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

PRINTED: 02/09/2006
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
	465057	A. BUILDING _____ B. WING _____	01/26/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR CORNERS REGIONAL CARE CTR	818 NORTH 400 WEST BLANDING, UT 84511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	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, it was determined that the facility did not promote care for residents in a manner that maintained or enhanced each resident's dignity for 2 of the 74 residents in the facility. Client identifiers: 4 and ********** Findings include: 1. On 1/23/06 at 4:25 PM, resident 4 was observed ambulating down the 100 hallway with a nurse aide. The surveyor noted that the plastic hook on the catheter bag for client 4 had been hooked onto the elastic waist bank on the back of her pants. The partially full catheter bag was observed to swing back and forth as the resident walked. 2. On 1/24/06 at 2:15 PM, a male resident was observed to be walking down the 300 hall with his pants unfastened and being held up by his hand. The nurse surveyor observed 2 different CNA's (certified nursing assistants) walk through the hall way without intervening on behalf of that resident. The resident continued down the hall and stated to the surveyor "to pee...", the CNA who had just entered a room 2 doors down came to help the resident after the nurse surveyor had explained to the resident that she could not take him to the bathroom.	F 241	2/23/06 POC acceptable Completion date 2/15/06 Lbusenbark RN This Plan of Correction is prepared as part of the Quality Assurance process for the provider. This Plan of Correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such is protected from discovery. This Plan of Correction is prepared submitted and/or executed solely because it is required by local, state and/or federal regulations, codes and/or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations. F 241 483.15(a) DIGNITY 1) A Mandatory Inservice will be held for all nursing staff on February 23rd, 2006, to train all nursing staff on proper ambulation of resident 4, including proper down drain bag handling while ambulating. The down drain bag will not be attached to residents clothing or hung on employees clothing while ambulating. The person or persons ambulating Resident 4 will carry the down drain bag in one hand keeping it below Resident 4's bladder for optimal drainage, the other hand will be securely on Resident 4's gait belt to prevent falls. The employee assigned to assist Resident 4 with ambulation will seek assistance to get Resident in and out of her wheelchair and assist with ambulation if agitated or leaning to one side.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Colette Lyman — TITLE: Administrator — (X6) DATE: 2-21-06

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 and plans of correction 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.

Utah Department of Health
FEB 23 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

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F 281	Continued From page 1	F 281	A leg bag is not an option at this time due	
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 on observation, and interviews with facility staff, it was determined that 1 dressing change/wound treatment provided by facility staff did not meet professional standards of quality, particularly those of infection control. Findings include: Resident 1 was admitted to the facility on 10/18/05 with diagnoses including: Diabetes Mellitus, hypertension, Right BKA (below the knee amputation), weakness, and Arteriosclerotic Cardiovascular Disease. Resident 1 was observed to have a stage 3 decubitus ulcer on her left heel for which she received a 20 minute whirlpool soak, and debridement by the physical therapy assistant (PTA). On 1/25/06 at 9:30 AM, 2 nurse surveyors observed the PTA finish residents 1's whirlpool, and place resident 1's calf onto a clean pillowcase and then leave to tell the nurse that resident 1 was ready for her dressing. There was a 14 minute time frame in which resident 1 had to wait for the nurse to arrive to do her dressing change. During that time resident 1 was observed to be moving her foot around on the bed in a manner in which her wound was repeatedly being contaminated by the bedspread, a towel left on the bed, and her own pants. At 9:44 AM, nurse surveyors observed the	F 281	to edema and Resident 4's behavior of pulling her pant legs up above her knees while sitting in her wheelchair. This issue will be discussed at Monthly Comprehensive QA meetings. 2) After lengthy discussion we are unable to determine who the resident is that needed assistance down 300 hall. If it was one of the blind gentlemen, they couldn't see the Surveyor to ask for assistance. The other 2 gentlemen that exhibit those behaviors don't reside at the end of Hall 300. Due to inability to identify the exact resident, we will have a Mandatory Inservice meeting on February 23, 2006, to discuss identifying residents needs in general. We will inservice all staff on assisting all residents, not just the ones they are assigned to, and assisting residents that don't usually need a lot of assistance. This issue will be discussed at Monthly Comprehensive QA meetings. We will be in Substantial Compliance by March 15, 2006. F 281 483.20 (k) (3) (i) COMPREHENSIVE CARE PLANS A Mandatory Inservice will be held on February 23, 2006, to review the Dressing Change (Clean) Protocol with all Charge Nurses. See Attachment A. Handwashing and changing gloves will be emphasized. All wounds in the facility have Physicians Orders for Clean Dressings. Nonsterile dressing	

