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
	465093	A. BUILDING ____ B. WING ____	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHAM CITY NURSING & REHAB	775 NORTH 200 EAST BRIGHAM CITY, UT 84302

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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 interview and record review, it was determined the facility did not notify the resident's legal representative of a significant change in the resident's physical condition for 2 of 11 sample	F 157	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F157 (D) Notification of changes **CORRECTIVE ACTIONS FOR IDENTIFIED RESIDENT** The physician for resident #3 was notified on 5-4-06 of a concern with the resident's catheter and penis. The family/ interested party for resident #11 was notified on 5-4-06 of a previous circumcision on 9-5-05. Immediate in service was given to all licensed nursing staff. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** Any resident who has a significant change in condition has the potential to be affected.	

5/8/06 POC acceptable completion date 6/2/06 [signature] RN

Utah Department of Health
761238
MAY 08 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 5-7-06

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

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residents. Specifically, the resident's medical Power of Attorney (POA) was not notified of a surgical procedure performed on one resident and the physician was not notified of one resident who experienced a painful infection. (Resident identifiers: 3 and 11)

Findings included:

1. Resident 3 was admitted to the facility on 1/22/06 with diagnoses including IDDM (Insulin dependent Diabetes Mellitus), COPD (Chronic Obstructive Pulmonary Disease), Right sided weakness from a CVA (Cerebral Vascular Accident), and a failed THA (Total Hip Arthroplasty).

On 4/9/06, resident 3's medical record was reviewed.

The "Daily Skilled Nursing Notes" documented the following entries.

On 4/7/06 at 9:00 PM "[Patient] very mad that [catheter] was inserted...".

On 4/8/06 at 3:15 PM "...Rash noted to pubic area. Penis red [and] swollen - [resident] denies pain to [perineal] area. Erythematous exudate noted [at approximately 9:00 AM] Checked later [and] minimal drainage noted....".

On 4/8/06 at 1:20 AM "...Some dried bloody drainage around tip of penis outside the [catheter] foley. "Resident complained of pain in the genital/perineal area...".

On 4/9/06 at 4:00 PM "...voiced [complaints

MEASURES TO PREVENT RECURRENCE

The licensed nursing staff will be in-serviced by the Director of Nursing (DON) or designee on the proper management of significant changes in condition, including immediate notification of the physician and prompt notification of the family and/or interested party. Change of Conditions will be tracked daily in stand up meeting.

MONITORING/QUALITY ASSURANCE

An audit tool will be developed by the DON or designee to monitor for notification of significant changes in condition. The DON or Designee will do audits 5 times per week until compliant with report to the Quality Assurance Committee weekly for 4 weeks. Further audits and reports will then be as directed by the Quality Assurance Committee.

The Director of Nursing will be responsible for continued compliance.

Completion date: June 2, 2006

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of] pain [with catheter at] times, [catheter] patent[et] draining ...".

There was no documentation noted in resident 3's medical record that the physician was notified of resident 3's change in condition.

On 4/10/06 at 8:45 AM a skin check was performed for resident 3 with a facility nurse and CNA. During this examination, it was noted by staff and surveyor that resident 3's penis was very swollen and red. One facility staff member was noted to say that it was worse than before.

On 4/12/06, A facility report log was reviewed. This report is used by staff nurses to communicate with one another any problems or changes in condition that residents have experienced during each shift.

On 4/7/06 during the Day shift the following was documented " [Catheter changes]. Bled little - watch if voiding". Later on afternoon shift it is documented that " voided in day, very unhappy...".

On 4/8/06 during the afternoon shift the following is documented " Rash pubic area. Some erythematous drainage noted from foley site, swelling".

On 4/9/06 day shift documented "penile pain around urethra area. Slight occult blood noted". The afternoon shift documented that "reports of pain [at] times.".

On 4/10/06 the day shift noted " [continues with complaints of] pain even 1 hour after med

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F 157	Continued From page 3 given...". The afternoon note states "pain med [times] 3". There was no documentation on the nurses report log or the MD communication book to indicated that the MD was notified of resident 3's change of condition. On 4/11/06 at 12:20 PM a staff nurse who had recently been assigned to care for resident 3 was interviewed. She stated that she was not aware of the problem resident 3 had been having. Later, she confirmed that she was told of the problem by the night nurse the other day. When asked if she had examined the resident or reported the change in condition to resident 3's physician, she stated that she had not. She was not aware if the physician had ever been notified of the problem. 2. Resident 11 was an 81 year old male who was admitted to the facility March 2005 with diagnoses that included dementia with depression, delusions, and agitated features. Resident 11's medical power of attorney (POA) was interviewed on 4/11/06 at 1:55 PM. The POA stated that she was concerned that she had not been notified by the facility that resident 11 was going to be circumcised. The POA stated she had learned about the surgery after it had been performed. The POA stated that, at the time she admitted resident 11 to the facility, she had provided the facility with documentation specifying she was resident 11's medical POA. The POA stated she was acting in behalf of resident 11 because the resident's spouse was overwhelmed with all that	F 157		

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F 157	Continued From page 4 was happening. Resident 11's medical record was reviewed on 4/11/06. A social service note, dated 3/1/06, revealed that the facility was notified that resident 11 had a POA and the social service worker (SSW) had met with the POA. The SSW note, dated 3/2/06, revealed the POA had met with activities personnel and with the SSW for resident 11's initial care plan meeting. The SSW note, dated 3/3/05, revealed resident 11's POA was notified regarding an incident and room change involving the resident. The SSW note, dated 9/14/05, revealed that resident 11's POA and his wife attended an interdisciplinary team meeting. The SSW documented that the POA had not been notified of resident 11's circumcision. The SSW documented that the POA asked to be notified of any serious doctor's appointments.	F 157		

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F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not post their annual survey in a place that was readily accessible to the residents. Findings included: On 4/10/06 at approximately 10:00 AM, the posted survey from March of 2005 was found to be in the front lobby in a wall cabinet behind a glass door with two wing tip chairs just underneath the cabinet. The chairs in front of the cabinet rendered the survey not readily accessible to the residents.	F 167	F167 (B) Examination of survey results **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** The 2657 was placed in a location that is accessible to the residents. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected. **MEASURES TO PREVENT RECURRANCE** The Administrator will check 5 times per week to ensure the 2567 is in it's new location and remains accessible for the residents. The administrator will work with the resident council to ensure the location remains convenient for them reach. **MONITORING/ QUALITY ASSURANCE** If the 2567 is found to be missing or not convenient for the resident's accessibility the Administrator will report to the Quality Assurance Committee for possible relocation. The Administrator will be responsible for continued compliance. Completion date: June 2, 2006	

