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

PRINTED: 09/05/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING _____ B. WING _____ SEP 15 2008	08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1115 LANE 12 LOVELL, WY 82431

(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 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, review of resident council minutes, and staff and residents interviews, the facility failed to ensure residents were treated with dignity and were provided a homelike dining atmosphere for 4 (#10, #13, #17, #18) of 13 sample residents and 13 (#9, #12, #15, #16, #21, #23, #24, #25, #26,#28, #29, #36, #38) non-sample residents. The findings were: 1. Observation in the east dining room on 8/18/08 at 6:05 PM revealed two certified nurse aides (CNA) A and B delivered the food trays to the following residents: #13, #17, #18, #15, #29, #21, #16, #9, #26, and #25. The CNAs left the plates and glasses on the plastic serving trays instead of placing the items on the tables. Observation in the east dining room on 8/19/08 at 7:51 AM revealed the plates and glasses remained on the plastic serving trays for the following residents: #13, #17, #18, #15, #29, #21, #9, #26, and #25. Observation on 8/20/08 at 5:55 PM in the sitting area outside of the East dining room revealed residents #28, #12, #24, and #23 had trays left under the food served. However, observation in the main dining room on 8/18/08 during the evening meal and on 8/19/08	F 241	The facility will ensure a resident receives care in a manner and in an environment that maintains and enhances each resident's dignity and respect. A)Plates and glasses are removed from plastic serving trays to include but not limited to residents #10, #13, #17, #18, #9, #12, #15, #16, #21, #23, #24, #25, #26, #28, #29, #36, and #38. B)Random rounds will be done weekly by nurse supervisor and charge nurses to monitor performance. The facility will ensure all foley drainage bags are covered to maintain resident dignity. Including Res #10 A)Performance will be monitored weekly by random nurse supervisor rounds. The facility will ensure resident dignity and respect are maintained by staff knocking on resident doors before entering residents rooms. A)Performance will be monitored weekly by random nurse supervisor rounds.	10-05-08

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE
CERTIFIED MAIL™
7006 2150 0005 0247 5710

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peter Stubbs — TITLE: CEO/Administrator — (X6) DATE: 9-12-08

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.

Accepted w/changes per phone call w/ Traci Harrison DON DOC: 10/5 on 9/19/08 @ 835 AM Loralee Russ 9/19/08

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F 241	Continued From page 1 during the breakfast meal revealed no trays were left under the food as served. 2. Observation on 8/19/08 at 2 PM revealed resident #10 had a urinary catheter with a drainage bag containing yellowish clear urine hanging in front of the resident's wheelchair in full view of other residents. Interview with the DON on 8/21/08 at 8:10 AM confirmed drainage bags were to be covered with a privacy bag. 3. Observation on 8/18/08 at 5 PM revealed a registered nurse (RN) C entered the room of residents #36 and #38 without knocking. The residents were in their rooms at the time. Interview with the director of nursing (DON) on 8/21/08 at 8:10 AM confirmed the facility's expectation concerning entering a resident's room was that staff would knock first and wait for permission to enter the room.	F 241	B)The education coordinator will provide education to the nursing staff on the residents' right to personal privacy and dignity with emphasis on tray removal at mealtime, covering foley catheter bags, and importance of knocking before entering a residents room. QA: this monitoring will be tracked by the facility QA program. Reported quarterly.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	The facility will ensure all residents ~~will receive complete comprehensive~~ assessments as scheduled and as needed. A)All residents will receive complete comprehensive assessments as scheduled and as needed. B)The MDS Coordinator will develop an assessment tracking form to ensure all departments are completing comprehensive assessments timely and in accordance with the MDS schedule. Res#18 Comm, ADLs, Falls assessment Res# 34, Tube feeding assessment	10-05-08

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F 272	Continued From page 2 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 medical record review and staff interview, the facility failed to provide comprehensive assessments in required areas for 2 of 15 sample residents (#18, #34). The findings were: 1. According to the 8/17/07 annual Minimum Data Set (MDS) assessment, resident #18 triggered for comprehensive assessments in the areas of Communication, Activities of daily living (ADLs) and Falls. Medical record review showed no resident assessment protocols (RAP) or other forms of comprehensive assessments were conducted in these three areas. Interview with the DON on 8/20/08 at 10 AM revealed these assessments were not completed. 2. Record review of an admission MDS dated 7/15/08 for resident #34 revealed the resident had a feeding tube. Further record review revealed no resident assessment protocol (RAP) was completed to address the tube feeding. Interview	F 272	C)The MDS Coordinator will monitor completion of assessments and report weekly at the Interdisciplinary Team Meeting. This will be reported quarterly as part of the facility Quality Improvement Program. D)The Director of Nursing will monitor MDS Coordinator reports weekly and monitor performance by weekly random chart checks by the Director of Nursing..	10-05-08