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F 281	Continued From page 2 dressing change for Resident 1. The following is a description of the dressing change. a. LPN 1 did not wash her hands prior to this treatment or at any time during the dressing change. b. LPN 1 placed the items necessary for the dressing change on the resident's bedside table. c. LPN 1 was observed to handle a bloody pillowcase without gloves. d. LPN 1 put on gloves (from the box on the hallway wall) without washing her hands. e. LPN 1 handled resident 1's foot to examine the wound with gloves on. f. Upon request for measurements, LPN 1 walked out into the hallway wearing her contaminated gloves, and used the hall phone to call the wound specialist to take measurements. g. After finishing the call, the nurse removed her gloves and again did not wash her hands. h. The wound specialist (LPN 2) entered the room to measure the wound, and put on gloves without washing her hands. i. LPN 2 measured the wound. j. LPN 1 returned to the bedside and put on gloves. k. LPN 1 opened a sterile 4x4 dressing and dipped it into a plastic cup containing what she described as normal saline. (the surveyors did not observe this being prepared) l. LPN 1 then washed the wound by dabbing the dressing around the wound in no particular pattern. m. LPN 1 then dipped another 4x4 into the the same solution and placed the dressing over the wound. n. LPN 1 placed another 4x4 over the first dressing to create a wet to dry dressing. o. LPN 1 used "clean" bandage wrap to wrap the foot and hold the dressing in place.	F 281	applications are used for chronic, established wounds, using aseptic technique, where the protocol has been evaluated and designated by a professional nurse. Facility Wound Care Nurse/ADON will continue to do Weekly Wound/Skin Assessments and will watch one dressing change weekly on Resident 1 for Quality Assurance purposes to monitor that Protocol is followed. A different nurse will be chosen each week. Central Supply will ensure that Blue Chucks will be available in Resident 1's closet for Physical Therapy to lay freshly whirlpooled wound on, to minimize contamination of wound, until Charge Nurse can come to do the dressing change. All skincare issues and dressing change QA's will be discussed in weekly QA meeting and at Monthly Comprehensive QA meetings. We will be in Substantial Compliance by March 15, 2006.	

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F 281	Continued From page 3	F 281		

There was no evidence of a red/orange biohazard bag in the resident's room, used for the proper disposal of hazardous waste, as required by OSHA (Occupational Health and Safety Administration).

3. During the dressing change, both LPN 1 and LPN 2 were interviewed as to how the wound was progressing. Both nurses stated that the wound was larger than it had been. When asked by surveyors, LPN 1 also stated that the dressing change was a "clean" procedure, but if it had been done in a hospital it would be considered a sterile procedure "...I don't know why..".

4. Fundamentals of Nursing Concepts, Process and Practice, sixth edition, February 2000. Pages 829, 835, and 837.
Clinical guidelines for treating pressure ulcers:
...clean and dress the ulcer using surgical asepsis...
Clinical guidelines for applying wet-to-damp dressing:
...open packages of the sterile dressing, gauze and solution...put on sterile gloves...clean the wound.. pack the slightly moistened dressing into all depressions and grooves of the wound, ensuring that all exposed surfaces are covered...to prevent maceration of the surrounding skin, pack only to the edge of the wound without overlapping the skin...apply a secondary dressing over the wet dressings to absorb excess exudate...cover all dressings with a surgipad or abdominal pad. The pad protects the wound from external contaminates...
Cleaning wounds:
...A major principle of cleaning wounds is to clean from "clean to dirty."...