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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 observations and interviews, it was determined the facility did not promote resident care in a manner and an environment to enhance each resident's dignity and respect. Specifically, it was discovered that the wait time associated with having call bells answered was lengthy. Residents' call lights were not answered timely for 7 of 8 alert and oriented residents who participated in a confidential group interview, for 2 of 3 sample residents and families who were interviewed individually and 1 confidential, supplemental interview. (Resident identifiers: 2 and 9) Findings included: 1. Call lights were observed to be unanswered for longer than five minutes. Observations on 4/9/06: The call light for room 38 had been activated 13 minutes, from 9:17 AM until 9:30 AM. The call light for room 10 had been activated 9 minutes, from 9:33 AM until 9:42 AM. The call light for room 22 had been activated 8 minutes, from 9:34 AM until 9:42 AM. The call light for room 20 had been activated 6 minutes, from 9:47 AM until 9:52 AM. The call light for room 10 had been activated 6 minutes, from 10:09 AM until 10:15 AM, when it	F 241	~~F241 (E) Quality of life~~ **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** Immediate in-service was done to include all residents. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected. **MEASURES TO PREVENT RECURRANCE** The Director of Nursing (DON) or designee will develop an audit tool to monitor the answering of resident call lights within the limits of the facility policy. Facility has implemented an "I brake for call lights" program. **MONITORING/ QUALITY ASSURANCE** The DON or designee will do random audits 5 times a week for 4 weeks with a weekly report to the QAC until compliant. The Committee will then determine if further audits and reports are necessary. The Recreational Activities will address call lights at each Resident Council Meeting and share with Administration any concerns. The Director of Nursing will be responsible for continued compliance. Completion date: June 2, 2006	

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F 241	Continued From page 7 was answered by a non-nursing staff member. Seven minutes later, the call light for room 10 was reactivated. The call light for room 20 had been activated 18 minutes, from 2:35 PM until 2:53 PM. The call light for room 13 had been activated 28 minutes, from 2:35 PM until 3:03 PM. Observations on 4/10/06: The call light for room 23 had been activated 12 minutes, from 9:00 AM until 9:12 AM. The call light for room 42 had been activated 13 minutes, from 1:04 PM until 1:17 PM. The call light for room 8 had been activated 19 minutes, from 1:27 PM until 1:46 PM. 2. A confidential interview was conducted with a group of 8 alert and oriented residents on 4/10/06 at 2:30 PM. Seven of the eight residents stated that they did not always get the help they needed when they turned on their call lights. They stated that they sometimes have had to wait 15 to 30 minutes for their call lights to be answered. The residents stated that during the day shifts, when staff did answer the call light, they would turn off the light and say they would come right back. The residents stated the staff don't return and the residents have to call again to get the help they needed. The residents stated that the night nurse aides don't come around at night because there doesn't seem to be enough of them. 3. On 4/11/06 at 10:15 AM, a resident was interviewed confidentially in the resident's room. The resident stated that call lights were answered too slowly. The resident stated that he/she had incontinent accidents 2 or 3 times that were related to staff answering the call light too slowly.	F 241		

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The resident stated that, a few weeks ago, he/she had experienced a period of diarrhea and frequent urination. The resident stated that the staff did not answer the call light timely. The resident stated they all laughed when the staff arrived in time to clean up, but he/she "had to laugh or would have cried." The resident stated that there were times when staff would not assist the resident to transfer out of bed as needed for toileting.

The resident stated that when he/she was assisted to use a bedside commode, the staff did not always empty the commode. The resident stated that it was a concern to him/her whether the bowl was left full in the resident's room, or in the bathroom. The resident stated that he/she had told the staff that the bowl should always be emptied and rinsed after use, but that it had been left again just that morning.

4. On 4/9/06 at 2:20 PM, resident 2 was interviewed. Resident 2 stated that staff didn't seem to notice her call light when she used it. The resident stated it wasn't uncommon for her to wait 20 minutes or more for someone to answer her call light.

5. During an interview on 4/11/2006 at 11:15 AM, with resident 9 and spouse, the resident's spouse stated she has personally observed wait times of twenty minutes or longer. The resident and spouse both stated that it is typical of nurse aides to come turn off the call bell and state "I'll be right back", but then do not come back to help the resident.

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F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility did not provide the social services necessary to attain each residents' mental, or psychosocial well-being. Specifically, resident 3 did not receive assistance from social services to assess, monitor, or treat the behaviors he was manifesting. Findings included: Resident 3 was admitted to the facility on 1/22/06 with diagnoses including IDDM (Insulin dependent Diabetes Mellitus), COPD (Chronic Obstructive Pulmonary Disease), Right sided weakness from a CVA (Cerebral Vascular Accident), and a failed THA (Total Hip Arthroplasty). On 4/9/06 and 4/11/06, resident 3's medical record was reviewed. The "Daily Skilled Nursing Notes" documented the following entries. 1. On 4/5/06 "[resident] had increased [amount] of sleep....Resident very angry [related to] life [circumstances] states he was 'fine till I came here'....lashing out verbally to this nurse...would recommend SSW(Social Service Worker) visit to help resident to calm and use	F 250	F 250 (D) Social Services **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** Resident #3 was be assessed by the Social Service Worker to determine any psychosocial needs that are not being met by the facility. The physician was contacted for any medication changes. Care Plan was updated. New behavior tracking sheets were put in place. Staff educated on how to properly deal residents behavior. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** Residents who have mental or psychosocial needs have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** Administrator will contact the VA to try to expedite a visit with a psychiatrist at the VA. Social Service Director will be in serviced on the importance of meeting resident's psychosocial needs. Resident #3 will be evaluated monthly and PRN at the psychotropic meeting. All new admits will be discussed in standup meeting after 72 hour conference to include their psychosocial needs.	