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F 272	Continued From page 3 on 8/21/08 at 8:30 AM with the MDS coordinator revealed the dietary department was responsible for completing tube feeding RAP. Further interview on 8/18/08 at 10:30 AM with the MDS coordinator confirmed there was no tube feeding RAP had not been done.	F 272	The facility will ensure professional standards are met to include but not limited to: nutritional assessments, nursing documentation, and medication administration. A)All comprehensive assessments for nutritional status will be completed and signed by the Registered Dietician according to the MDS schedule. B)Performance will be monitored weekly by random chart checks by the MDS Coordinator and reported weekly at the Interdisciplinary Team Meeting. Results will be reported quarterly as part of the facility Quality Improvement Program.	10-05-08
F 281 SS=F	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure professional standards were met regarding nutrition assessments, nursing documentation, and medication administration for 13 of 13 sample residents (#4, #10, #11, #13, #17, #18, #19, #27, #34, #42, #52, #56, #63) and 2 non-sample residents (#65, #67). In addition, one of four medication carts was unlocked and unattended. The findings were: NUTRITION ASSESSMENTS 1. Review of the 5/6/08 admission Minimum Data Set (MDS) assessment for resident #19 revealed the resident required a comprehensive assessment for nutritional status. Review of the 4/30/08 Resident Assessment Protocol (RAP) for nutrition revealed it was completed and signed by the certified dietary manager, and not the registered dietitian (RD). In addition, another RAP dated 7/3/08 and a Nutrition Risk Assessment dated 7/3/08 were both completed and signed by the certified dietary manager.	F 281	? The nutrition assessments for res # 19, 13, 10, 4, 17, 52, 18, 63, 56, 27, 11, 34 + 42 have been completed See pg 8 for remainder of POC for 281.	

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F 281	Continued From page 4 2. Review of the 7/8/08 significant change MDS assessment for resident #13 revealed the resident required a comprehensive assessment for nutritional status. Review of the 7/3/08 RAP for nutrition and the 7/3/08 Nutrition Risk Assessment showed the certified dietary manager completed and signed the assessments. 3. Review of the 7/10/08 Nutrition Risk Assessment for resident #10 showed the certified dietary manager completed and signed the assessment. 4. Review of the 8/14/08 Nutrition Risk Assessment for resident #4 revealed the certified dietary manager completed and signed the assessment. 5. According to the significant change MDS assessments dated 5/12/08 and 8/11/08, resident #52 required comprehensive assessments related to his/her nutritional status. Review of the "Nutrition Risk Assessments" dated 5/5/08, 5/12/08, and 5/26/08 and the 5/12/08 RAP review module showed all were completed and signed by the certified dietary manager. The record lacked evidence an RD was involved in the assessment process. 6. Medical record review revealed the nutritional risk assessments for resident #17 dated 12/6/07 and 7/17/08 were signed as completed by the certified dietary manager. 7. Medical record review showed the nutritional risk assessment dated 8/17/07 and the nutritional risk assessment and the dietary RAP dated 8/7/08 for resident #18 were signed as completed	F 281		

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F 281	Continued From page 5 by the certified dietary manager. 8. Medical record review revealed the nutritional risk assessments for resident # 63 for 12/27/08, 3/19/08, and 6/19/08 were signed as completed by the certified dietary manager. 9. Further review revealed the nutrition risk assessment and the dietary RAP dated 6/5/08 for resident #56 were signed as completed by the certified dietary manager. 10. Medical record review revealed the nutritional assessments for resident #27 for 9/20/07, 12/4/07, 3/5/08/08, and 5/29/08 were signed as completed by the dietary manager. Further review revealed the dietary RAP for 7/12/08 was signed as completed by the dietary manager. The record lacked evidence the RD was involved in the assessment process. 11. Medical record review revealed the nutritional assessments for resident #11 for 6/4//07 and 6/3/08 were signed as completed by the dietary manager. Further review revealed the dietary RAP for 3/9/08 was signed as completed by the dietary manager. The record lacked evidence an RD was involved in the assessment process. 12. Medical record review for resident #34 revealed nutrition risk assessments dated 7/12/08 and 8/4/08 and a nutrition RAP dated 7/12/08 were signed as competed by the certified dietary manager. 13. Medical record review for resident #42 revealed nutrition risk assessments dated 2/21/08 and 7/17/08 and a nutrition RAP dated 7/17/08 were signed as completed by the dietary	F 281		

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F 281	Continued From page 6 manager. 14. Interview with the dietary manager on 8/19/08 at 2 PM confirmed she routinely completed the nutritional assessments and dietary RAPs. Interview with the dietary manger and registered dietitian (RD) on 8/20/08 at 1:25 PM revealed they had not realized the RD was responsible for all dietary assessments. Reference: According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals...for nutrition risk factors...It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients." NURSING DOCUMENTATION 1. Review of the medical record showed resident #18 had a long standing diagnosis of hypothyroidism. Review of the monthly physician	F 281		