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F 323	Continued From page 4	F 323		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews, it was determined that the facility did not ensure that the resident environment remained as free of accident hazards as was possible. Specifically, the facility did not assess the potential for physical harm created by broken equipment. Findings Include: On 1/24/06 at 4:45 PM, multiple bedside commodes were observed to be located in the 100 hallway. Two of the commodes were observed to have both of the plastic armrests broken. The broken armrest presented an accident hazard due to the plastic forming very sharp edges were it had been broken. On 1/25/06 at 1:54 PM, the 100 hall shower/tub rooms were inspected. Upon asking a CNA (certified nursing assistant) to unlock the shower doors, she stated that the #2 shower room was the only room being used by residents at the time. The CNA also explained that the facility has 2 shower beds, and that the shower bed located in the #2 room was the main bed, and was used the majority of the time. She also stated that she was concerned by the condition of the shower bed, and was afraid a resident could be hurt while on it. The shower bed was inspected and observed to have a fractured pole at the top and bottom	F 323	F 323 483.25 (h) (1) ACCIDENTS Maintenance will do a Monthly QA on all equipment in the facility to monitor for broken equipment and/or safety hazards. All results will be written on the Maintenance Log. See Attachment B. A Mandatory Inservice will be given to all staff on February 23, 2006. They will be informed to constantly monitor for broken equipment and remove any broken equipment immediately and take it back to Maintenance. Maintenance will fix the equipment or put it in the dumpster if unfixable. Anything in the entire facility that needs fixed needs to be written on the Maintenance Log located at the Nurses Station. See Attachment B. All Maintenance QA's and the Maintenance Log will be discussed at Monthly Comprehensive QA meetings. All broken equipment observed by the Surveyors have been taken out of service and will be fixed by Maintenance. We will be in Substantial Compliance by March 15, 2006.	

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F 323	Continued From page 5 corners of the right edge of the bed. The poles mentioned are approximately 1- 2 inches in diameter, and were made of a hard plastic type material. Both of the broken poles created sharp, jagged points which could potentially cause serious physical harm to a resident being bathed or transported on it. On 1/25/06 between 2:05 PM and 2:30 PM, 3 additional CNA's were questioned about the shower bed. None of the CNA's could recall when the bed was broken; however, one of the CNA's stated that it had to have been approximately a month because he hadn't worked the 100 hall since then.	F 323		
F 326 SS=D	483.25(i)(2) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for 6 of 74 clients in the facility, the facility did not ensure the resident's received a therapeutic diet when there was a nutritional problem. Resident identifiers: 10, 16, 18, 19, 20 and 21. Findings include: 1. The medical record of resident 10 was reviewed on 1/24/06. Resident 10 had	F 326	F 326 483.25 (i) (2) NUTRITION We discussed the thickened liquids issue in QA meeting and determined that the process used by Dietary Staff to thicken liquids was inefficient. Dietary was thickening each individual glass of liquid separately and the consistency was not reaching or staying at nectar thick consistency. There was also a problem with trayline accuracy. A new process of making an entire pitcher of thickened liquid and then pouring each glass after the consistency was determined to be correct, was implemented on February 10,2006, and has worked effectively. The last dietary person in the trayline is designated to be the "Trayline Checker" and they are responsible for doing a final check for diet accuracy before the tray goes out. A Mandatory Inservice will be	