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F 250	Continued From page 10 coping skills. Will pass on...". 2. On 4/6/06 "...[Patient] soft spoken today - unusual for [patient] When questioned about behavior and how he feels today diverted his eyesight downward [and] stated he 'feels fine'. ....Resident quiet [and] withdrawn....". 3. On 4/9/06 "[Patient ...discouraged with health status...will ask for meds 30 [minutes] after receives them...". 4. On 4/10/06 "upset with all cares. [Resident] almost hit this LPN (Licensed Practical Nurse) ....cursing and swearing with cares...[Resident] expecting to go to [hospital] in AM.". 5. On 4/11/06 "Family talked [with resident] on trip back...[resident] promised family he would be polite to staff [and] try harder.". The "Social Service Progress Notes" documented the following entries. 1. On 3/7/06 "...[Resident] is very disappointed as is family. Will continue to provide support.". No further entries were present as of 4/11/06 at 11:00 AM. On 4/11/06 at 11:15 AM the SSW was interviewed. When asked if the staff had spoken to her about the change in resident 3's behavior, she stated no, that she had read about it in resident 3's medical record. She stated that she has not spoken much with resident 3, as he has good family support,and that he is very angry and abusive to staff. When asked why she felt that behavior was occurring she stated that it was something that they should probably be tracking. She felt that if resident 3 was depressed maybe medication could be helpful; however, resident 3	F 250	**MONITORING/QUALITY ASSURANCE** The Social Services Worker (SSW) will then report weekly to the Quality Assurance Committee for 4 weeks or until compliant. The Committee will then determine if further audits and reports are necessary. The Social Services Worker will be responsible for continued compliance. Completion date: June 2, 2006	

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is just frustrated and angry which is understandable given his situation. The SSW stated that she writes down everything she sees, and as a team they talk about how to approach residents. She further agreed that no care plan had been put in place, but it was probably something she should start.

On 4/12/06 at 9:00 AM, resident 3's medical record was again reviewed. At that time, the following entry was recorded in the Social Service Progress Notes. On 4/11/06 " Staff reports that {resident] continues to display anger and frustration with his situation. Will continue to provide support to [resident] and family."

On 4/9/06 at 4:52 PM, an interview was conducted with resident 3. Resident 3 was very polite, and encouraged surveyor to return later to talk to him.

On 4/12/06 at 11:40 AM, an interview was conducted with resident 3. Upon asking resident 3 if he was visited by the SSW he stated that he did not know her, but she may have come in before and he does not remember. Resident voiced his frustration about just "wanting to be fixed", and being repeatedly put off. At that time his eyes began to fill with tears and he began wiping his eyes repeatedly. He stated that he knew he "griped at the girls" (the staff), but explained to surveyor that if they do something incorrectly and he does not tell them, they will continue to do it wrong. Resident 3 further stated that "I know that they all think I [gripe] at them for nothing, but I just want things done right." Upon asking resident 3 if anyone from the facility came to him just to talk about how he's feeling, he

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F 250	Continued From page 12	F 250		

stated no. Resident 3 continued wiping at his eyes and thanked the surveyor for talking to him. Finally, he expressed to surveyor that all he felt he could do was pray, and hope someone hears him.

On 4/12/06 at 12:10 PM, an interview was conducted with the SSW. When asked by surveyor about the new behavioral care plans and monitoring in resident 3's chart she stated that she felt that after our last talk, that tracking should be started to monitor his behaviors. She continued by saying that resident 3 is combative, cusses at the staff, and had raised his fist to a staff member, so it had become necessary to document his abusive behaviors. The SSW stated that she had not really talked much with resident 3, but she felt that he was just an angry man, and that his swearing could possibly be attributed to his military service. Resident 3 also has been noted by staff to grin while he is swearing, and that it was mostly for affect. She stated that resident 3 was not trying to be mean, but that the staff seemed to personalize his behaviors. The SSW further stated that " I know anger is an outward expression of inner turmoil, and he probably is depressed, but he's really angry..." She also mentioned that in the next psychotropic meeting, she would suggest that maybe an antidepressant medication would be helpful to resident 3. After the surveyor shared with the SSW some of the concerns identified after speaking with resident 3, she stated that it was sad that he prays and hopes to get answers, and he has probably lost hope that things will change. Lastly, she stated that " maybe I can look for some outside counseling for him and his family..."

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations from 4/9/06 through 4/10/06, it was determined that the facility did not provide maintenance services to maintain a sanitary and comfortable environment. Findings included: 1. On 4/9/06 the following was observed: a. Room 23: The wooden bathroom door (side facing into room 23) had numerous scraps and dents from the door knob down. b. The bathroom between rooms 30 and 31: There was a 12 inch by 4 inch area behind the toilet of peeling finish on the paneling. There was areas of peeling paneling butting up against the tile coving on the three walls surrounding the toilet. c. Room 28: The bathroom door surface, facing room 28, had varnish that was severely rubbed off exposing bare wood. d. The bathroom between rooms 26 and 27 had a 21 inch by 4 inch area of missing one inch tiles under the sink. The light fixture did not light up when the switch was in the on position. The coving tile near the floor underneath the sink was	F 253	F253 (E) Housekeeping/ Maintenance **CORRECTIVE ACTION** P.O.s will be issued by June 12, 2006 for the following items; Carpet between rooms 6 and 10. Bathroom doors in rooms 23, 28, 19. The finish on the paneling in bathrooms of rooms 30, 31, 26, 27, 18, 19. The tiling in the bathrooms of rooms 26, 27, 24, 25, 32, 33. The light fixtures in bathrooms 26, 27, 18, 19 were repaired. The toilet tank lid from bathroom 32, 33 was repaired.. The Maintenance Director was immediately in-serviced importance of providing and maintaining a sanitary and comfortable environment.	

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F 253	Continued From page 14 missing. There was chipped and peeling paneling next to the sink and 1 inch up from the intact coving tile. e. Between rooms 10 and 6, in the south hall, there were greater than 15 ripples in the carpet from approximately 7 feet to 1 foot long causing a potential tripping hazard. 2. On 4/10/06 the following was observed: a. The bathroom between rooms 18 and 19 had paneling with chipped areas exposing a brown underlay that was unsanitizable behind the sink, behind and next to the toilet and a 5 inch by 1 inch area next to the sink. The light fixture had no cover exposing a bare light bulb. Near the base of the toilet there were 5 one inch tiles missing. The surface of the bathroom door, the side exposed to room 19, the varnish was severely rubbed off exposing bare wood. b. The bathroom between rooms 24 and 25 had 2 missing tiles and 4 broken tiles on the floor in front of the toilet. Behind the toilet on the floor was a 16 inch by 18 inch area of no tile exposing the under flooring. c. The bathroom between rooms 32 and 33 had a broken 6 inch coving tile across from the sink. The toilet tank lid had a chipped area near the handle and a 7 inch crack. Behind the toilet was a 6 inch by 1/2 inch area of chipped paneling.	F 253	**IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected. **MEASURES TO PREVENT RECURRANCE** The Maintenance supervisor will develop a maintenance log for routine rounds of resident rooms. A maintenance log will be provided at each nurses station for reporting daily repairs needed. **MONITORING/ QUALITY ASSURANCE** Administrator will review log on a daily basis and report weekly to the QAC for 4 weeks or until compliant. The results will be reported to the Quality Assurance Committee. The Committee will then determine if further audits and reports are necessary. The Administrator will be responsible for continued compliance. Completion date: June 2, 2006	

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F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not ensure that the Minimum Data Set (MDS) assessments were complete and that the MDS accurately reflected residents' status for 5 of 11 sample residents. (Resident identifiers: 1, 2, 4, 10 and 11.)	F 278	F278 (B) Resident Assessment **CORRECTIVE ACTION** All residents identified will be reviewed by MDS nurse and Utilizations Services Consultant and corrected as needed. MDS Coordinator will be in-serviced by corporate Utilizations Services Consultant on how to complete and MDS correctly. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** An audit tool will be developed by Utilizations Services Consultant to be completed by the MDS nurse and turned in to the DON to ensure compliance with Federal Regulations. **MONITORING/QUALITY ASSURANCE** The Director of Nursing (DON) will do audits on new admissions. The findings will be reported to the Quality Assurance Committee weekly for 4 weeks or until compliant. The Committee will then determine if further audits and reports are needed.	