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F 281	Continued From page 7 order sheets revealed the resident was prescribed and received levothyroxine (Synthroid) 75 mcg (micrograms) daily on a routine basis. However review of the medication administration record (MAR) showed the resident did not receive the Synthroid on five days; 7/1/08, 7/4/08, 7/9/08, 7/12/08 and 7/13/08. Interview with the director of nursing (DON) on 8/19/08 at 10 AM revealed the nurse on duty on those days administered the medication, but "forgot" to record it in the MAR. The sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin lists one of the six rights to safety is "documentation." MEDICATION CARTS/MEDICATION PASS: 1. Observation on 8/19/08 at 7:45 AM revealed licensed practical nurse (LPN) D was passing medications on the transitional unit. At that time, the LPN left the medication cart and left the unit. Further observation revealed the medication cart was unlocked, and there were blister packs containing medications lying on top of the cart. Interview with the director of nursing (DON) on 8/21/08 at 8:10 AM revealed she expected all medication carts to be locked when not in view of the nurse. In addition, the DON stated that medications should not be left on an unattended medication cart. "Nursing Interventions and Clinical Skills" 4th edition, by Elkin, Perry, and Potter, copyright 2007, page 375 revealed the nurse was to, "Keep drugs secure...Medication carts must be kept locked when unattended and the key kept by an authorized person." 2. Observation on 8/19/08 at 7:45 AM revealed LPN D touched one of resident #67's pills and 14 pills intended for of resident #65, with her bare	F 281	The facility will ensure all medications are administered appropriately and timely. A)Resident #18 is receiving medications as ordered. B)All residents will receive medications as ordered and administered according to the nursing standards of practice. C)Nursing staff will be inserviced on following proper medication administration techniques as well as proper procedure for documenting on the medication administration record. The inservice will also include locking medication carts to keep drugs secure, five rights of medication administration, and the importance of not touching medications with the fingers. D)Performance will be monitored by weekly random rounds observing medication administration by nurse supervisors and pharmacist and reported monthly as part of the facility Quality Improvement Program.	10-05-08

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F 281	Continued From page 8 hands. "Nursing Interventions and Clinical Skills" pages 374 and 383 revealed, "...avoid touching tablets and capsules...Do not touch medication with fingers..."	F 281		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of 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 ensure the drug regimen was free of unnecessary medications for 1 (#4) of 15 sample residents. The findings were:	F 329	The facility will ensure the drug regimen is free of unnecessary medications for all residents. A)A comprehensive sleep assessment has been done for resident #4. B)A procedure will be developed to ensure all residents who have not used antipsychotic drugs are not given these drugs unless necessary to treat a specific condition and gradual dose reductions are done along with behavioral interventions in an effort to discontinue these drugs. C)Performace will be monitored by random chart checks by the Director of Nursing and Pharmacist monthly during drug regimen review and reported quarterly as part of the facility Quality Improvement Program.	10-05-08

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F 329	Continued From page 9 Review of physician's orders for resident #4 showed that on 4/10/08 Temazepam [sedative-hypnotic]15 milligrams (mg) at bedtime as needed was ordered. Review of the July 2008 medication administration record (MAR) revealed the resident received the Temazepam on 27 nights. According to the August 2008 MAR, the resident received Temazepam 16 nights (through 8/19/08). Review of the medical record showed no comprehensive sleep assessment had been done to determine possible causes of the resident's insomnia. On 8/20/08 at 3 PM, the DON stated a comprehensive sleep assessment was not completed.	F 329		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility procedure, observation and staff interview, the facility had three medication errors out of sixty opportunities which resulted in a 5% error rate. The findings were: Observation on 8/19/08 at 8 AM during a medication pass on the transition unit revealed LPN D administered 14 different medications to resident #65. The following concerns were noted: a. Observation revealed LPN D administered Lotrel 5/20 milligrams (mg), Prozac 10 mg, and Furosemide 40 mg along with 11 other medications to the resident. b. Review of this resident's physician's orders revealed there were no orders for Lotrel and	F 332	The facility will ensure it is free of medication error rates of five percent or greater. A)Nursing staff will be inserviced on following proper medication and administration techniques including the five rights of medication administration and reading each label three times before administering medications. B)Performace will be monitored by weekly random rounds, observing medication administration by nurse supervisors and Pharmacist and reported monthly as part of the facility Quality Improvement Program. Resident #65 is receiving medications as ordered.	10-05-08

