimum Data Set (MDS) assessment dated 12/26/06 for resident #44 revealed s/he required limited assistance for bed mobility (2), extensive assistance for ambulation (3), was continent of bowel (0), and usually continent of bladder (1). Further review of a quarterly MDS assessment dated 3/9/07 revealed the resident declined to a 3 in bed mobility, was an 8 for ambulation, a 3 for bowel continence at 3, and a 3 for bladder continence. Based on these documented declines, the 3/9/07 assessment met the criteria for a significant change assessment. Interview on 7/19/07 at 9:45 AM with the nursing home administrator confirmed the 3/9/07 quarterly assessment	F 274	audit for comprehensive MDS assessments for significant changes.	8/31/07

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F 274	Continued From page 18 should have been a significant change assessment. Medical record review revealed the last MDS assessment completed for this resident was dated 3/9/07. A physician's order dated 5/31/07 showed, "Physical therapy to provide wound care to sacral stage II decubitus." At the time of the survey, six weeks later, a significant change MDS assessment had still not been completed. Observation on 7/18/07 at 2:25 PM confirmed the resident had two stage II pressure ulcers on the sacral area. Interview with the nursing home administrator on 7/19/07 at 9:45 AM confirmed a significant change MDS assessment should have been completed for this resident. b. Review of the medical record revealed resident #24 was admitted to the facility on 8/10/06. Review of the 9/5/06 admission MDS assessment revealed the presence of several stage I pressure ulcers on the resident's coccyx, buttocks and left heel. Review of the medical record revealed the pressure ulcers were healed as of 12/9/06. A quarterly MDS assessment, dated 3/15/07, confirmed the resident remained free of pressure ulcers. However, review of the medical record revealed a physician's order dated 5/31/07, that requested a physical therapy consult to care for a "right gluteal stage two decubitus." Review of the resident's medical record revealed there was no MDS assessment conducted reflecting the change in resident's pressure ulcer status. Interview with the MDS coordinator on 07/18/07 at 3:00 PM verified that a significant change assessment should have been completed.	F 274		
F 276 SS=E	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State	F 276		

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F 276	Continued From page 19 and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete quarterly assessments for 4 (#13, #23, #32, #41) of 11 sample residents who should have had them. The findings were: 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, unless complete RAI assessments are required, quarterly Minimum Data Set (MDS) assessments must be provided every three months for all residents. Every three months is further defined as no more than every 92 days. Failure to follow this requirement was identified for the following residents: a. Medical record review revealed an admission RAI assessment was completed on 4/5/07 for resident #13. However, a quarterly MDS assessment had not been completed as of 7/17/07, an elapsed time of 103 days. b. Review of the significant change RAI assessment for resident #23 revealed it was completed on 3/29/07. However, a quarterly assessment was lacking when the record was reviewed on 7/18/07, 110 days later. c. Medical record review showed resident #32 had an annual MDS assessment completed on 3/8/07. This was the last MDS assessment in the resident's medical record. At the time of the survey, 128 days had elapsed since the last assessment. Interview on 7/19/07 at 9:46 AM with	F 276	F276 QUARTERLY REVIEW ASSESSMENT This facility strives to ensure that all residents have an assessment using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every three months. This will be evidenced by the following: Residents #13, #23, #32, and #41 will have their quarterly RAI completed and added to their medical record. All resident medical records will be audited to ensure that each has had a quarterly RAI and that is added to their medical records. The DON or designee will audit 5 charts per week for four weeks then monthly until three consecutive months of 100% compliance then quarterly thereafter. The audits will be presented to the Administrator and submitted to the quarterly QA meeting. 8/31/07	

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F 276	Continued From page 20 the nursing home administrator confirmed the last assessment completed for the resident was 3/8/07, and a quarterly assessment should have been completed when it was due. d. Record review revealed a significant change RAI assessment was completed for resident #41 on 4/8/07. Further review showed a quarterly MDS assessment was lacking on 7/18/07, a time period which exceeded the allotted 92 days. During an interview on 7/18/07 at 12:40 PM, the MDS coordinator stated if an assessment was not in the record, then she had not done it yet. She also stated all completed assessments were filed, and there was nothing waiting to be finalized.	F 276		
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	F 278	F278 RESIDENT ASSESSMENT This facility strives to ensure that a registered nurse will conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse will sign and certify that the assessments is completed and each individual who completed a portion of the assessment must sign and certify the accuracy of the portion of the assessment. This will be evidenced by the following: Residents #13, #14, #23, #32, #33, #41, and # 44 will have their MDS assessments completed and	)

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F 278	Continued From page 21 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 review of medical records and staff interview, the facility failed to assure assessments were accurate for 7 (#13, #14, #23, #32, #33, #41, #44) of 10 completed open resident records The findings were: 1. Review of the 5/17/07 admission Minimum Data Set (MDS) assessment for resident #14 showed the following inaccuracies: a. "Section AD: Face Sheet Signatures" was not signed or dated. In addition, the date of entry was listed as 5/2/07; the date of admission on the face sheet showed the resident was admitted on 5/3/07. b. Section Vb1 and Vb3 were not signed. Those sections are for the registered nurse (RN) coordinator for the assessment process and the person completing the care plan decision, respectively. Furthermore, neither the care planning decisions or the location of information were indicated. c. In "Section P. Special Treatments and Procedures," the resident was coded as receiving hospice services. However, interview with the acting director of nursing (DON) on 7/16/07 at 3:30 PM revealed no one at the facility was receiving hospice care as that service was not provided. d. Section R2a, the section for the signature of the MDS coordinator, verifying completion of	F 278	updated. All individuals who complete a portion of the assessment will sign and certify the accuracy of their portion. Each will be signed and certified for completion by a registered nurse. These assessments will be added to their medical record. All resident medical records will be audited for completion and accuracy of the MDS assessment and that all individuals who complete a portion of the assessment will sign to certify the accuracy of the assessment and a registered nurse will sign to certify its accuracy and completion. The DON or designee will audit 5 resident medical records per week for four weeks then monthly until three consecutive months of 100% compliance then quarterly thereafter. The audits will be presented to the Administrator to be submitted at the quarterly QA meeting.	8/31/07

PRINTED: 08/02/2007
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OMB NO. 0938-0391

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

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F 278	Continued From page 22 the assessment, was not signed. 2. Review of the 4/5/07 admission MDS assessment for resident #13 revealed Section AD was not signed or dated. In addition, the location of assessment information was not indicated in Section V. 3. Review of the 3/29/07 significant change MDS assessment for resident #23 revealed the following concerns with accuracy: a. Section V lacked the care plan decision for all triggered areas or the location of assessment information for some of the comprehensive assessments. b. The resident was coded as no significant weight loss. However, according to the record, the resident lost over 20 pounds in 6 months, a loss of more than 10 percent in 180 days. 4. Review of the 04/19/07 quarterly MDS assessment for resident #33 showed that the "Section R. Assessment Information" lacked the signature of the person who coordinated the assessments. Interview with the MDS coordinator on 07/16/07 at 4 PM confirmed the missing R2 signature. 5. Medical record review revealed an annual MDS assessment for resident #37 was dated 3/8/07 at Section R2b. In addition, all signatures under AA8 were dated 3/9/07. 6. Review of a quarterly MDS assessment for resident #44 showed the R2b date was 3/8/07, and all signatures under AA8 were dated 3/9/07. 7. Section V for the 4/8/07 significant change MDS assessment for resident #41 lacked the	F 278		

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

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F 278	Continued From page 23 care planning decisions and the location of assessment information. Interview with the MDS coordinator on 7/16/07 at 4:10 PM revealed she was aware the care planning decision and location of information at Section V needed to be completed; she just did not do it. In addition, she verified Section V was not signed by the RN coordinator. Furthermore, she stated that areas not signed were because the assessments "probably got filed" while she was waiting for signatures. 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, "The RN coordinator must not sign and attest to completion of the assessment until all other individual team members participating in the assessment have finished their portions of the MDS. The aforementioned reference further instructed that Sections AD, R2a , and Vb 1 and 3 must be signed, the care plan decision and the location of assessment information must be indicated in Section V, the MDS should be completed accurately, and Section R2a and R2b must not be signed and dated before all other sections are completed.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		

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

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F 279	Continued From page 24 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop comprehensive care plans related to assessed areas of concern for 2 sample (#14, #24) and one non-sample (#15) resident. The findings were: 1. Review of the 5/7/07 admission Minimum Data Set (MDS) assessment showed resident #14 was assessed for cognitive impairment. However, review of the care plan revealed the problem of cognitive impairment was not addressed. Interview with the administrator on 7/19/07 at 3 PM confirmed the facility had not developed a care plan for impaired cognition. 2. Review of resident #15's medical record revealed a history and physical form from a previous facility, dated 5/1/07, that stated the resident smoked three packs of cigarettes a day. The admission nursing notes from the facility, dated 6/11/07, documented the resident as a smoker . A smoking data collection and assessment, dated 6/19/07, determined that the	F 279	F279 COMPREHENSIVE CARE PLANS This facility strives to ensure that we develop a comprehensive care plan for each resident. This care plan will include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. This will be evidenced by the following: Resident #14 will have an updated assessment for cognitive impairment which has been addressed on the care plan. The updated assessment and care plan will be added to their medical record. Resident #15 will have a care plan which addresses the resident's smoking and will be added to the resident's medical record.. Resident #23 will have a care plan which addresses the resident's pain, peri-rectal excoriation, and scabbed right ear added to their medical	