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F 278	Continued From page 16 Finding included: 1. Resident 11 was admitted to the facility in December of 1995 with diagnoses that included congestive heart failure, cerebral vascular accident and an open reduction internal fixation of the left femur. On 5/23/05, a quarterly MDS (Minimum Data Set) was signed by a RN (registered nurse) in section R2a signifying that the MDS was completed. However, in section AA - 9 ("Signatures of persons completed a portion of the accompanying assessment or tracking form") there were 5 different signatures of staff, two of which were dated 5/24/05, and 3 that were dated 5/29/05, after the RN had signed that the assessment had been completed. 2. Resident 1 was admitted to the facility in May of 2001 with diagnoses that included congestive heart failure and osteoarthritis. Resident 1's annual MDS dated 12/1/2005, section R2a, was not signed by an RN signifying that the MDS was completed. The "Assessment Reference Date", section A-3, of the Annual Assessment was given as "12-02-2005". The "Signatures of Persons Who Completed a Portion of the Accompanying Assessment or Tracking form", section AA-9, was signed and dated on 2/05/06. 3. Resident 2 was admitted to the facility May of 2002. The annual comprehensive MDS assessment, dated 8/31/05, and the quarterly MDS assessments, dated 12/2/05 and 2/25/06,	F 278	The Director of Nursing (DON) will be responsible for continued compliance. Completion date: June 2, 2006	

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F 278	Continued From page 17 revealed resident 2 had exhibited no behavioral symptoms in section E-4. The facility Administrator was interviewed on 4/12/06 at 11:10 AM. The Administrator stated that resident 2 had presented them with some of their biggest challenges. The Administrator stated that resident 2 had put nursing staff in tears. The Administrator presented documentation detailing concerns regarding resident 2's behaviors, demanding and resisting cares and being verbally abusive to staff dating from August 2004 to present. 4. Resident 4 was admitted to the facility February of 2006. The comprehensive MDS assessment, dated 2/25/06, had not been signed in section AB. The comprehensive MDS assessments, dated 2/25/06 and 3/20/06, revealed in section K5a that resident 4 was receiving parenteral IV (intravenous) nutrition. The DON stated, on 4/11/06, that resident 4 had not received parenteral IV nutrition at the facility. 5. Resident 10 was admitted to the facility April of 2002. A quarterly MDS assessment, dated 2/1/06, revealed in section J-4 that resident 10 had no history of falling within the past 180 days. Nurse's notes, dated 10/18/05, revealed resident 10 had fallen from her wheelchair at 1:30 AM on that date, which was within 180 days of the MDS assessment.	F 278		

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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 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 record review it was determined that the facility did not use the results of resident 3's admission assessment to develop, review and revise the comprehensive plans of care for 1 of 11 sampled residents. (Resident: 3) Findings included: Resident 3 was admitted to the facility on 1/22/06 with diagnoses including IDDM (Insulin Dependent Diabetes Mellitus), COPD (Chronic	F 279	F279 (D) Comprehensive Care Plans **CORRECTIVE ACTION** Resident #3 care plan reviewed and updated. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** At the 72 hour conference the chart will be reviewed for completeness and care plans. Medical Records will do a 7 day audits to ensure chart, including care plan, is complete. **MONITORING/QUALITY ASSURANCE** The minutes of the 72 hour conference will be reviewed by the QAC weekly for 4 weeks or until compliant. The Committee will then determine if further audits and reports are needed. The Administrator will be responsible for continued compliance. Completion date: June 2, 2006	

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F 279	Continued From page 19 Obstructive Pulmonary Disease), Right sided weakness, HTN (Hypertension), PVD (Peripheral Vascular Disease), and a failed THA (Total Hip Arthroplasty). Resident 3's medical record chart was reviewed on 4/9/06 through 4/12/06. Resident 3 had an Admission MDS (Minimum Data Set) assessment completed on 2/2/06. Based on the results of that assessment for resident 3, the following RAP's (Resident Assessment Protocol) were triggered to be investigated further: 1. ADL (Activities of Daily Living) 2. Urinary Incontinence/Catheter 3. Psychosocial 4. Behavior 5. Falls 6. Nutrition 7. Fluid Status/Dehydration 8. Pressure Ulcers On the RAP Summary sheet of the 2/2/06 MDS, the facility indicated that each of the RAP Problem Areas triggered would be care planned. The following Care Plans were located in resident 3's medical record as of 4/12/06 at 11:00 AM. 1. IV Fluids, UTI 2. Oxygen requirements 3. Risk for skin breakdown 4. Personal Hygiene 5. Recreation Therapy 6. Nutritional Status Although the facility interdisciplinary team had	F 279		

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F 279	Continued From page 20 decided the concerns needed to care planned for resident 3, there were no care plans for the resident in the following areas: 1. Psychosocial 2. Behaviors 3. Falls	F 279		
F 281 SS=D	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 upon observation by two surveyors, it was determined that facility services did not meet professional standards of quality for 1 of 11 sample residents. Specifically, a facility nurse was observed to contaminate a clean dressing change to the resident's wound. (Resident identifier: 1) Findings included: On 4/09/2006 at 11:50 A.M, a licensed practical nurse (LPN) at the facility was observed as she changed a dressing to resident 1's buttocks. Resident 1 stood at the toilet as she held on to her walker. The nurse opened three gauze pad containers. She then opened a container of sterile water. The nurse set the opened container of water upon the hand rail next to the toilet with the mouth of the container in contact with the wall. She placed clean gloves on her hands. The nurse moistened the first gauze pad by pouring	F 281	F281 (D) Comprehensive Care Plans (Professional Standards of Care) **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** Resident wound was redressed using clean technique. All nurses were in-serviced on dressing changes using clean technique. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents with dressing changes have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** The Licensed Nursing Staff will be in-serviced by the Director of Nursing on the proper procedure for dressing changes. Competency will be done for all Licensed Nursing staff on proper dressing changes. Competency checklist will be completed on all new hires.	