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F 332	Continued From page 10 Prozac, and the Furosemide order was for 10 mg every other day. Interview on 8/19/08 at 9:30 AM with the LPN confirmed this. c. Review of the facility's specific medication administration procedures revealed, "...F. Read medication label three times before pouring...K.... document administration in the medication administration record (MAR)..." d. Interview on 8/19/08 at 9:30 AM with LPN D revealed another resident's medication blister packs were mixed with resident # 65's medication blister packs. The LPN also confirmed she did not read the resident's name on the blister packs and did not match the medication with the resident's MAR, which resulted in resident #65 receiving another resident's medication.	F 332		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, cleaning schedule review, and staff interview, the facility failed to ensure four of four reach-in refrigerator/freezer units and one of two microwave units located outside the kitchen were maintained in a clean condition. The findings were: Observation on 8/19/08 from 12:40 PM to 1:10 PM revealed the following concerns: a. The refrigerator/freezer unit in the family dining room on the first floor had spilled food and crumbs on the bottom with a spill-over onto the	F 371	The facility will store, prepare, distribute and serve food under sanitary conditions. A)The refrigerator/freezer units and microwaves for the family dining room, room #2137, pantry behind second floor medication room, and room #3255 have been cleaned. B)All kitchens have been placed on a weekly cleaning schedule to be done by night shift certified nursing aides. C)Performance will be monitored weekly by random nurse supervisor rounds and reported quarterly at the facility Quality Improvement Meeting. Education to staff (CNAs & nursing) Responsible will be inservices related to clean tasks.	10-05-08

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F 371	Continued From page 11 floor. Various food supplies were stored among the debris. b. An accumulation of crumbs was noted on the bottom of the refrigerator located in the server room (#2137). Food for resident consumption was being stored in the soiled area. c. The bottom of the refrigerator/freezer unit in the pantry behind the second floor medication room contained scattered food and crumbs. Food was being stored among the debris. Also, the interior of the microwave unit was noted to be soiled inside with dried, caked-on, blackened food residue. d. The interior of the refrigerator/freezer unit in room #3255 contained an accumulation of crumbs on the bottom. Again, food was being stored in contact with the food debris. Review of the kitchen cleaning schedule revealed the refrigerator/freezer units and microwave units outside of the kitchen were not listed for cleaning. Interview with the dietary manager on 8/20/08 at 1:20 PM confirmed the refrigerator/freezer units and microwave units outside of the kitchen were not on the dietary cleaning schedule, and she did not know when they were last cleaned. According to the Food Code 2005, U.S. Public Health Service, Food and Drug Administration, 3-305.11: "(A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location...According to the Food Code 2005, U.S. Public Health Service, Food and Drug Administration, 4-602.12: "(B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING _____ B. WING _____	08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 12 procedure."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to report the pharmacist's recommendations for 1 (#18) of 13 sample residents to the physician. The findings were: Review of the medical record and the medication administration record (MAR) for resident #18 revealed the resident was taking two antidepressants. The resident began taking Zoloft once a day on 11/28/06 and Remeron once a day on 4/18/05. Review of the pharmacist's drug regimen review over the previous year revealed no written recommendation regarding the two antidepressants. However interview with the DON on 8/20/08 at 10 AM revealed the pharmacist had discussed the issue with the DON, but the DON stated she did not contact the physician. She stated the pharmacist's recommendation was that the resident receive either a gradual dose reduction or the physician should document a justification for the continued use of the two	F 428	The facility will ensure the monthly pharmacist recommendations are reported to the physician. A)The pharmacist recommendations for resident #18 for Zoloft and Remeron have been communicated to the physician. B)Random chart checks will be performed by the Director of Nursing and pharmacy monthly during drug regimen review, and reported quarterly as part of the facility Quality Improvement Program to ensure irregularities are reported to the attending physician and Director of Nursing and appropriate action has been taken. Staff education will be completed for all nursing staff.	10-05-08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 13 antidepressant medications.	F 428		
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 reports were filed in the medical record for one (#18) of 13 sample residents. The findings were: Review of the medical record for resident #18 revealed a diagnosis of hypothyroidism. A physician's order sheet, dated 5/1/08, requested a blood thyroid stimulating hormone (TSH) test be done. Further record review revealed a lab requisition slip dated 5/2/08 was prepared indicating the TSH order was communicated to the lab. However, review of the lab results revealed no TSH results were filed in the record. Interview with the DON on 8/19/08 at 1:48 PM confirmed the TSH results were not in the medical record. Facility staff then contacted the lab and determined the test was done and requested the results be faxed to the facility.	F 507	The facility will ensure lab reports are filed in the medical record. A)The TSH level results for resident #18 is in the resident's medical record. B)Random chart checks will be performed by the Director of Nursing and pharmacy monthly during pharmacy review and reported quarterly as part of the facility Quality Improvement Program. Staff will be educated re: lab reporting system; DN	10-05-08