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F 279	Continued From page 25 resident could smoke independently. However, review of the resident's care plan revealed there was no plan developed to address the resident's smoking. Interview with the nursing home administrator on 7/19/07 at 9:45 AM confirmed there was no care plan addressing the resident's smoking. 3. According to the 3/29/07 significant change MDS assessment, resident #23 was assessed for pain. Observation on 7/18/07 at 3:40 PM revealed the resident also had peri-rectal excoriation and a scabbed right ear. Review of the care plan showed these concerns had not been addressed.	F 279	record. All resident medical records will be audited to ensure there is an updated and accurate care plan that addresses all concerns identified in the comprehensive care plan. The DON or designee will audit five medical records for four weeks then monthly until three consecutive months of 100% compliance then quarterly thereafter. The results will be presented to the Administrator to be submitted to the quarterly QA meeting.	8/31/07
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.	F 281	F281 COMPREHENSIVE CARE PLANS This facility strives to ensure that services provided meet professional standards of quality related to physician orders, medication administration, and assessments. This will be evidenced by the following:	
	This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to assure professional standards of practice related to physician orders, medication administration, and assessments were maintained for 5 of 11 sample residents (#13, #14, #23, #41, #46) and 1 non-sample resident (#31). The findings were: Unless otherwise noted, the described practices that follow do not meet one or more of these professional standards: a. Wyoming Nursing Practice Act, July 2005, which states that nurses must practice under the direction of a physician. b. Helm, Ann. 2003. Nursing malpractice: sidestepping legal minefields. Philadelphia:		Resident #13's blood sugar levels order will be clarified and written in accordance with the physicians wishes and added to their medical	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 26 Lippincott Williams & Wilkins, which states " ...don ' t carry out any order from a physician if you have doubts about its accuracy or appropriateness. Follow your facility ' s policy for clarifying ambiguous orders. " c. Helm, Ann. 2003. Nursing malpractice: sidestepping legal minefields. Philadelphia: Lippincott Williams & Wilkins, which states, " A nurse is obligated to administer a prescribed medication unless she has reason to believe that the medication is contraindicated for the patient... " d. Smith, Sandra Fucci, Donna Duell, and Barbara Martin. 2004. Clinical nursing skills: basic to advanced skills. Upper Saddle River, N.J.: Pearson/Prentice Hall. which states " ...if a written order is ...questionable for any reason, the physician must be notified for clarification. " e. Smith, Sandra Fucci, Donna Duell, and Barbara Martin. 2004. Clinical nursing skills: basic to advanced skills. Upper Saddle River, N.J.: Pearson/Prentice Hall, which lists one of the components of appropriate medication orders as the " ...Name of medication. " 1. Review of the medical record for resident #13 showed the following: a. The June, 2007, recapitulation of orders was signed by the nurse as correct for blood sugar levels three times per day "ac"[before meals] "after meals and at bedtime." The orders indicated the physician was to be notified if the blood sugars were below 70mg/dl or above 400mg/dl. Interview with the acting director of nursing (DON) on 7/17/07 at 3 PM revealed the order was entered incorrectly and should have read "qid pc and hs" [four times a day, after meals, and at bedtime]. The order was signed by the physician, but there was no evidence it had	F 281	record. The DON or designee will monitor the compliance and documentation of the orders daily for one week then once a week for three months then monthly thereafter. Any irregularities will be reported to the Administrator for further action.. Resident #13 has had the order for Haldol discontinued by the physician therefore no further action or monitoring is necessary. The nursing staff wil be inserviced on the requirements for a correct and accurate physician order. All resident medical records have been audited for accurate, complete and clear orders. The DON or designee will audit five charts weekly for accurate and clear physician orders for four weeks then monthly until three consecutive months of 100% compliance then quarterly after that. The audits will be presented to the Administrator to be submitted to the quarterly QA meetings. Resident #13 is no longer in need for an Unna boot therefore no	8/31/07 8/31/07

DEPARTMENT OF HEALTH AND HU[illegible]N SERVICES
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F 281	Continued From page 27 ever been clarified. Review of the blood sugar records showed the resident's blood sugar was 434 mg/dl on 6/7/07 at 2 PM. The physician was notified, and an order to recheck the blood sugar after dinner was received. There was no evidence in the record that this check was ever completed. On 7/18/07 at 12:50 PM the acting DON stated she was also unable to find any evidence the resident's blood sugar was rechecked in accordance with the physician's order. b. An order for Haldol (antipsychotic medication) 3 milligrams (mg) to be given as needed for agitation was included in all of the recapitulations of orders since admission in March 2007. All orders were signed by the physician. Review of the nursing notes revealed licensed practical nurse (LPN) #6 administered 1 mg of Haldol to the resident on 5/14/07. The LPN originally document that a 3 mg dose was administered, but that figure was crossed out, and 1 mg was written above it. The nursing notes also revealed the LPN administered 1 mg of Haldol to the resident on 5/16/07. Review of the medication administration records (MARs) showed the order was entered as "3 mg." Review of all verbal and written orders revealed no order had been written for 1 mg of Haldol. The acting DON was interviewed on 7/18/07 at 8:50 AM. She stated they were not giving the resident any Haldol. Observation of the resident's medications on 7/19/07 at 10:50 AM verified Haldol was not included. c. Review of nursing notes dated 7/17/07 at 1:30 AM showed LPN #6 applied an "Unna boot" (a boot-like dressing of the lower extremity made of gauze and a zinc oxide paste in a glycogelatin base) to the resident's right lower leg for a purulent stasis ulcer with a foul odor. The LPN documented he cultured the area and faxed the	F 281	further corrective action can be taken on this matter. The nursing staff will be inserviced on the policy and procedure for physician order requests and receipt. . All resident treatments will be audited to verify existence of physician orders. The DON or designee will audit five residents with treatments for coinciding physician orders for four weeks the monthly until three consecutive months of 100% compliance then quarterly thereafter. The audits will be presented to the Administrator to be submitted to the quarterly QA meeting. Resident #14 has had the Novasource tube feeding orders clarified from the physician on 8/6/07 and added to their medical record. The CT scan has been completed on 8/8/07. Orders for labs will be clarified and added to their medical record and will be followed through. by nursing staff. The nursing staff will be inserviced on the policy and procedure for order requests and receipt as well as proper follow through with these orders. This resident will be included in the audit concerning	8/31/07

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F 281	Continued From page 28 physician. Review of the medical record and the physician's standing orders failed to show an order for the "Unna boot" or culture of the wound. On 7/18/07 at 12:50 PM the acting DON stated she was unable to locate any orders for a "Unna boot." 2. Review of the medical record for resident #14 showed the following: a. According to the June 2007 Recap of orders, the resident was to receive one can of Novasource (diet given by feeding tube) three times a day per gravity flow. Review of the MARs showed the feedings were scheduled at 8 PM, midnight, and 4 AM, and the resident consistently refused the midnight feeding in July 2007. Review of the nursing notes showed the resident frequently complained of nausea, and on 7/7/07 and 7/8/07 LPN #6 decreased the amount of Novasource administered. Review of the medical record revealed no evidence the LPN obtained an order before decreasing the amount of either feeding. On 7/18/07 at 9:50 AM, the acting DON verified there was no order to decrease the amount of the Novasource. b. According to information faxed to the physician on 6/28/07, the facility requested a pump to use for the night tube feedings. By 4 PM on 7/16/07, the surveyor found no response in the record to this request. When questioned, the acting DON reported on 7/18/07 at 9:50 AM that the physician had not yet responded to the request. However, on 7/18/07 at 8:30 AM, the administrator handed the surveyor a response from the physician which ordered a CT (computerized tomography) scan of the neck and chest on 6/28/07. The administrator stated it was found in a basket at the nursing station and had not been noted. On 7/19/07 at 3:02 PM, the	F 281	treatments with coinciding physician orders. The DON will monitor follow up and this resident to ensure proper care. Any non-compliance will be reported to the Administrator for further action. Resident #23 will have the orders concerning the scab to their right ear clarified and added to their medical record.. The nursing staff will be inserviced on the policy and procedure for order requests and receipt as well as proper follow through with these orders. This resident will be included in the audits concerning treatments with coinciding physician orders. The DON will monitor follow up on this resident to ensure proper care. Any non-compliance will be reported to the Administrator for further action. Resident #31 has received the Bacitracin Ophthalmic Ointment as ordered. The nursing staff have been inserviced on the importance of prompt administration of new medications. The pharmacy has been notified of the importance of prompt delivery of new	8/31/07 8/31/07

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F 281	Continued From page 29 administrator reiterated she had checked with the staff and the test was not done. c. Review of the physician's orders since the resident's admission on 5/3/07 showed laboratory tests were ordered weekly for a complete blood count with differential, a comprehensive metabolic panel, and magnesium levels. Review of the laboratory test results showed that none of the appropriate tests were completed for the week of May 16, 2007, and on 7/5/07 and 7/12/07, the magnesium test was not completed. On 7/17/07 at 1:25 PM, the acting DON confirmed the tests were not done as ordered and nursing did not follow up. 3. Observation on 7/17/07 at 3:27 PM revealed resident #23 had a scabby area on the outside of his/her right ear. During the observation the resident stated s/he applied a cream to the ear, and pointed to a small jar on the bedside table. The cream was labeled "AdaptSkin." Further observation on 7/18/07 at 3:40 PM showed the resident's right ear was covered with white ointment. A container of AdaptSkin and another of an unlabeled white ointment identified by registered nurse (RN) #10 as A&D ointment with Zinc were on the resident's bedside table. At the time of the second observation, the resident stated, and the RN confirmed, s/he personally applied the ointment to his/her ear. Review of the physician's July 2007 Recap of orders sheet showed no orders to apply AdaptSkin and A&D ointment with Zinc to the resident's ear. Additionally, there was an order on the July 2007 Recap of orders, as well as on the previous order sheets, to cleanse the scabbed area on the right ear daily and as needed and apply an antibiotic ointment twice daily until healed. The name of the antibiotic ointment was not identified	F 281	medications. The DON or designee will audit all new orders for prompt action for one week then audit five resident medical records for four weeks then monthly until 100% compliance then quarterly thereafter. The audits will be presented to the Administrator to be submitted to the quarterly QA meetings. Resident #41 will have all medications in which they are allergic discontinue. The nursing staff will be inserviced on the policy and procedure for order request and receipt which included adding allergies to order requests and verification against allergies upon order receipt. All residents will have their allergies cross referenced with their medication administration record for any irregularities. The allergies of each resident will be cross referenced with what the pharmacy has listed in order to maintain accuracy and consistency. The DON will monitor medication orders versus allergies for any irregularities. In any non-compliance is noted it will be	8/31/07

DEPARTMENT OF HEALTH AND HUM. ..N SERVICES
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F 281	Continued From page 30 on the order or on the MAR on 7/18/07 when copied by the surveyor at 3:20 PM. When questioned between 3:20 PM and 4:05 PM on 7/18/07, the acting DON stated she was sure the order was for Triple Antibiotic Ointment, and when the MAR was rechecked by the surveyor at 4:05 PM, Triple Antibiotic Ointment was written on it. However, all Recap of orders contain the phrases "Discontinue all previous orders...Continue these [new] orders for 30 days unless otherwise specified." No new order for Triple Antibiotic Ointment was found in the record. On 7/19/07 at 6:15 PM, the acting DON confirmed she did not obtain a new order for the ointment. 4. Medical record review for resident #31 revealed a doctor's order written and noted on 7/10/07 for "Bacitracin Ophthalmic Ointment 1/2 inch ribbon ou [both eyes] qid [four times a day]." Observation during a medication pass on 7/17/07 at 7:30 AM revealed the resident did not receive the eye ointment. Interview at 9 AM with LPN #5 revealed the eye ointment had not been delivered to the facility yet. Interview on 7/19/07 at 9:45 AM with the nursing home administrator revealed her expectation was that a medication be started within 24 hours of its being ordered. 5. According to the admission face sheet, resident #41 was admitted on 2/26/04. Further review of the face sheet showed the resident was allergic to Iodine, Penicillin, Zanaflex, Sulfur, Lasix, and Nitrofurantoin (Macrodantin). Review of the June 2007 Recap of orders showed the resident had been on Lasix 200 mg daily (in divided doses) since before 5/9/07. Review of a faxed note to the physician dated 6/7/07 showed the resident was allergic to Lasix and "...continues	F 281	reported to the Administrator for further action, Resident #46 is no longer in need of an antibiotic therefore no further corrective action can be taken. The nursing staff will be inserviced on the policy and procedure for order requests and receipt as well as proper follow up which includes family notification and verification of prompt order receipt.	8/31/07 8/31/07