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

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F 281	Continued From page 21 the liquid onto the pad, and replaced the opened bottle of water in the same position with the mouth of the container in contact with the wall. She proceeded to wipe the opened area of the wound with the gauze pad and folded the pad. She again wiped the opened area of the wound with the same pad. The nurse touched a second gauze pad to the rim of the water container as she moistened the pad. With the second gauze pad, she wiped the open wound twice with the same gauze pad.. When she was finished with the gauze pad, she attempted to throw it into a garbage can, but missed. She retrieved the pad from the floor and threw it away in the garbage can. She did not wash her hands. She continued to cleanse the wound using a third gauze pad moistened with water from the contaminated bottle. As before, the nurse wiped the open wound, folded the gauze pad and wiped the wound a second time. According to Lippincott's Manual of Nursing Practice, Eighth Edition, (Procedure Guidelines) for changing a dressing, it is important to use "another moistened gauze" so that each swipe of the wound is done with a fresh gauze to "prevent contamination" (Lippincott, 2006).	F 281	**MONITORING/QUALITY ASSURANCE** The Wound Nurse will monitor dressing changes weekly using competencies to ensure compliance. The competencies will be reported to the Quality Assurance Committee weekly for 4 weeks or until compliant. The Committee will then determine if further audits and reports are needed. The Director of Nursing (DON) will be responsible for continued compliance. Completion date: June 2, 2006	

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F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility did not provide the necessary nursing care and services for respiratory care of continuous oxygen for 1 of 11 sample residents. (Resident identifier: 13.) Findings included: On 4/10/06 at 2:30 PM, resident 13 participated in a confidential group interview. Resident 13 was sitting in a wheelchair that held a portable E-tank of oxygen. The resident required continuous oxygen administration at 2 1/2 to 3 liters per minute to keep her oxygen saturation greater than 90 percent. Resident 13 wore a nasal cannula with tubing connected to the E-tank. Resident 13's lips were slightly gray. At 2:45 PM, a family member of resident 13 joined the group. The family member noticed immediately resident 13's color and checked the E-tank and cannula. The E-tank indicator for the level of oxygen remaining was in the red warning	F 328	F328 (D) Special Needs **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** Resident 13 had a pulse regulator placed on the O2 E-tank to reduce the amount of O2 wasted per E-tank. Resident has since discharged from the facility. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** Residents who have respiratory services have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** The Director of Nursing (DON) will in-service nursing staff on proper handling of E-tanks including turning on and off. Proper handling of E-tanks will be included in new hire checklist including turning on and off. **MONITORING/QUALITY ASSURANCE** All new hire check list will be reviewed for completeness by the Director of Nursing. Compliance rounds (to include checking of e-tanks) will be done 5 times per week by the department managers. Findings will be reported to the Quality Assurance Committee for 4 weeks or until compliant. The committee will then determine if any further audits and reports are needed.	

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F 328	Continued From page 23 area, indicating the oxygen level was empty or low. It was determined that resident 13 was not receiving any oxygen. Nursing assistants were called out of an inservice meeting to get oxygen to resident 13 and to check resident 13's oxygen saturation level. The first nursing assistant was unable to get the E-tank to deliver oxygen and left to get an electric concentrator for resident 13. The nursing assistant stated that someone else had gone to get a pulse oximeter to check resident 13's oxygen saturation level. A nursing assistant brought the concentrator to resident 13 and attempted to connect it to the oxygen tubing the resident was wearing. Another nursing assistant arrived and demonstrated how to use the E-tank for the first nursing assistant. It was determined the E-tank resident 13 was using had not been turned on. Resident 13's nasal cannula was connected briefly to the E-tank after it had been turned on. The second nursing assistant explained that the other nursing assistants didn't understand how to work the oxygen E-tanks. The second nursing assistant stated there was going to be training at the inservice (being conducted at that same time) to teach the nursing assistants how to use the E-tanks correctly. A third nursing assistant arrived, resident 13's oxygen was discontinued briefly to test the resident's saturation level. The nursing assistant stated that resident 13's oxygen saturation was "87 to 88" percent. Oxygen was reconnected to resident 13's cannula and the resident's lips became pink.	F 328	The Director of Nursing will be responsible for continued compliance Completion date: June 2, 2006	

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F 328	Continued From page 24 Resident 13's family member was interviewed on 4/10/06 at 3:10 PM. The family member stated that the biggest concern with resident 13's care was the oxygen issue. The family member stated that it was not uncommon for resident 13 to be without oxygen and that she needed the staff to understand that was vital for resident 13's wellbeing that she have continuous oxygen. The family member stated that resident 13 was confined to her room too much because she had to have continuous oxygen and was often limited to using the electric concentrator in her room. Resident 13's family member stated she had discussed the oxygen issue with the nursing staff repeatedly. The family member stated she had been assured in the past that the staff was going to be trained regarding the use of the oxygen E-tanks. On 4/11/06 at 3:45 PM, the Director of Nursing (DON) was interviewed. The DON stated she was aware the nursing assistants were having a problem with the E-tanks. The DON stated they were often running out the oxygen by leaving the E-tanks running after reconnecting resident 13 to the concentrator in the her room. The DON stated there was going to be an inservice for the nursing assistants on use of the E-tanks. On 4/12/06 at 9:55 AM, resident 13 was observed in her room using the oxygen concentrator. Resident 13's family member was with the resident. The family member stated that there had been a problem again that morning with resident 13 not receiving her oxygen. The family member stated that she visits often and is worried because she has repeatedly found the resident	F 328		

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F 328	Continued From page 25 without oxygen. The family member stated that she has learned to check resident 13's oxygen first thing when she visits. Resident 13's family member stated oxygen was a major issue that brought the resident to the facility.	F 328	F354 (B) Nursing Services- Registered Nurse **CORRECTIVE ACTION** RN will cover 8 consecutive hours per day per federal regulation.	
F 354 SS=E	483.30(b) NURSING SERVICES - REGISTERED NURSE Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interviews with the facility director of nurses (DON) and review of the facility nursing schedule, the facility failed to have a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week from March 17th through April 13th. Findings included: On 4/10/06, a review of the nurses' schedule for March 17th through April 13th revealed that the	F 354	**IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All Residents have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** Nursing Administrative team will continue to cover the RN coverage until a replacement is found or waiver is applied for. We will continue to work on recruitment and retention. Ads will continue to be placed. Competitive wages will continue to be offered. DON will review staffing sheets daily to ensure there is RN coverage. DON will notify Administrator if no RN coverage is available. **MONITORING/QUALITY ASSURANCE** The Director of Nursing (DON) will report the findings of staffing sheet audit weekly to the Quality Assurance Committee for 4 weeks or until compliant . The committee will then determine if any further audits and reports are needed.	

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F 354	Continued From page 26 facility did not have 8 hours of RN coverage on 3/19/06, 3/25/06, 3/26/06, 4/1/06 and 4/8/06. On 4/12/06 at 11:35 AM, the facility DON stated that she works Monday thru Friday. She stated that the facility has been unsuccessfully trying to hire additional RNs for the last few months. She stated that if on the weekends the schedule doesn't document that an RN was scheduled,then there was no RN coverage that day. She also stated that she is available by phone.	F 354	The Director of Nursing will be responsible for continued compliance Completion date: June 2, 2006	
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility did not always serve foods that were palatable and at a safe temperature. Findings included: 1. Group interview: A confidential group interview was conducted with a group of 8 alert and oriented residents. The residents stated that food served to residents in their rooms was served too cold. The residents stated the boiled eggs were rubbery and partially frozen. They stated that if they asked for coffee,	F 364	F 364 (E) Food **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** A schedule will be developed by the Administrator to monitor the dining room and meals. Administration met with Resident Council, they identified they would like to change meal times to 8:00 am, 12:30pm and 6:00pm. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected.	

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F 364	Continued From page 27 the staff would forget to come back with it. The residents stated they didn't ask for alternatives or to have their food heated because the staff wouldn't come back. One of the residents stated that they had talked with the dietary department about trying to get warm food. The resident stated they were told that the facility did not have the heated carts required to keep the meals warm. 2. Individual resident interviews: During initial tour, on 4/9/06 at 9:30 AM, a resident was observed to have a breakfast tray at bedside. The resident stated that the boiled egg was not edible. The resident stated that, "I think they just took them out of the freezer and cut them." On 4/9/2006 at 4:00 PM, an interview was conducted with resident 1. The Resident stated the food was "often" cold and "too cold by the time it comes. They will heat it up if you ask" . On 4/11/2006 at 11:15 AM, an interview was conducted with resident 9. The resident stated, "I like better food" and therefore the resident did "not eat much here". 3. The Test Tray was sampled on 4/11/2006 at 9:01 AM, at the time the last resident tray was delivered. The test tray contained the following items: Milk at 48 degrees F (Fahrenheit), which was palatable and fresh-tasting,	F 364	**MEASURES TO PREVENT RECURRENCE** Dining rooms will be monitored by department managers. Recreation Therapy will address this issue at each resident council meeting. Dietary and Nursing staff was in-serviced on the importance of providing palatable food at the proper temperature. Facility re-educated resident council that Administration will be available for any concerns including palatability of food and food temperatures. Administrator will directly address with each resident the policy and procedure of grievance forms. The Dietary Manager or designee will do test trays every meal for two weeks to ensure temperature and palatability. **MONITORING/QUALITY ASSURANCE** All resident council concerns must be addressed within 72 hours and reported to the Administrator. Administrator will sign off on all Grievances to ensure completeness and timeliness. The Recreation Therapist will give the Administrator the resident concerns within 96 hours showing that they have been completed. The social service director will maintain a log showing all grievances have been addressed within 72 hours. The Social Services Director and Recreations Therapy Director will report to the Quality Assurance Committee weekly for 4 weeks or until compliant. Dietary manager will maintain temperature and palatability logs. The Dietary Manager will report weekly to the QAC committee . The Committee will then determine if further audits and reports are needed.	

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F 364	Continued From page 28 One unpeeled Banana, which was very overripe. (Peeling of the banana revealed more than ½ of the fruit was bruised) Biscuits and Gravy at 102 degrees F, which were lukewarm and not palatable, Scrambled Eggs at 102 degrees F, which were rubbery and lukewarm, (Both Biscuits and Egg entrees were served on a non-insulated plate). Oatmeal at 138 degrees F (in an insulated bowl), which was palatable, Apple Juice, Ice Water.	F 364	Completion date: June 2, 2006 F 368 (E) Frequency of Meals **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** Met with Resident council, they desired to change meal times to 8:00 am, 12:30pm and 6:00pm. Dietary Manager was counseled on flexibility of snack menus.	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by:	F 368	**IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** The Dietary staff and Dietary consultant met with the DON to expand the snack menu. Dietary Manager will provide a weekly snack menu at the beginning of each week to Administrator. Charge Nurse will provide Administrator and DON documentation of previous HS snack passed to ensure dietary staff is following snack menu.	

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F 368	Continued From page 29 Based on observation and interview, it was determined that the facility allowed greater than 14 hours to elapse between the evening meal and breakfast meal. Findings included: 1. On 4/9/06, the dietary manager provided a copy of the facility's posted meal times: 7:30 AM, Breakfast, 12:00 PM, Lunch, 5:30 PM, Dinner. 2. On 4/10/06 the facility's main dining room was observed from 7:20 AM until 9:00 AM. At 7:30 AM, no one was in the dining room and the tables were not set. At 7:36 AM, dietary staff began to put utensils on the tables. At 7:37 AM, two independent residents arrived in the dining room. The two independent residents were served at 7:40 AM. At 7:50 AM, the first dependent resident was brought to the dining room and seated at the assistance table. No other residents had entered the dining room. At 7:55 AM, other residents began to arrive. Most of the independent residents were served soon after arriving. At 8:10 AM, eating utensils were set on the assistance table. One of the residents at the assistance table was being assisted with a high calorie beverage. At 8:40 AM, 7 residents were seated at the assistance table and none had been served their breakfast. One of the 7 had been given hot chocolate and was being assisted to drink. At 8:48 AM, the assistance table was being	F 368	**MONITORING/QUALITY ASSURANCE** All snacks will be reviewed by Administrator weekly for variety at QAC meeting for 4 weeks or until compliant. The Committee will then determine if further audits and reports are needed. The Administrator will be responsible for continued compliance. Completion date: June 2, 2006	