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F 281	Continued From page 31 to c/o [complain of] itching all over...Resident is allergic to Lasix...taking Lasix 120 mg po qd [orally every day] and Lasix 80 mg q PM [every night]" The physician ordered the Lasix discontinued. Although the resident's allergies were clearly listed, staff failed to clarify the order when it was received. Additionally, on 7/2/07 at 2:35 PM the facility received an order for Macrodantin 100 mg twice daily for 10 days then every day for 3 months. Again, no one clarified the order although the allergies listed included Macrodantin. Review of the MAR showed the resident received the medication until 7/6/07 when a faxed order from the physician ordered "Discontinue nitrofurantoin [Macrodantin] pt [patient] is allergic!" 6. Review of a urine dipstix dated 6/25/07 showed resident #46 was positive for nitrites and leukocytes. The corresponding nurse's note dated 6/25/07 at 10 PM showed the urine sample was to be sent in for a culture and sensitivity test. Eight days later, a nurse's note dated 7/3/07 showed the resident was started on Bactrim for a urinary tract infection. However, there was no evidence of a physician's order for the Bactrim. In addition, the facility lacked evidence that a culture and sensitivity test was done. Interview with the acting DON on 7/18/07 at 1:28 PM confirmed staff should have followed up with a phone call the next day to obtain an order for the antibiotic. She stated an order for the Bactrim and the culture and sensitivity results were not found.	F 281		
F 309 SS=G	483.25 QUALITY OF CARE 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	F 309		

PRINTED: 08/02/2007
FORM APPROVED
OMB NO. 0938-0391

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

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F 309	Continued From page 32 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation; resident, family, and staff interviews; medical record review; and review of policies and procedures, the facility failed to assure 2 of 11 (#14, #25) open sample residents and 1 non-sample resident (#12) received the necessary care and services to reach their highest practicable levels of well-being. Due to the lack of care and services there was no evidence that the pain for resident #14 and the bowel incontinence for resident #25 were unaboidable. The findings were: 1. Review of the 5/7/07 admission Minimum Data Set (MDS) assessment showed resident #14 complained of daily, moderate headaches and other pain. According to a pain assessment dated 5/16/07, the resident had left sided oral pain, mouth pain, and headaches. The total score was left blank, but the intensity of pain on an average day was rated 6 to 8 on a scale of zero (no pain) to 10 (worst pain). Further review of the assessment showed pain interfered with the resident's ability to communicate, ability to ambulate, mood, relations with other people, toileting, eating, sleeping, and enjoyment. The rating of interference ranged from 2 to 10, on a scale of zero (no interference) to 10 (complete interference) with eating and enjoyment being 10, sleeping 8, and mood 6. Interventions described as effective on the assessment included prescribed medications, over-the-counter medication, and non-medications, but the	F 309	F309 QUALITY OF CARE This facility strives to ensure that each resident is provided with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment and plan of care. This is evidenced by the following: Resident #14 will have a comprehensive pain assessment completed and added to their medical record Pain management (pharmacological and non-pharmocological) methods will be added to the residents care plan. The CT scan was completed on 8/8/07 and the results will be added to their medical record.. The Pain Management Policy and Procedure will be reviewed and revised and a copy sent to the Medical Director for approval. The nursing staff will be inserviced on this new Policy and Procedure. The nursing staff will be inserviced on the policy and procedure for physician order requests and receipt as well as follow through on these orders. All	

DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 33 non-pharmaceutical interventions were not identified. Both the oral pain and headaches were described as radiating. The following concerns related to treatment of the resident's pain were identified: a. During an interview on 7/17/07 at 9:40 AM, the resident stated s/he was nauseated and had a headache. On 7/17/07 at 10 AM, a family member stated s/he believed the resident's nausea was caused by severe headaches which might be ithe result of bone spurs in the resident's neck. b. According to the facility's 11/06 policy and procedure entitled "Pain Management Policy," "Residents experiencing pain will have that pain managed to their acceptable level thereby allowing them to reach their highest practicable level of functioning and well-being." Further review showed residents with a score of 5 or greater will be re-assessed weekly for four weeks and then quarterly if the pain is managed satisfactorily. In addition, residents "will be re-assessed by the nursing staff weekly for four weeks after each pain medication change or until pain is managed satisfactorily...Pain assessments will be done q [every] week on residents with scheduled pain medication and charted on the Pain Assessment Sheet." The pain assessment dated 5/16/07 was the only one in the medical record. c. On 7/18/07 at 9:50 AM, the acting director of nursing (DON) stated the resident's pain was usually from headaches. Although they were documented on the assessment as being effective, the DON further stated the facility had not tried any non-pharmacological interventions to control or minimize the resident's pain. d. Review of the 5/17/07 care plan showed headache pain was not addressed. In addition,	F 309	residents will have an updated comprehensive pain assessment and it will be added to their medical record. The DON or designee will audit five residents for complete Pain Management which will include an updated comprehensive pain assessment and monitoring and documentation of current pain control methods (both pharmacological and non-pharmacological) for four weeks then monthly until three consecutive months of 100% compliance then quarterly thereafter. The audits will be presented to the Administrator to be submitted to the quarterly QA meetings. Resident #25 will be placed on a monitored turning and bowel and bladder schedule. An updated comprehensive MDS assessment and a bowel and bladder assessment will becompleted and added to their medical record. An updated comprehensive pain assessment will be completed and added to their medical record. Monitoring and documentation of pain control methods	8/31/07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 34 non-pharmacological interventions were not included for oral pain. e. Review of the physician's orders revealed the resident was on a routine pain patch, was being treated for thrush, and had a topical anesthetic at the bedside. Further review showed the dose of the pain patch was doubled on 6/15/07 to 50 micrograms, Ultram 100 ER once or twice daily was added on 6/29/07, and Tylenol with Codeine (Tylenol #3), one or two tablets every 4 to 6 hours as needed was continued for breakthrough pain. Although the dose of the pain patch was doubled, review of the medication administration record (MAR) for July 2007 showed the resident usually still received Tylenol #3 two to four times daily. In addition the resident received Ativan for anxiety almost daily. f. Review of the nursing notes from admission through 7/8/07 showed frequent documentation of pain and nausea. On 6/28/07, the facility received a faxed order from the physician for a CT scan of the neck and chest to be done that day. This order was not in the record, and on 7/18/07 at 8:30 AM the administrator stated it was found in a basket at the nurses' station. On 7/19/07 at 3:02 PM, the administrator confirmed the scan had not been done. 2. The following concerns were identified related to the management of bowel incontinence for resident #25: a. Observation on 7/17/07 from 1:35 PM to 4:10 PM showed the resident was not toileted or checked and changed during the two hour and 35 minute observation. At 4:10 PM on 7/17/07, CNAs #9 and #19 checked and changed the resident, who had been incontinent of a large bowel movement. b. Medical record review showed there was	F 309	(pharmacological and non-pharmacological) will be implemented. The resident's care plan will be updated to reflect the comprehensive MDS assessment, the bowel and bladder assessment, and the comprehensive pain management assessment and added to their medical record. The CNA's and nursing staff will be inserviced on the bowel and bladder and turning schedule policy and procedure. The nursing staff will be inserviced on the updated Pain Management Policy and Procedure. The DON or designee will monitor the compliance of the turning schedule and the bowel and bladder schedule. Any non-compliance will be reported to the Administrator for further action. Resident #12 has expired therefore no corrective action can be taken. The nursing staff will be inserviced on the importance of proper body positioning and cueing during the dining room experience. The DON or designee will monitor the dining room for compliance. Any noncompliance will be reported to	8/31/07

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OMB NO. 0938-0391

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

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F 309	Continued From page 35 no evidence a bowel assessment was ever completed for the resident. In addition, there were no MDS assessments, including one for bowel continence, for the resident who, according to the medical record face sheet, was admitted to the nursing home on 2/12/07. Interview with the acting DON on 7/18/07 at 2:10 PM confirmed there was no record of any bowel assessment for this resident. c. Further review showed no care plan related to any aspect of the resident's care. Interview with the nursing home administrator on 7/19/07 at 1:55 PM confirmed there was not a care plan for this resident. d. Review of the facility's undated wound care policy and procedure showed the skin alert program was to be followed for any resident identified as having pressure ulcers or a history of pressure ulcers. As outlined in the policy and procedure, the skin alert program included establishing a toileting plan to keep the resident' skin dry and clean. 3. Observation of the evening meal on 7/16/07 at 6 PM showed resident #12 leaned to the right out of the geri-chair (a high backed, reclining, wheeled chair). Observation of the breakfast meal on 7/17/07 from 8:05 AM through 8:20 AM showed the resident remained leaning out of the chair with his/her head completely off the back of the chair. Although certified nurse aide (CNA) #7 was seated directly across from the resident, she did not reposition the resident or cue the him/her to reposition independently. The resident fell asleep at 8:15 AM; at 8:20 AM the CNA awakened, but did not attempt to reposition the resident.	F 309	the Administrator for further action.	8/31/07
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING	F 311		

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

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F 311	Continued From page 36 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and family and staff interviews, the facility failed to ensure services were provided to enhance activities of daily living for one (#37) non-sample resident and 1 (#46) of 11 sample residents. The findings were: 1. Family interview on 7/18/07 at 1 PM revealed they had concerns about a lack of assistance with dining being provided for resident #37. They stated they were told assistance was being provided for all meals. However, when the family would stop in during a meal service, they found the resident more than once without anyone providing assistance, and the resident's food would be spilled onto the floor. Observation on 7/18/07 from 6:15 PM to 6:40 PM revealed the following concerns related to dining for the resident: a. The resident had contracted hands and was unable to completely open his/her fingers. The resident's meal was served in a scoop plate, with regular utensils and a straw in one of the two beverages. The resident was able to hold the spoon in the right hand, and used it to scoop toward the left side of his/her body. The plate was turned so the deep portion was at the 2 o'clock position and was, therefore, not beneficial based on the resident's ability. Much of the food was pushed out of the plate onto the serving tray. The resident attempted to get the glass without the straw close enough to sip from the rim as s/he	F 311	F311 ACTIVITIES OF DAILY LIVING This facility strives to ensure services are provided to enhance activities of daily living (ADL's) for all residents. This will be evidenced by the following: Resident #37 will have an OT assessment of their dining assistance needs to maintain an optimal dining experience. A care conference will be set up with the family to discuss the assessment and to update the resident's care plan to reflect these needs. Nursing staff will be made aware of these needs. The DON will monitor this resident's dining experience for compliance. Any non-compliance will be reported to the Administrator for further action. QA to review Quarterly Resident #46 will have a bowel and bladder assessment completed and added to their medical record. The CNA's have been inserviced on the need to offer toileting to residents after all resident cares. The DON or designee will monitor the staff for compliance. Any non-	8/31/07

DEPARTMENT OF HEALTH AND HU...N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 311	Continued From page 37 could not lift it off the table. S/he was able to drink less than half of the beverage. At no time during the 25 minute observation was the resident offered any assistance from staff. The resident consumed less than 50% of the meal. b. Review of the 8/18/06 care plan related to potential nutritional deficit showed the resident required assistance of one as needed, straws for liquids, and positioning of food and fluids within reach. c. Review of a nursing note, dated 7/13/07, showed the resident had experienced a weight loss of 6.5 pounds in the past two months, and food intake at meals was documented as 75-100% consumed. d. Review of the meal intake record for July 2007 showed 13 days from 7/1-7/18 where the breakfast and lunch meal intakes were recorded. These meal intakes ranged from 50-100%. However, only three evening meal intakes were recorded for the resident. e. Interview with the director of nursing on 7/18/07 at 2:37 PM confirmed the family had expressed concern about dining assistance, and the resident was to be assisted as needed. She further stated the resident ate 75-100% of meals when assisted. 2. Review of the 3/9/07 significant change Minimum Data Set (MDS) assessment for resident #46 showed s/he required extensive assistance for toileting, and was incontinent of bladder all or most all of the time. On 7/17/07 at 3:50 PM, CNA #4 lowered the full length side rail, changed the resident's incontinence brief, and then raised the rail back up without offering the resident the opportunity to use the toilet. Medical record review showed there was no evidence of a bladder assessment to determine a toileting	F 311	compliance will be reported to the Administrator for further action. QA to review Quarterly	8/31/07

DEPARTMENT OF HEALTH AND HUM.. .N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 311	Continued From page 38 schedule for the resident. Interview with the director of nursing on 7/18/07 at 1:07 PM revealed the resident was supposed to be taken to the toilet, and "actually transfers easily."	F 311		
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 observations, family and staff interviews, medical record review, and review of policies and procedures, the facility failed to provide appropriate care during 5 of 6 observations of incontinence (perineal) care, and 1 of 2 observations of urinary catheter care. In addition, the facility failed to ensure adequate bathing services were provided for 4 (#5, #25, #46, #47) of 12 sample residents and one (#37) non-sample resident. The findings were: Related to incontinence and urinary catheter care: 1. Observation on 7/16/07 at 5:30 PM revealed licensed practical nurse (LPN) # 11 performed perineal care for resident #6. The LPN cleansed the perineal area several times with the same area of the wipe. Review of "Nursing Assistant" 9th edition, by Hegner, Acello, and Caldwell published in 2004, page 364, revealed "....Avoid scrubbing back and forth. Always wipe from clean to dirty with a single swipe, then turn or discard the cloth..." 2. Observation on 7/16/07 at 3:45 PM revealed	F 312	F312 ACTIVITIES OF DAILY LIVING This facility strives to provide appropriate peri-care, catheter care, and adequate bathing services to all residents. This will be evidenced by the following: Residents #6, #10, #5, #44, #25, and #44 will have their peri- care monitored by the DON or designee for compliance with the facilities Policy and Procedure on peri-care and catheter care. Any non-compliance will be reported to the Administrator for further action. The nursing staff will be inserviced on the Policy and Procedure and all CNA's will complete a skills checklist to include these cares. All newly employed nursing staff will be required to perform the skills checklist prior to working on the residents by themselves. The DON will do five audits on peri-care and catheter care weekly for four weeks	

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

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F 312	Continued From page 39 certified nurse aide (CNA) #12 performed perineal care for resident #10. The CNA used the same area of the wipe while cleansing the perineal area several times. Review of "Nursing Assistant" 9th edition, by Hegner, Acello, and Caldwell published in 2004, page 364, revealed "....Avoid scrubbing back and forth. Always wipe from clean to dirty with a single swipe, then turn or discard the cloth..." 3. Observation on 7/16/07 at 3:50 PM # 5 revealed training nurse aide (TNA) #18 performed perineal care for resident #5. The TNA used the same area of the wipe while making several swipes back to front of the perineal area. Review of "Nursing Assistant" 9th edition, by Hegner, Acello, and Caldwell published in 2004, page 364, revealed "....Avoid scrubbing back and forth. Always wipe from clean to dirty with a single swipe, then turn or discard the cloth..." 4. Observation on 7/17/07 at 4:35 PM showed CNAs #19 and #9 provided incontinence and catheter care to resident #25. During catheter care, CNA #9 cleansed the catheter, which was covered with feces, using the same area of the wipe to complete three strokes away from the urinary meatus before changing to a clean section of wipe. Review of the facility's undated policy and procedure, "Urinary Catheters", revealed clean technique during care was not addressed. However, on 7/18/07 at 1:32 PM, the acting director of nursing (DON) stated a new area of the wipe should be used with each stroke. 5. On 7/17/07 at 7:27 AM observation showed resident #44 was incontinent of urine. When providing incontinence care, CNAs #20 and #4 cleansed only the resident's buttocks; they did not	F 312	then quarterly thereafter. The audits will be presented to the Administrator to be submitted to the quarterly QA meetings. A work group, consisting of the Administrator, DON, and several nursing staff will review and revise the bathing policies and procedures to ensure that all residents receive baths in a timely manner in accordance with their needs and wishes. All nursing staff will be inserviced on this policy and procedure including proper and accurate documentation. Residents #39, #46, #26, #5, and #47 will be put on a weekly bath schedule. All residents/family will be asked for bathing requests and also put on a weekly bath schedule. The DON or designee will audit all baths for completion and documentation weekly for three months then quarterly thereafter. The audits will be presented to the administrator to be submitted at the quarterly QA meetings.	8/31/07 8/31/07

DEPARTMENT OF HEALTH AND H AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 40 cleanse the anterior groin or genitalia which were also in contact with urine. After transferring the resident to the toilet, the CNAs provided perineal care a second time. Again the resident's anterior groin and genitalia were not cleansed and CNA #20 did not use a clean area of the wipe for each stroke. Review of the facility's 7/06 policy and procedure entitled "Providing Perineal Care" verified staff were to ..."wash...from front to back of perineum." Use clean section of washcloth for each stroke." 6. Observation on 7/17/07 at 3:50 PM revealed resident #46 was incontinent of urine. CNA #16 cleansed the resident's buttocks but failed to cleanse the anterior groin and genitalia. According to the facility's 7/06 policy and procedure entitled "Providing Perineal Care", staff are to were to ..."wash...from front to back of perineum." Related to bathing services: 1. Interview with family members on 7/18/07 at 1 PM revealed they were concerned about the quality of bathing being provided to non-sample resident #37. Observation at that time revealed the resident had a build-up of body soil behind his/her left ear. Review of the current bath form showed the resident was last bathed on 7/12/07. 2. Review of the current bath and skin assessment form for resident #46 showed the resident received one bath/shower in June 2007 on 6/10/07 and the next bath/shower recorded was on 7/5/07, 25 days later. There were not any documented refusals by the resident. In addition, the 7/5/07 bath/shower was the only one recorded from 7/1/07 to 7/19/07 without any refusals by the resident	F 312		

DEPARTMENT OF HEALTH AND HUM N SERVICES
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F 312	Continued From page 41 3. On 7/19/07 review of the current bath and skin assessment form for resident #26 showed there were no baths/showers recorded for the month of July 2007, and no refusals by the resident were documented. The last bath recorded was on 6/21/07. 4. Review of the current bath and skin assessment form for resident #5 showed one bath was received in June 2007, on 6/7/07, and there were not any documented resident refusals. 5. Review of the closed record for resident #47 revealed bath documentation was lacking for May and June 2007. Interview with the nursing home administrator (NHA) on 7/19/07 at 1:55 PM confirmed there was not any record found for resident #47 related to bathing for these two months. 6. Interview with the NHA on 7/19/07 at 1:55 PM verified the documentation and indicated there were no other records to review.	F 312		
F 314 SS=H	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. This REQUIREMENT is not met as evidenced by:	F 314	F314 PRESSURE SORES This facility strives to ensure that all residents admitted without pressure sores do not develop sores unless the individual's clinical condition demonstrates that they were unavoidable and residents having pressure sores receive necessary treatment and services to promote healing, prevent infection,	

DEPARTMENT OF HEALTH AND H[illegible]AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 42 Based on observation, staff interview, policy and procedure review, and medical record review, the facility failed to provide treatment and services to prevent the development of avoidable pressure ulcers for 4 (#24, #25, #32, #44) of 4 sample residents who had acquired pressure ulcers while in the facility. The findings were: Review of an undated policy and procedure for skin care revealed pressure ulcers were to be assessed at least weekly or with dressing changes. Any residents with pressure ulcers or a history of pressure ulcers were to be on a skin alert program. The skin alert program was described as including a repositioning program with a frequency of at least every two hours and notifying the dietary department of the need to evaluate the affected resident's nutritional needs. The following concerns were noted related to the failure of the facility to follow this policy: 1. Review of the admission nursing notes form dated 2/12/07 showed resident #25 was confined to bed and required total assistance with activities of daily living. The form included a current skin assessment that revealed a stage IV pressure ulcer on the right heel and a reddened coccyx. The following concerns were noted with the development of two Stage II pressure ulcers while in the facility: a. Observation on 7/16/07 at 7:45 PM during wound rounds with licensed practical nurse (LPN) #6 revealed resident #25 had a stage II pressure ulcer on the coccyx that was approximately 4 centimeters (cm) in diameter. A large area of the resident's buttocks and back were noted to be reddened. The stage IV pressure ulcer on the heel was resolved. The LPN stated that the pressure ulcer on the coccyx was being cleaned	F 314	and prevent new sores. This will be evidenced by the following: A work team consisting of the Administrator, the DON, nursing staff, CNA's, physical therapy , and the Dietary Consultant will review and revise the Skin and Wound Care Protocol. This protocol will include the following: a weekly wound care meeting,; a weekly wound and skin report with copies going to the Administrator and the DON; weekly weights and nutrition meeting; weekly skin assessments on bath day. All newly admitted residents will receive a comprehensive skin assessment and Braeden scale completed and added to the medical record. All staff will be inserviced on pressure sore prevention and healing, nutrition and hydration, positioning, activities, continence care, and the reporting and documentation, and pressure preventing devices. The nurses will be inserviced on the Skin and Wound Care Protocol will have a written exam to verify understanding. Audit tools will be	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 43 with a wound cleanser and left open to air. b. Observation on 7/17/07 from 1:35 PM to 4:10 PM revealed the resident was lying in bed on his/her back with a sheet covering the legs. The resident's left leg appeared to be propped up and the right leg was resting against the left. During the 2 hour and 35 minute observation, the resident was not repositioned. Observation again at 4:35 PM showed the resident remained in the position described above (a total elapsed time of 3 hours). Another open area, approximately 2 cm in diameter was noted on the resident's right knee. c. Medical record review revealed no evidence of any completed Minimum Data Set (MDS) assessments, a comprehensive nutrition assessment, or any care plan. The most current nutrition assessment was dated 2/19/07 and showed the resident had increased nutritional needs, but intake was poor at every meal. There was no documented assessment of actual calorie or protein needs. Interview with the acting director of nursing (DON) on 7/18/07 at 2:10 PM confirmed there was no record of any MDS assessments for this resident, and she was unsure when the pressure ulcers on the back/buttocks area or the knee were first identified. d. Review of a 4/2/07 nursing note revealed the resident had an open area on the buttocks; however, there were no measurements documented. Review of bath and skin assessment forms revealed the aide had documented "sores on the bottom" on 4/8/07. With the exception of the nursing admission assessment in February 2007, there was no evidence of any other wound assessment being done prior to 6/3/07. e. The 6/3/07 wound assessment revealed	F 314	implemented to monitor success of the protocol. 8/31/07 Resident #32 has expired therefore no corrective action taken.. Residents #25, #44, and #24 will have an updated comprehensive skin and wound care assessment completed and added to their medical record. Updated care plans reflecting the residents needs will be implemented. The Skin and Wound Care Protocol will be followed for each of these residents. Each residents physician will be notified of the resident's status. Any new orders received will be immediately implemented. All nurses staff will be inserviced on each resident care plan. Physical therapy will assess pressure releasing devices, and other means of therapy to reduce pressure sores such as ambulation and positioning. Results of the weekly wound care team will be presented to the Administrator to be submitted at the quarterly QA meeting. 8/31/07	