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F 368	Continued From page 30 served. The last tray was served at the assistance table to the first resident who had arrived at 7:50 AM. At 8:55 AM, the hall trays were delivered. At 9:00 AM, breakfast trays were delivered to the special needs dining room. On 4/10/06 at 5:30 PM until 6:00 PM, dinner was observed to be served. The first tray cart went to the special needs dining room at 5:30 PM, followed by delivery of the hall trays and service to the main dining room. On 4/11/06, it was observed that breakfast was served between 8:00 AM and 8:50 AM in the main dining room and 8:55 AM to the halls and the special needs dining room. Observations on 4/10/06 and 4/11/06 revealed there was from 14 1/2 to 15 1/2 hours between dinner and breakfast at the facility. 3. On 4/10/06 at 2:30 PM, an interview was conducted with 8 alert and oriented residents. The residents who ate meals in their rooms stated that they were served at 9:00 AM and their food came cold. They stated that they ate it anyway. The residents stated that they were so hungry by breakfast time they would take whatever they could get. One resident stated, "You're hungry and you're waiting for your meal, you don't want to send it back and wait longer." A resident stated that by then, "You eat what you get or starve." None of the residents in the confidential group interview knew that breakfast was supposed to be	F 368		

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F 368	Continued From page 31 at 7:30 AM, but they knew dinner was at 5:30 PM. All 8 of the residents stated they were never offered bedtime snacks to hold them over. One of the 8 residents stated he could go get a snack from the dining room after dinner. Three of 8 residents stated they could get corn chips, a banana or juice if they requested it. All 8 of the residents stated they were never offered bedtime snacks to hold them over. Two residents stated they would love to get a sandwich or ice cream at night. 4. The resident council minutes were reviewed on 4/10/06. There was no record that the council had given permission to wait more than 14 hours between meals.	F 368		
F 371 SS=E	483.35(h)(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, it was determined that the facility did not store, food under sanitary conditions. Specifically, on the initial tour of the kitchen several food items in the refrigerator and freezer were not labeled or dated, and the kitchen did not appear as clean as could be expected. Findings included: On 4/9/06 at 9:15 AM the initial tour of the kitchen was performed. The following items were found	F 371	F371 (E) Sanitary Conditions- Food Prep and service **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** All foods identified were removed. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** The Dietary Manager was in-serviced by the Administrator on following policy and procedures and Federal Guidelines. The dietary staff was in-serviced by the dietary manager on following policy and procedures and Federal Guidelines **MONITORING/QUALITY ASSURANCE** Sanitation audit tool will be used on a daily basis for 2 weeks then 3 times per week on an ongoing basis. Findings will be reported to the Quality Assurance Committee weekly for 4 weeks or until compliant. The Committee will then determine if further audits and reports are needed.	

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F 371	Continued From page 32 in the walk in refrigerator: 1. A bowl containing an unlabeled white substance was found with a date of 3/19/06. 2. An open container of sugarfree jelly was found to have no date. 3. A box of Neufchatel cheese was found to be open with a date of 4/1/06. 4. A bag of American cheese slices were found with no date 5. 2 bags of brownish colored identified meat were found. One appeared whole, while the other was chopped. No label or date was found on either bag. 6. A box containing 14 Chocolate no sugar Health Shakes was found to not have a thaw date on it. On 4/9/06 at 9:15 AM the initial tour of the kitchen was performed. The following items were found in the walk in freezer: 1. A package of Farmland ham was found with no date. 2. A package of what appeared to be raspberries was found with no label or date. 3. A blue plastic bag of what appeared to be french toast sticks was found with no label or date. 4. A bag of 6 breaded unidentified meat patties	F 371	The Administrator will be responsible for continued compliance. Completion date: June 2, 2006	

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F 371	Continued From page 33 was found with no label or date/ 5. A plastic bag of meat was found with no label or date. 6. A package of Chocolate Ice Cream was found with no date. 7. A bag of unidentified ground red meat was found with no label or date. 8. A bag of Peas, Onion Pearls, and Broccoli were found to not be dated. On 4/9/06 at 9:15 AM the initial tour of the kitchen was performed. The following items were noted during the walk through. 1. A gallon of Fat free Viva Milk was dated 1/15/06 in the holding fridge. 2. A container of purple punch dated 3/29/06 was in the holding fridge. 3. A container of orange punch dated 4/3/06 was in the holding fridge. 4. The meat slicer was noted to have unidentified meat pieces on it. There was no meat product served that day for breakfast.	F 371		

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F 426 SS=E	483.60(a) PHARMACY SERVICES - PROCEDURES 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not provide pharmaceutical services that assured the accurate administering of drugs and biologicals to meet the needs of 1 out of 11 sampled residents. (Resident identifier: 3) Findings included: Resident 3 was readmitted to the facility in January of 2006 with diagnoses that included insulin dependent diabetes mellitis, a failed total hip arthroplasty, cerebral vascular accident and hypertension. A review of resident 3's medical record was completed on 4/12/06. The physician's admission orders for January of 2006 documented the following insulin orders on the January 2006 MAR (medication administration record): Sliding scale (s/s) Humalog regular AC (before meals) & HS (at hour of sleep) 100-200 BS (blood sugar) = 5 units (u) regular insulin 200-300 BS = 10u of regular insulin	F 426	F426 (E) Pharmacy Services- Procedures **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** Resident #3 will have his pharmaceutical medications reviewed by his physician to ensure they meet his needs. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** Residents with insulin dependant diabetes have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** The licensed nursing staff was re-educated on the seven rights of medication administration and proper documentation. An audit was completed by the DON to check completeness of all resident's insulin orders. Nursing Administration will monitor MARs for holes, and accuracy of transfer of new medications daily. **MONITORING/QUALITY ASSURANCE** DON will report audit of telephone orders weekly to Administrator to ensure completeness. DON will report to the Quality Assurance Committee weekly for 4 weeks or until compliant. The Committee will then determine if further audits and reports are needed. The Director of Nursing will be responsible for continued compliance. Completion date: June 2, 2006	

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

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F 426	Continued From page 35 >300 BS 20 units and call MD (physician) On 1/28/06 at 7:00 AM resident 3's BS was 322. Resident 3 should have received 20u of regular insulin, but the box indicating the amount of insulin given was blank. The physician's orders dated 2/2/06 documented the following insulin orders for Humalog (regular insulin): <150 BS= 0u insulin 150-249 BS= 4u regular insulin 250- 350 BS= 8u regular insulin > 350= 12u regular insulin On 2/10/06 at 9:00 PM resident 3's BS was 315. Resident 3 should have received 12u of regular insulin, but instead received 8u. On 2/24/06 at 9:00 PM resident 3's BS was 193. Resident 3 should have received 4u of regular insulin, but instead received 0u. The physician's orders dated 3/7/06 documented the following insulin orders: Humulin R (100u/ml) 10u sq prior to AM and PM meals Humulin N (NPH) (100U/ml) 12u SQ (subcutaneous) QPM (each evening) Humalog R SQ AC & HS 70-149= NONE 150-200=2u 201-250=4u 251-300=6u 301-350=8u if > 350 give 8u	F 426		