DEPARTMENT OF HEALTH AND HU .N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 44	F 314		

the resident had three Stage II pressure ulcers. They were located on the back/buttocks, the right heel, and the right knee. The assessment did not include any measurements for the ulcer on the back/buttocks; However, a body diagram was marked, showing a shaded area covering approximately 100% of the buttocks, and approximately 25% of the back. On the shaded area was a circle on the cocoyx, and two small circles on the left buttocks; the circled areas did not have any measurements. The right heel ulcer measured 1/2 centimeter (cm) by 1/2 cm, and the right knee ulcer was measured as "nickle" sized." The wound status for the three Stage II pressure ulcers were marked as "Non-healing," and the wound care section was blank.

f. Review of July 2007 treatment record showed no documentation for the back/buttocks pressure ulcer. The only physician's order, dated 2/12/07, was for barrier cream to be applied as needed for recurrent breakdown of the right buttocks.

g. Review of the 6/21/07 physical therapy plan of treatment for this resident showed the plan for healing the pressure ulcers on the buttocks included bed positioning and air drying. There were written comments made by physical therapy about this wound on 6/25/07, 6/26/07, 6/29/07, 7/12/07, and 7/17/07. None of these comments included quantitative measurements of the wound.

2. Review of medical record for resident #32 revealed a 3/8/07 annual MDS assessment that showed the resident had limited bed mobility, needed assistance with ambulation, was frequently incontinent of urine, occasionally incontinent of bowel and had no pressure ulcers. The following concerns were noted:

DEPARTMENT OF HEALTH AND H[illegible]AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 48 the care plan was not revised. b. Review of the care plan showed the pressure ulcer, which developed in May 2007, had not been addressed. c. Observation on 7/18/07 showed the resident was seated in his/her room at 1:30 PM. At 1:45 PM staff wheeled the resident from his/her room to the dining room where s/he remained. The resident was still seated at the dining room table at 6 PM when the surveyor left the facility. A time period of 4.5 hours elapsed during which staff did not check the resident for incontinence or reposition him/her. Review of the facility's undated policy and procedure, "Skin Care Protocol," showed staff were to "Develop a repositioning schedule (at least every two hours)...Keep skin dry/clean. Establish a toileting plan or frequent checks for wetness." According to the professional reference: Hegner, Barbara R., Barbara Acello, and Esther Caldwell, 2004 Nursing assistant: a nursing process approach. Clifton Park, N.Y.: Delmar Learning: Measures used to prevent pressure sores include keeping the skin clean and dry, removing feces or urine from skin, and changing a resident's position every two hours or more.	F 314		
F 318 SS=D	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	F 318	F318 RANGE OF MOTION The facility strives to assure that residents receive a restorative program as needed. This is evidenced by the following:	

DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 318	Continued From page 49 by: Based on medical record review, staff interview, and interview with contracted personnel, the facility failed to assure two (#13, #23) of three sample residents on a restorative program received it as scheduled. The findings were: On 7/18/07 at 4:27 PM the physical therapy assistant (PTA) stated that therapy referred residents to the restorative program and developed the program. At the completion of the restorative program, the resident was transferred to the maintenance program, normally a continuation of the restorative program performed on a less frequent basis. The PTA also stated they had revised the format so each resident's restorative and/or maintenance program was indicated on a referral form. The following concerns with the programs were identified: a. Review of the 5/16/07 restorative referral for resident #13 showed the program was ordered 1 to 2 times a week. Review of the 2007 documentation showed the program was not provided from June 1st through June 12th and July 5th through July 18th. No refusals by the resident were documented during these periods. b. According to an undated restorative referral, resident #23 was to be on the restorative program twice weekly for one month. The goals were to "maintain current level of endurance" and "maintain gait to all meals" by utilizing the "walk to dine" program; no exercises were specified. Review of the documentation showed the program started April 17, 2007 and continued through July 2007, but it also described upper and lower body exercises performed by the resident. Further review showed the program was not provided from May 17th through June 6th and June 21st through June 27th. No refusals by the	F 318	The restorative program will be reviewed and revised to reflect the needs of the facility and residents. Weekly restorative meetings will be held with the DON, physical therapy, and restorative aides. Residents #13 will have their programs will be re-assessed for their restorative needs. Physical therapy will review and update the care plans and goals. Nursing staff will be inserviced on the need for restorative and maintenance programs and their responsibilities in those programs. The facility is actively recruiting for consistent, knowledgeable restorative aides. DON, physical therapy, and Administrator will monitor for accurate completion of the program. Results will be submitted to the quarterly QA meetings. Resident #23 has moved to the Shepard of The Valley nursing home in Casper.	8/31/07 8/31/07

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

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F 318	Continued From page 50 resident were documented. Interview with the administrator on 7/18/07 at 1 PM revealed the restorative program was not always done if the restorative aide was reassigned to assist with resident care.	F 318		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to attempt gradual dose reductions of antipsychotic medications for three (#13, #44, #41) of four sample residents on antipsychotic medication. The findings were:	F 329	F329 UNNECCESSARY DRUGS This facility strives to attempt gradual dose reductions of antipsychotic medication. This is evidenced by the following: A complete Social Services and antipsychotic medication assessment was completed on resident #13 on 8/9/07. and added to their medical record. The medication was discontinued therefore no further corrective action was taken. Resident #41 will have a comprehensive antipsychotic medication assessment completed and added to their medical record. The results will be forwarded to the	

DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 51 1. Review of the physician's orders and the medication administration records (MARs) showed resident #13 received Haldol (an antipsychotic medication) periodically. The original order, dated 3/26/07, was for Haldol 3 milligrams (mg) three times a day as needed for agitation. Review of the current order showed it remained unchanged. The following concerns were identified: a. According to nursing notes dated 5/14/07, the resident was demanding and frequently called out to staff. one milligram of Haldol was noted as given, and the resident was asleep by 9 PM. Nursing notes, dated 5/16/07, documented that the resident was trying to sit up in bed on his/her buttocks, therefore 1 mg of Haldol was given and the resident fell asleep. Review of the medical record showed no evidence that there was an order for 1mg Haldol. b. Review of a facility generated form for guidelines dealing with psychotropic utilization, showed the resident was supposed to receive 3mg of Haldol as needed for agitation. Furthermore, the documentation revealed the resident experienced an increase in anxiety, agitation, and excessive worrying when the dose of Haldol was decreased. c. Review of the psychotropic monitoring forms utilized by the facility showed the resident's behaviors were not monitored during July 2007. 2. According to physician's orders and the MARs, resident #41 received 25mg of Seroquel (an antipsychotic medication) at bedtime every evening. Review of the 4/8/07 significant change Minimum Data Set (MDS) assessment showed the resident expressed repetitive, non-health related concerns, which were easily altered, up to	F 329	physician for any potential dose increase or reduction. A behavior monitoring for antipsychotic drugs will be implemented and care planned to reflect accurate information. The nursing staff will be inserviced to accuratel monitor and document residents behavior and medication effectiveness and/or side effects with physician notification of any significant change. Resident's need for continuation or reduction of medication will be reviewed quarterly. Resident #44 has had an updated comprehensive antipsychotic drug assessment completed and added to their medical records. The recommendations will be added to the updated care plan and added to the medical records. Nursing staff will be inserviced on the need to document accurately and timely. All residents will be audited to review antipsychotic drug use and dose reductions. All care plans will be updated to reflect the recommendations and added to their medical record. All residents will be reviewed quarterly. DON,	8/31/07

DEPARTMENT OF HEALTH AND HU .N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 52 five days a week. The MDS also documented there was no change in the resident's mood status. Although the monitoring forms used by the facility for psychotropic medications were incomplete, record review showed no indications of delusions of persecution, paranoia, or excessive anxiety during May and June 2007. The following concerns were identified: a. Review of the comprehensive assessment for mood patterns revealed the assessment was incomplete. Review of the comprehensive assessment for psychotropic medications revealed the resident had been taking Seroquel prior to admission on 2/26/04, and it was further noted that the resident had recently demonstrated a decline in cognition and short term memory loss. According to the psychotropic medication assessment: "...mood issues continue." b. Review of the monitoring forms revealed the side effects of the medication were not being monitored. In addition, there had been no monitoring for behaviors or medication side effects during the month of July 2007. c. Review of a facility generated form for guidelines dealing with utilization of psychotropic medications, dated 2/12/07, showed the resident had been on the same dose of Seroquel since 10/19/05. Documented reasons for not attempting a dose reduction were increased mood issues, depression, increased anxiety, delusions of abandonment, verbalizations of excessive fears, tearfulness, excessive fears of health decline, feelings of hopelessness/helplessness, increased periods of shortness of breath, and sleeplessness. Review of the medical record failed to show evidence of these reasons. During an interview on 7/19/07 at 3:10 PM, the social service designee stated he was unable to locate	F 329	SS, and Administrator will monitor for compliance. Any non-compliance will be reported to the Administrator for further action.	8/31/07

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

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F 329	Continued From page 53 any information in the record documenting what happened the last time a dose reduction was attempted or the date it was attempted. 3. Medical record review revealed resident # 44 had received 1mg Haldol daily since 4/19/05. A form letter with also was in the medical record. This letter, dated 12/14/06, stated Haldol was prescribed for psychotic disorder with hallucinations. The letter also documented that decreases or withdrawal of the medication resulted in mood decline, increased delusions and hallucinations, paranoid ideations, feelings of persecution, hypochondriac symptoms as evidenced by verbalizations or assurity of contraction of catastrophic diseases, and insistence of immediate doctor or emergency room appointments. Further medical record review revealed no evidence that there had been a dose reduction attempted at any time during the resident's stay at the facility. The psychoactive medication monthly flow record for June 2007 showed no targeted behaviors by the resident. The July psychoactive medication monthly flow record was not available. Interview on 7/18/07 at 6:50 PM with the pharmacist revealed he was unaware of an attempted dose reduction of Haldol for this resident.	F 329		
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient	F 353		

DEPARTMENT OF HEALTH AND HU[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 353	Continued From page 54 numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interviews, medical record review, and review of the posted schedule and policies and procedures, the facility failed to maintain sufficient staff to provide care and services for 8 (#5, #12, #13, #24, #25, #32, #44 and #47) of 12 sample residents and 2 non-sample residents (#4, #37). Concerns were noted related to bowel incontinence, dining assistance, repositioning, bathing and restorative care. The findings were: 1. Scheduling: Review of the nurses schedule from June 17, 2007 thru July 19, 2007 showed a variation of the number of certified nurse aides (CNAs) scheduled on specific shifts. The following concerns were noted: a. The schedule for the CNAs for the evening shift from June 17th - 30th, 2007 revealed 10 of the 14 evenings had 4 CNAs scheduled on the evening shift. June 19th (Tuesday), 25th (Monday), and 30th (Saturday), each had 3 CNAs	F 353	F353 NURSING SERVICES-SUFFICIENT STAFF This facility strives to maintain sufficient staff to provide cares and services to all residents. This is evidenced by the following: The scheduling did not reflect the accurate changes that were made to cover call ins, terminations or resignations, however the facility is using all avenues to maintain sufficient staff. These avenues are as follows: use of four separate agencies; TNA'a awaiting notification of licensure; inquiries waiting for classes to start at EWC campus 9/17/07; review of the recruiting, training, and retention practices of the facility. The facility recognizes inconsistencies in the scheduling as well as the quality of the staff effect the resident care.and is not always due to the number of staff. All staff will be inserviced on the facility practices and responsibilities for resident care. The Administrator and the DON will monitor staffing	

DEPARTMENT OF HEALTH AND HU[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 353	Continued From page 55 scheduled. On June 23rd (Saturday), there were only 2 CNAs scheduled for the evening shift. b. The schedule for the CNAs for the day shift from July 1 - 14, 2007 revealed 11 of the 14 days had 4 CNAs scheduled on the day shift. On July 7th (Saturday), 8th (Sunday), and 14th (Saturday) there were 3 CNAs scheduled on the day shift. c. The schedule for the CNAs for the evening shift from July 1st - 14th, 2007 revealed 5 of the 14 evenings had 4 CNAs scheduled for the evening shift. July 1st (Sunday) had 5 CNAs on the evening shift. Monday and Tuesday, July 2nd and 3rd, 2007 had 3.5 CNAs and July 6th (Friday), 12th (Thursday), and 13th (Friday) had 3 CNAs scheduled. On Saturday, July 7th, there were 1.5 CNAs and on Sunday, July 8th, there were 2.5 CNAs scheduled. d. The schedule for the CNAs from July 16th to 19th, 2007 revealed 3 days with four CNAs on the day shift, 1 day with 5 CNAs and one day with 3 CNAs on the day shift. The schedule showed 3 evenings on the evening shift with 4 CNAs and 2 evenings with 3.5 CNAs. The resident census did not change during the times of reduced staffing. 2. Interviews: a. Interview with family member of non-sample resident #4 on 7/17/07 at 6:20 PM revealed that in a conversation with facility staff, the family member was told fewer staff were scheduled to work on weekends because "...many residents are on weekend leave and there is less need for staff." b. When questioned about the greatly reduced number of staff on the weekends on 9/18/07 at 7:15 PM, the administrator and social services designee confirmed they were aware of it.	F 353	needs daily. QA will review results quarterly. The facility maintains that staff is not reduced intentionally on weekends. There is no policy to reduce staff based on resident leaves. Staff shortages occur when staff call off and cannot be replaced. Programs and policies are in place to recruit staff, use of agency, and train or discipline existing staff as needed. This team was confused as to whether a TNA could work alone, so while surveyors were in the building they worked as a team.	8/31/07 8/31/07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 353	Continued From page 56 c. Interview with the administrator on 7/18/07 at 1 PM revealed the restorative program was not always done if the restorative aide was pulled to assist with resident care. d. Family interview on 7/18/07 at 1 PM revealed they had concerns with bathing. They also stated cleaning wasn't being done adequately because staff were too hurried. 3. Repositioning and pressure ulcers: Refer to F314 for further details related to pressure ulcers and a lack of positioning as per policy. a. Observation on 7/17/07 showed resident #25 remained in the same position from 1:35 PM until 4:35 PM. When repositioned, observation showed the resident had three pressure ulcers. b. Observation on 7/18/07 at 1:20 PM showed resident #32 had two Stage II pressure ulcers, one on each buttock. The resident had remained in bed on her/his left side from approximately 1:30 PM after the aides completed cares until 5:30 PM. During the 4 hour observation, the resident was not repositioned to prevent further skin breakdown. c. Observation on 7/18/07 at 2:25 PM revealed resident #44 had two Stage II pressure ulcers on the sacral area. When the observation ended at 5:15 PM, two hours and fifty minutes later, the resident had not been repositioned. d. According to the medical record , resident #24 developed a pressure ulcer sometime in May 2007. Observation on 7/18/07 showed the resident seated in his/her room at 1:30 PM. At 1:45 PM staff wheeled the resident from his/her room to the dining room where s/he remained. The resident was still seated at the dining room table at 6 PM when the surveyor left the facility. A time period of 4.5 hours elapsed during which	F 353		

DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 353	Continued From page 57 staff did not reposition the resident. 4. Bathing: a. Interview with family members on 7/18/07 at 1 PM revealed they were concerned about the quality of bathing being provided to non sample resident #37. Observation at that time revealed the resident had a build-up of body soil behind his/her left ear. Review of the current bath form showed the resident was last bathed on 7/12/07. b. Review of the current bath and skin assessment form for resident #46 showed the resident received one bath/shower in June 2007 on 6/10/07 and the next bath/shower recorded was on 7/5/07, 25 days later. There were not any documented refusals. In addition, the 7/5/07 bath/shower was the only one recorded from 7/1/07- 7/19/07. C. Review of the current bath and skin assessment form on 7/19/07 for resident #25 showed there were no baths/showers recorded for the month of July 2007, and there were not any documented refusals. The last bath recorded was on 6/21/07. d. Review of the current bath and skin assessment form for resident #5 showed one bath was received in June 2007 on 6/7/07, and there were not any documented refusals. e. Review of the closed record for resident #47 revealed bath documentation was lacking for May and June 2007. Interview with the nursing home administrator (MYA) on 7/19/07 at 1:55 PM confirmed there was not any record found for this resident related to bathing for these two months. Hf. Interview with the MYA on 7/19/07 at 1:55 PM confirmed there was a lack of documentation to show bathing occurred at acceptable levels for these residents.	F 353		

DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 353	Continued From page 58 5. Restorative program: 1. The following concerns with the restorative programs were identified: a. Review of the 5/16/07 restorative referral for resident #13 showed the program was ordered 1 to 2 times a week. Review of the 2007 documentation showed the program was not provided from June 1st through June 1st and July th through July 1st. No refusals by the resident were documented during these periods. b. According to an undated restorative referral, resident #23 was to be on the restorative program twice weekly for one month. Record review showed the program was not provided from May 1st through June th and June 1st through June nth. No refusals by the resident were documented. 6. Bowel incontinence: Observation showed resident #25 was not checked for incontinence from 1:35 PM until 4:35 PM, a 3 hour time period. When checked at 4:35 PM, the resident had been incontinent of a large amount of feces. 7. Observation of working arrangements: Observation during the evening shift on 7/16/07 showed staff consisted of two training aides and one CNA. All the staff worked together when providing care for the residents and went from side to side of the facility. This left alternating sides of the facility without staff.	F 353		
F 356 SS=B	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name, o The current date, o The total number and the actual hours worked	F 356		

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

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F 356	Continued From page 59 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to post the nurse staffing data at the beginning of each shift. The findings were: Observation on 7/18/07 at 12:05 PM showed the nurse staff data was posted for the entire day. Interview with the administrator and social services designee at the time of the observation revealed the night nurse always posted the information for the entire day. Neither the administrator nor the social services designee	F 356	F356 NURSE STAFFING This facility strives to ensure that the posting of the facility name, current date, total number and actual hours worked of all licensed and unlicensed nursing staff directly responsible for resident care by shift on a daily basis. This is evidenced by the following. The Policy and Procedure for Posting Daily Staffing on Duty will be reviewed and revised by the Administrator and the DON. The nursing staff will be inserviced on this new policy and procedure. The DON or deignee will monitor for compliance on a daily basis for one month then weekly thereafter. Any non-compliance will be reported to the Administrator for further action. QA to review quarterly.	8/31/07

DEPARTMENT OF HEALTH AND HU. AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 356	Continued From page 60 wee aware if changes were made to the posted information if the schedule changed.	F 356		
F 386	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the physician reviewed the total program of care and wrote, signed, and dated progress notes at each visit for 2 (#13, #14) of 12 sample residents seen by the physician. The findings were: 1. Medical record review revealed the only documented physician visit for resident #13 occurred on 4/2/07. Interview with the acting director of nursing (DON) on 7/18/07 at 12:50 PM revealed the physician saw the resident in the clinic on 6/15/07. The acting DON confirmed there was no progress note related to that visit in the medical record. 2. Review of physician progress notes for resident #14 revealed the medical record lacked any notes which documented a physician reviewed the resident's total program of care. On 7/18/07 at 9:55 AM, the acting DON reported the physician saw the resident on 6/15/07; however, she	F 386	F386 PHYSICIAN VISITS The facility strives to ensure the physicians review the resident's total program of care, write, sign, and date progress notes at each visit. This is evidenced by the following. The physicians office will be contacted for a copy of resident #13's physician visit. The copy will be placed in the medical records. All residents will be placed on a schedule to see physicians on a minimum of a quarterly basis. Medical records will audit for timely vistis and for for completion of signed and dated progress notes after each physician visit. The results of the audit will be presented to the Administrator to be submitted to the quarterly QA committee.	8/31/07

DEPARTMENT OF HEALTH AND HU..N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 386	Continued From page 61 confirmed there was no documentation of this visit in the medical record.	F 386		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 2 (#13, #46) of 12 sample residents were seen by a physician at the required frequency. The findings were: 1. According to the admission face sheet, resident #13 was admitted on 3/26/07. Review of the physician progress notes showed the only documented physician visit for resident #13 occurred on 4/2/07. Interview with the acting director of nursing (DON) on 7/18/07 at 12:50 PM revealed the physician saw the resident in the clinic on 6/15/07. The acting DON stated the resident was not seen by a physician in May 2007. 2. Review of the medical record face sheet for resident #46 showed s/he was admitted to the nursing home on 4/15/05. The most current physician visit recorded in the record was on 3/30/07. Interview with the acting DON on 7/18/07 at 1:28 PM confirmed the physician had not	F 387	F387 FREQUENCY OF PHYSICIAN VISITS The physicians office will be contacted for a copy of resident #13's physician visit. The copy will be placed in the medical records. All residents will be placed on a schedule to see physicians on a minimum of a quarterly basis. Medical records will audit for timely vistis and for for completion of signed and dated progress notes after each physician visit. The results of the audit will be presented to the Administrator to be submitted to the quarterly QA committee.	8/31/07