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F 426	Continued From page 36 On 3/26/06 at 6:30 AM resident 3's BS was 216. Resident 3 should have received 4u of regular insulin, but instead received 2u. On 3/30/06 at 6:30 AM resident 3's BS was 353. Resident 3 should have received 8u of regular insulin, but instead received 6u. On 4/2/06 at 4:30 PM resident 3's BS was 202. Resident 3 should have received 4u of regular insulin, but the box indicating the amount of insulin given was blank. On 4/4/06 at 4:30 PM and on 4/5/06 at 4:30 PM, resident 3 should have received 10u of regular insulin prior to the PM meal. On 4/3/06 at 9:00 PM and on 4/7/06 at 9:00 PM resident 3 should have had his blood sugar tested and received the appropriate amount of insulin, but the boxes indicating the blood sugar level and the amount of insulin needed were blank. On 4/7/06 at 12:00 PM resident 3's BS was 176. Resident 3 should have received 2u of regular insulin, but the box indicating the amount of insulin given was blank. On 4/5/06 at 4:30 PM resident 3 should have had his blood sugar tested and received the appropriate amount of insulin, but the boxes indicating the blood sugar level and the amount of insulin needed were blank. On 4/4/06 at 9:00 PM resident 3's BS was 153. Resident 3 should have received 2u of regular insulin, but instead received 0u.	F 426		

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	465093	A. BUILDING ______ B. WING ______	04/12/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 426	Continued From page 37 On 4/12/06 at 12:00 PM, the DON (Director of Nursing) was interviewed about the insulin administration records. She stated that after calling several nurses, they were able to go through the glucometer and retrieve a few blood glucose results, but that there were many that could not be rectified. When asked how the nurses were able to distinguish which result went to which resident on what day, she stated that there are only a couple of residents with orders to have blood glucose levels drawn making it possible to differentiate. The DON could not explain why there were numerous blanks left on the insulin record, or why the errors had occurred.	F 426		

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F 496 SS=E	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not check the Nurse Aide Registry before allowing 3 of 4 recently hired nursing assistants to work directly with facility	F 496	F496 (E) Required training of Nurse aides **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** No residents were identified. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** The Nursing Administration staff and the Human Resources personnel was in-serviced by the Administrator on the proper procedure for nurse aide registry verification. Administrator will review checklist of all new hires for completeness. **MONITORING/QUALITY ASSURANCE** Administrator will report findings weekly to the Quality Assurance Committee for 4 week or until compliant. The Committee will then determine if further audits and reports are needed. The Administrator will be responsible for continued compliance. Completion date: June 2, 2006	

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F 496	Continued From page 39	F 496		

residents.

Findings included:

Personnel records and payroll records were reviewed on 4/11/06. It had been documented that:

Nurse aide 1's date of hire was 10/13/05. The facility allowed nurse aide 1 to work directly with residents during a 7.5 hour shift on 10/14/05 and a 7 hour shift on 10/15/05. The facility checked with Registry on 10/17/05 to verify if nurse aide 1 was registered or had any negative findings in his record.

Nurse aide 2's date of hire was 1/19/06. The facility allowed nurse aide 2 to work with facility residents on and after 12/10/06 without checking to verify if nurse aide 2 was registered or had any record of abuse.

Nurse aide 3's date of hire was 2/7/06. The facility allowed nurse aide 3 to work with facility residents for 8.5 hour shifts on 2/13/06 and 2/15/06 without checking to verify if nurse aide 3 was registered or had any record of abuse.

The facility administrator was interviewed 4/11/06. The administrator stated that new employees initially work 1 to 3 hours shifts for employee orientation. The administrator stated that when the employees worked six or more hours, it was to provide direct care to the residents.

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F 505 SS=D	483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview and medical record review, it was determined that the facility did not promptly notify the physician of laboratory findings. Specifically, Resident 3 had physician's orders to notify the physician if resident 3's blood glucose results were above or below certain levels. There was no documentation that the physician was notified consistently. Findings included: Resident 3 was admitted to the facility on 1/22/06 with diagnoses including IDDM (Insulin dependent Diabetes Mellitus), COPD (Chronic Obstructive Pulmonary Disease), Right sided weakness from a CVA (Cerebral Vascular Accident), and a failed THA (Total Hip Arthroplasty). On 4/9/06 through 4/12/16, resident 3's medical record was periodically reviewed. On 2/2/06 the physicians order stated that he was to be notified if resident 3's blood glucose level fell below 60 or above 400. Resident 3's February 2006 MAR (Medication Administration Record) documented the following blood glucose results: 1. On 2/3/06 at 11:00 AM resident 3's blood glucose was 44. 2. On 2/7/06 at 6:00 AM resident 3's blood	F 505	F505 (D) Laboratory Services **CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** Resident #3s physician was notified about the resident's low blood sugars. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** All insulin dependant residents have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** The licensed nursing staff was in-serviced by the Director of Nursing (DON) on the proper procedure for notification of an attending physician of laboratory findings,,the completeness of the 24 hour report and when to fill out a medication error report. The 24 hour report will be reviewed daily at stand up meeting to insure the physician and family have been notified. **MONITORING/QUALITY ASSURANCE** All medication error reports will be reviewed daily in stand up meeting and reported weekly to QAC committee for 4 week or until compliant. The Committee will then determine if further audits and reports are needed. The Director of Nursing will be responsible for continued compliance. Completion date: June 2, 2006	

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F 505	Continued From page 41 glucose was 24. 3. On 2/8/06 at 6:00 AM resident 3's blood glucose was 57. 4. On 2/13/06 at 6:00 AM resident 3's blood glucose was 40. 5. On 2/17/06 at 6:00 AM resident 3's blood glucose was 58. There is no documentation in resident 3's medical record, or in the facilities physician communication book that the physician was notified of the results as had been ordered. On 3/7/06 the physician's order stated that he was to be notified if resident 3's blood glucose level fell below 70 or above 350. Resident 3's March and April MAR's documented the following blood glucose results: 1. On 3/8/06 at 6:30 AM resident 3's blood glucose was 69. 2. On 3/9/06 at 4:30 PM resident 3's blood glucose was 60. 3. On 3/26/06 at 12:00 PM resident 3's blood glucose was 407. 4. On 3/30/06 at 6:30 AM resident 3's blood glucose was 389. There was no documentation in resident 3's medical record, or in the facilities physician communication book that the physician was notified of the results as had been ordered. On 4/11/06, the facility DON (Director of Nursing) was interviewed about resident 3's insulin administration records. The DON was unable to explain or understand why the physician had not	F 505		

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F 505	Continued From page 42 been notified of the above blood glucose results.	F 505		