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F 387	Continued From page 62 visited the resident since 3/30/07.	F 387		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to obtain medication from the pharmacy in a timely manner for 1 (#31) non-sample resident. The findings were : Review of physician orders dated 7/10/07 revealed an order for Bacitracin Ophthalmic Ointment, 1/2 inch ribbon in both eyes four times a day for 10 days. The following concerns were noted: a. Observation on 7/17/07 at 7:30 AM	F 425	F425 PHARMACY SERVICES. This facility strives to obtain medication from the pharmacy in a timely manner. This is evidenced by the following. Resident #31 has received her ophthalmic ointment. A policy and procedure will be created and reviewed by the Administrator to ensure all residents receive medication in a temely manner. Pharmacist and nursing staff will be inserviced on the new policy and procedure prior to implementation. The DON and Pharmacist will audit all new medication orders monthly. The results will be presented to the Administrator to be submitted to the quarterly QA meetings.	8/31/07

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F 425	Continued From page 63 revealed the resident did not receive the eye ointment during a routine medication pass. b. Interview with licensed practical nurse (LPN) #5 at 9 AM revealed the ointment had been ordered, but it had not yet been obtained from the pharmacy. On the afternoon of 7/17/07, the LPN obtained the medication. c. Interview on 7/19/07 at 9:45 AM with the nursing home administrator revealed her expectation was that medication would be started within twenty four hours of being ordered by the physician.	F 425		
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the direotor of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the monthly medication regimen was reviewed by a licensed pharmacist for 11 (#5, #13, #14, #23, #24, #25, #32, #33, #41, #44, #46) of 11 sample residents who resided in the facility at the time of the survey. The findings were: Review of the monthly medication regimen reviews for residents #5, #13, #14, #23, #24, #25, #32, #33, #41, #44, #46 revealed the last review	F 428	F428 DRUG REGIME REVIEW The facility strives to ensure the monthly mediation regiment is reviewed and revised by a licensed Pharmacist. All residents will have a pharmacy review completed this month and monthly thereafter. Administrator and DON will monitor for compliance. The results will be submitted to the quarterly QA meetings.	8/31/07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 428	Continued From page 64 date was 5/31/07. Interview with the nursing home administrator on 7/18/07 at 3:45 PM revealed she spoke to the pharmacist and, because of his vacation, he was late in reviewing the medication regimens for the month of June 2007.	F 428		
F 441 SS=F	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, medical record review, family and staff interview, and review of policy and procedure, the facility failed to implement an effective infection control program. The findings were: The following concerns were noted with the infection control policy and procedure, dated 5/07: a. The policy and procedure repeatedly referred to the infection control officer. Interview on 7/19/07 at 3 PM with social service designee revealed there was not an infection control officer for the facility. b. The policy and procedure documented, "... Proper isolation precautions will be implemented per Policy and Procedure by the ICO [infection	F 441	F441 INFECTION CONTROL This facility strives to ensure that it establishes and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. This is evidenced by the following. The Administrator and DON will review and revise the Infection Control Policy and Procedure book which will be approved by the Medical Director. The policy and procedure will include the following; a designated Infection Control Officer; description of all levels of precautions; procedure for the culturing and follow up on all infections; tool for monitoring employee illnesses; educational material for old and newly hired staff regarding handwashing,	

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F 441	Continued From page 65 control officer] or designee..." Interview with the social service designee on 7/19/07 at 3 PM revealed these isolation precautions were not included in the policy and procedure and there wasn't a separate isolation policy and procedure. c. Review of the infection control log from 6/13/07 to 7/3/07 revealed 10 infections reported, but only one culture was done. There were four eye infections in this two week period with no cultures or follow up. There were three urinary tract infections with no cultures, but all three residents received antibiotics. There were no follow-up cultures to see if the antibiotics were effective. There were two infections where the site of the infections were not identified. d. Interview on 7/19/07 at 3 PM with the social service designee revealed there had been no monitoring of employee illnesses. Nor was there any policy with criteria for when ill employees should stay, or go, home or could return to work. e. Further interview with the social service designee revealed there had been no monitoring of, or education about, handwashing, perineal care, or catheter care. Please refer to F444 (handwashing), and F312 (incontinence and catheter care) for problems in these areas. Other examples of lack of an effective infection control program: - Observation on 7/17/07 at 3:25 PM showed certified nurse aides (CNAs) #7 and #16 stripped the bed for resident #27, bundled up the dirty linen, and both CNAs held it next to their clothing before putting it in a bag. CNA #16 then leaned over another bed and changed the incontinence brief for resident #46. - On 7/17/07 at 7:53 AM observation during the breakfast meal revealed CNA #1 repeatedly picked up drinking glasses by placing her fingers	F 441	perineal care, and catheter care; proper disposal and handling of linen in soiled incontinence products; and proper infection control technique in the dining room. All staff will be inserviced on the new policy and procedure and the aforementioned items will be added to the skill checklists for all employees were appropriate. The IFO will audit the infection control log for accuracy and completeness daily for one month then weekly for three months then monthly thereafter. The results will be presented to the Administrator to be submitted to the quarterly QA meetings.	8/31/07

DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 66 on the drinking surfaces around the rims. She assisted residents #28 and #31 to drink from the same glasses. During the same observation, CNA # 9 also picked up the drinking glasses by the rim and then gave resident #28 a drink.	F 441		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and standard handwashing procedure guidelines, the facility staff failed to wash their hands as indicated by accepted professional practice. The findings were: 1. "Nursing Assistant" 9th edition, by Hegner, Acello, and Caldwell, copyright 2004, page 172 revealed, "...Handwashing should be done:...Before and after caring for each patient..." The following concerns with failure to implement this standard were noted: a. On 7/16/07 at 7:20 PM licensed practical nurse (LPN) #6 washed his hands after performing wound care on resident #42. The LPN left this resident's room and pushed the treatment cart to the room of resident #22. Before the LPN entered the room, he put on a pair of gloves without washing his hands first. The LPN then performed wound care on the resident, removed the soiled gloves, and washed his hands. The LPN left this resident's room and pushed the treatment cart to resident #32's room. Before the	F 444	F444 PREVENTIN SPREAD OF INFECTION This facility strives to ensure it requires staff to practice proper standard precautions which includes hand washing after each resident contact for which hand washing is indicated by accepted professional practice. This is evidenced by the following. Proper hand washing technique will be posted in all areas where hand washing is necessary. LPN #6, TNA #18 and #17, and all staff will be inserviced on the proper technique for hand washing and will return demonstrate technique. The DON or designee will monitor five staff members weekly for proper hand washing technique for one month then five staff members weekly for three months then monthly thereafter. The results will	

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F 444	Continued From page 67 LPN entered the room, he put on a pair of gloves without washing his hands first. The LPN then performed wound care on resident #32, removed the soiled gloves, and washed his hands. The LPN left the room and pushed the treatment cart to the room of resident #25. Before he entered the room, he put on a pair of gloves without washing his hands first. He entered the resident's room and performed wound care. b. On 7/16/07 at 7 :20 PM training nurse aide (TNA) #18 and certified nurses aide (CNA) #17 performed incontinence care on resident #22 who had been incontinent of bowel. The TNA and CNA washed their hands before leaving the resident's room then came out into the hall and pushed the two barrels that contained soiled linen and garbage down the hall to resident #32's room. When they entered that room, they put on gloves without washing their hands and performed incontinence care for that resident. When they completed the incontinence care, they removed their gloves, washed their hands and returned to the hall. Again, they pushed the two barrels that contained dirty linen and garbage down the hall to the room of resident #25. They entered the resident's room, put on gloves without first washing their hands, and performed incontinence care for the resident. 2. Observation on 7/16/07 at 5:45 PM showed a staff member spilled a glass of water onto the floor while serving the evening meal. Training nurse aide (TNA) #17 cleaned up the water with a towel, picked the towel up off the floor and placed it on the end of the assisted table, wiped it around, and then assisted resident #22 with the meal (the plates, silverware, and glasses remained on a tray). The TNA failed to cleanse her hands prior to assisting the resident. Review	F 444	be presented to the Administrator to be submitted to the quarterly QA meeting.	8/31/07

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

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F 444	Continued From page 68 of the facility's undated policy and procedure entitled "Hand Hygiene" showed it did not address cleansing the hands after contact with contaminated objects. However, it did reference the 2002 "CDC Guidelines for Hand Hygiene in Health-Care Settings." According to those guidelines healthcare workers should: "Decontaminate hands before having direct contact with patients...after contact with patient's intact skin....after contact with inanimate objects in the immediate vicinity of the patient...Before eating...,wash hands..."	F 444		
F 465 SS=E	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 environment for residents, staff, and the public. The findings were: 1. Periodic observations from 7/16/07 at 1 PM through 7/19/07 at 10:10 AM revealed metal baseboard heater covers were either missing or bent out away from the wall and projecting into the interior of the hall or resident rooms. Interview with the facility maintenance director on 7/19/07 at 10:10 AM verified the sharp edges of the baseboard covers represented a safety hazard to resident's, staff, and guests. The following locations were noted: a. The hallway opposite resident rooms #25, #28, #24, #17, #8, #20. b. The hallway next to resident rooms #4,	F 465	F465 OTHER ENVIRONMENTAL CONDITIONS This facility strives to provide a safe environment for residents, staff and the public. This is evidenced by the following. The Maintenance Supervisor will replace or repair the heating covers in rooms #'s 25, 28, 24, 17, 8, 2, and in resident bathroom in room #27, in the hallway by rooms #14 and #2 and in the dining room and T.V. room by doors and windows in the east wing. The Maintenance Supervisor will monitor for broken or missing heater covers on daily rounds and will replace or repair as needed. The Maintenance Supervisor will clean and replace	

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F 466	Continued From page 69 #14, #2, and the dining room. c. In the dining room along both the west and east walls; d. In resident room #27 and also in the resident's bathroom. e. In the communal TV room by back door, near west window. 2. Observations on 7/16/07 at 11:30 AM revealed a bead of mold approximately 5 inches long on the floor where the floor met the wall in the shower stall in the "shower room," B wing, near room #23. In addition, the counter cabinet door was pulled away from the frame exposing both the hinge and the sharp pointed wood screws in the dirty utility room near the nurse's station. Two of the five dining room fans did not work. Interview with the facility maintenance director on 7/19/07 at 10:10 AM verified the presence of the mold, the exposed metal screws, and the broken fans.	F 465	caulking in the shower room B and repair the counter cabinet door in the dirty utility room. Broken fans will be replaced. The Maintenance Supervisor will monitor on daily rounds and fix or repair as needed. The results of his daily rounds will be presented to the Administrator to be submitted to the quarterly QA meetings.	8/31/07
F 492 SS=E	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 observation, staff interview, and medical record review, the facility failed to ensure state rules and regulations were met for 2 of 11 sample residents. This failure related to assessments completed by licensed practical nurses (LPNs) for resident #14 and duties	F 492	F492 ADMINISTRATION This facility strives to ensure State rules and regulations are met for all residents. This is evidenced by the following. All assessments, including resident #14 will be completed and signed by an RN. An audit will be implemented and results will be submitted to the quarterly QA meeting.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 492	Continued From page 70 performed by certified nurse aides (CNAs) for resident #23. In addition, temperature requirements for hot water accessible to residents in rooms #5 and #6 and certification requirements for the dietary manager were not met . The findings were: 1. Related to assessments completed by an LPN: Review of the Wyoming Nursing Practice Act July 2005 and Administrative Rules and Regulations November 2003 revealed the following: "Section 3. Standards of Nursing Practice for the Licensed Practical Nurse (a) Standards related to the licensed practical nurse's contribution to the nursing process. (i) The licensed practical nurse shall: (A) Contribute to the nursing assessment by: (I) Collecting, reporting and recording objective and subjective data in an accurate and timely manner. Data collection includes: (1.) Observation about the condition or change in condition of the client; (2.) Signs and symptoms of deviation from normal health status." This regulation was not met as evidenced by: Review of the comprehensive assessments for activities of daily living, falls, and pressure ulcers revealed they were completed by licensed practical nurse (LPN) #11 on the 5/17/07 admission Minimum Data Set assessment for resident #14. The acting director of nursing (DON) confirmed this on 7/16/07 at 4 PM. 2. Related to duties performed by CNAs: Observation on 7/17/07 at 1:35 PM showed	F 492		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 492	Continued From page 71 resident #23 was in a wheelchair in the hall way. The resident asked CNA #7 to check his/her oxygen, and see if it was out. CNA #7 looked at the oxygen regulator on the back of the wheelchair, and saw it was set to zero. She then adjusted the knob to three liters per minute (lpm). The oxygen flow rate was not posted on the oxygen tank. The CNA stated she would have the resident check at the nurses station to see if it was an accurate liter flow. Once the resident felt the flow of oxygen, s/he left toward the dining room, and did not stop at the nurses station; the aide went about her work not checking the liter flow rate with a nurse. Medical record review showed the July 2007 recapitulation of orders was for oxygen at 2 lpm continuously. According to the May 2001 decision by the Wyoming State Board of Nursing (BON), a CNA may be delegated the task of adjusting the oxygen liter flow if the liter flow is clearly marked by the nurse on the concentrator and/or oxygen tank. 3. Interview with the facility administrator on 7/17/07 at 3:48 PM revealed the dietary manager had been employed in that capacity for approximately one month but was not yet certified. According to the Rules and Regulation for Program Administration of Nursing Care Facilities, Chapter 11, Section 11. Dietetic Services, (a)(i) If the qualified supervisor is not a Registered Dietician, she/he shall be a graduate of a dietetic technician program approved by the American Dietetic Association or a dietary manager's educational program approved by the Certifying Board for Dietary Managers. 4. Observation on 7/19/07 at 11:11 AM while in the presence of the facility maintenance manager revealed the bathroom faucet water temperature	F 492	All residents requiring oxygen will have their oxygen flow rates posted on the concentrator so the CNA's will be able to change the oxygen and apply and take off the oxygen. All nursing staff will be inserviced on this procedure. The DON or designee will monitor for labeling on a daily basis for compliance. The results will be presented to the Administrator to be submitted to the quarterly QA meetings. The Dietary Manager has applied and received her course materials. The Dietary Manager will complete the course in approximately one year. The Dietary Consultant will be preceptor and monitor progress. The quarterly QA will monitor the progress. The mixing valve was repaired on 7/24/07. Water temperatures in all rooms are within normal range. Maintenance Supervisor will monitor the water temperature daily. The results will be presented to the Administrator to be submitted to the quarterly QA meeting.	8/31/07 8/31/07 8/31/07

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F 492	Continued From page 72 In rooms #5 and #6 were 118 and 117 degrees Fahrenheit, respectively. According to the Rules and Regulation for Program Administration of Nursing Care Facilities, Chapter 11, Section 6. Physical Environment, (a)(iv) Shower/bath and resident lavatories shall be set to provide water of a temperature not to exceed 110 degrees Fahrenheit.	F 492		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure laboratory (lab) tests were completed, as ordered, for 2 of 11 (#14, #23) sample residents who resided in the facility at the time of the survey. The findings were: 1. Review of the 5/3/07 admission physician's orders showed resident #14 was to have a weekly comprehensive metabolic panel, complete blood count with differential, and magnesium lab tests. Review of the lab test results showed no tests were completed on 5/16/07 and the magnesium level was not done on 7/5/07 and 7/12/07. Interview with the acting director of nursing (DON) on 7/17/07 at 1:25 verified the tests were not done as ordered. 2. According to physician orders dated 3/22/07, resident #23 was to have monthly digoxin and PT/INR (tests to determine if the blood is too thin)	F 502	F502 LABORATORY SERVICES The facility strives to assure laboratory test will be completed as ordered. This is evidenced by the following: The Administrator and DON will develop a policy and procedure for laboratory test completion and tracking. The nursing staff will be inserviced on this policy and procedure prior to implementation. The DON and MDS coordinator will monitor for compliance weekly. The results will be presented to the Administrator to be submitted to the quarterly QA meeting.	8/31/07

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F 502	Continued From page 73 levels. Review of the lab test results revealed the tests were not done in May 2007. On 7/19/07 at 3 PM the administrator confirmed the lab tests were not completed as ordered.	F 502		
F 507 SS=D	483.75(j)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory results were included in the resident record for 2 (#14, #46) of 11 sample residents. The findings were: 1. Review of the 5/3/07 admission physician's orders showed resident #14 was to have a weekly comprehensive metabolic panel, complete blood count with differential, and magnesium lab tests. Review of the lab test results showed the tests for 7/5/07 were missing. Interview with the acting director of nursing (DON) on 7/17/07 at 1:25 PM revealed those tests had been completed, but the results were still at the lab. 2. Review of a urine dipstix dated 6/25/07 showed resident #46 was positive for nitrites and leukocytes; the corresponding nurses note dated 6/25/07 at 10 PM showed the urine sample was to be sent in for a culture and sensitivity. Eight days later, a nurses note dated 7/3/07 showed the resident was started on Bactrim for a urinary tract infection. Further review showed the urinary analysis (UA) and culture and sensitivity results	F 507	F507 LABORATORY SERVICES This facility strives to ensure it files the resident's record laboratory reports that are dated and contain the name and address of the testing laboratory. This is evidenced by the following. The newly developed policy and procedure for laboratory completion and tracking will include the filing in the resident's record laboratory reports that are dated and contain the name and address of the testing laboratory. Residents #14 and #46 will have their laboratory results filed in their medical records.	8/31/07

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F 507	Continued From page 74 were not included in the medical record. Interview with the acting DON on 7/18/07 at 1:28 PM confirmed the UA and culture and sensitivity results were being faxed over from the physician's office.	F 507		
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of medical records, the facility failed to ensure clinical records were accurately and completely maintained and systematically organized for four (#13, #25, #47, #48) of 12 sample residents. The findings were: 1. Medical record review for resident #25 showed there was no Minimum Data Set (MDS) assessments, no care plan for any aspect of the resident's care, and no vital signs flow record for the month of July 2007. Interview with the acting director of nursing on 7/18/07 at 2:10 PM confirmed these records were not included in the resident's medical record.	F 514	F514 CLINICAL RECORDS This facility strives to ensure clinical records are accurately and completely maintained and systematically organized. This is evidenced by the following. ~~A new Medical Records Supervisor~~ will be hired and trained. All medical records for ~~residents~~ ALL and # 13, 25, [illegible] will be review and organized to contain all assessments and care plan records needed for resident care. 8/31/07 Resident #47 and #48 will have their medical records organized and closed per facility procedure.	

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F 514	Continued From page 75 2. Medical record review revealed the record for resident #13 was incomplete. According to the face sheet, the resident was admitted on 3/26/07 and identified concerns were partially assessed. However, there was no available care plan for the resident. On 7/19/07 at 11:30 AM the administrator stated the facility was unable to find any care plan for the resident. 3. Review of the closed medical record for resident #47 revealed s/he was discharged from the facility on 6/11/07. When the record was retrieved it was not bound, and pages were sticking out and not in any particular order. The bathing record for May and June 2007, and certified nurse aide flow sheet for June 2007 were not found in the closed record. Interview with the nursing home administrator on 7/19/07 at 1:55 PM confirmed she could not locate these items. 4. Review of the closed record for resident #48 revealed all the pages were unbound and placed in random order in manila folders. Review of the record was extremely difficult as nothing was systematically organized.	F 514	The Administrator and MRD will audit the medical records quarterly for compliance. The results will be submitted to the quarterly QA meetings.	8/31/07
F 520 SS=H	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. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520	F520 QUALITYASSESSMENT AND ASSURANCE The facility strives to maintain an effective Quality Assurance Program. This is evidenced by the following. The Administrator and the QA committee will develop and	

PRINTED: 00/02/2007
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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
	535040	A. BUILDING _____ B. WING _____	C 07/19/2007

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

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F 520	Continued From page 76 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the quality assessment and assurance (QA) committee meeting minutes, the facility failed to maintain an effective committee. The findings were: Interview on 7/18/07 with the current administrator and acting director of nursing (DON), and review of the QA committee meeting minutes, revealed the last QA meeting was on 6/22/07. Prior to that meeting, the committee met on 12/29/06 and 7/12/06. A physician did not attend any of the meetings and actually signed off as reviewing the minutes for the December 2006 meeting on 2/12/07, two months later. Further review showed only the previous administrator and a nurse were present at the 12/29/06 meeting. In addition, the minutes of both meetings consisted of an outline with only the heading of the topic to be discussed. During the aforementioned interview with the administrator, she and the acting DON confirmed a physician never attended the meetings. The acting DON stated she was the nurse at the QA meeting with	F 520	implement a Quality Assurance Policy and Procedure to be approved by the Medical Director. Meetings of the QA committee will me held monthly for six months and then quarterly thereafter. All staff and the Medical Director will be inserviced on the program. The Administrator will monitor monthly for compliance. The Administrator and the QA committee will review all audits for trends and effectiveness of procedures.	8/31/07

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F 520	Continued From page 77 the previous administrator on 12/29/06, and she confirmed they were the only two people present. No information related to concerns, or areas identified as needing improvement by the facility, was available. Furthermore, evidence of selected indicators, benchmarks, action plans, on-going evaluation, and/or revised action plans was lacking. That lack confirmed there were no current, effective QA projects in place.	F 520		