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F 326	Continued From page 6 physician's orders to receive nectar thick liquids. Resident 10 was observed during the breakfast meal on 1/24/06. She had three glasses of fluid. None of the fluid appeared to be thickened. Resident 10 was observed to cough multiple times while being given these fluids. Resident 10 was again observed during the breakfast meal on 1/15/06. The fluids in her glasses did not appear to be thickened. The surveyor approach the table and interviewed the aide who was assisting resident 10 to eat and drink. The surveyor told the aide that resident 10 had orders to receive nectar thick liquids and then stated that the fluid on resident 10's tray did not appear to be thickened. The aide stated, "No, it's not." 2. On 1/25/06, the surveyor observed the kitchen staff preparing the resident's breakfast trays. The initials "SNP" were identified on some of the resident's tray cards. The cook was asked what this meant. The cook stated that it was a special nutrition program to help people gain weight. When asked how these diets differed from the regular diets, the cook stated that for those with a SNP diet she added a special mixture to their hot cereal. Five resident trays labeled "SNP" were observed to leave the kitchen and the food eaten by the residents without having the special mixture added. Those trays included residents 16, 18, 19 , 20 and 21.	F 326	held on February 23, 2006, to train and update the knowledge base of each dietary staff on Therapeutic diets, SNP, liquid consistency, and the importance of trayline accuracy. All nursing staff will receive a general inservice also. A list of all residents requiring thickened liquids is hanging on the inside of the Dining Room closet and identified on each residents meal tray slip. The Dietary Supervisor will do 1 Breakfast, 1 Lunch, and 1 Dinner QA every week to double check trayline accuracy. See Attachment C. Dietician will continue to check trayline accuracy on her monthly visits. All QA's will be discussed in Weekly and Monthly QA meetings. We will be in Substantial Compliance by March 15, 2006.	
F 329 SS=D	483.25(l)(1) 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	F 329	F 329 483.25 (I) (1) UNNECESSARY DRUGS After discussing this issue with specific regard to Resident 6, it was noted that all behaviors that we were monitoring for at	

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F 329	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of medical records, it was determined that for 1 of 15 sample residents, the facility did not ensure that the resident's drug regimen was free from unnecessary drugs. Resident identifier: 6. Findings include: The medical record for resident 6 was reviewed on 1/24/06. Resident 6 was a 60 year old female. The most recent physician's history and physical, dated 2/17/05, describes resident 6 to be in a "vegetative state since 2/04 from head injuries." During review of her medical record, it was noted that resident 6 has orders to receive Zyprexa 5mg every day for her traumatic brain injury with agitation. This medication and dosage began on 11/1/04. Zyprexa is an antipsychotic medication. A note from a mental health professional who assessed resident 6 on 11/15/04 wrote in his note "...began Zyprexa 5mg to address break through of agitation...The patient occasionally shows mild agitation when nursing provides care but it is well tolerated and the patient @ worst softly grabs	F 329	the time of initiation of Zyprexa were absent and we had not added to monitor for more current behaviors i.e.self mutilation, scratching herself until she has open sores. We also had not conveyed the need to our APRN in charge of med management, that a drug reduction was indicated and other behaviors needed to be added to the list to monitor. On February 23, 2006, a Mandatory Meeting will be held to discuss a formal Policy to Monitor Need for Drug Reduction, as the Administrator could not find one. See Attachment D. Our nurses will continue to administer medications as ordered and monitor for specific side effects and targeted behaviors daily. In IDT meeting we will discuss the residents current Physicians orders for Psychotropic Meds, Current Behaviors we are monitoring for, the need to add any new behaviors, side effects if any. If <10 targeted behaviors have been reported in the last 3 months, the resident will be referred to the APRN or MD for evaluation for med reduction. If any side effects are noted the resident will be referred to the APRN or MD for evaluation for med reduction. The APRN usually comes in on Mondays, the Social Service Director will have a list ready for updates and new evaluations. All residents on Psychotropic Medications will be discussed in Monthly Comprehensive QA Meeting. Resident 6's targeted behaviors were updated and she will be reviewed again by APRN for med management/reduction per protocol.	

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F 329	Continued From page 8 nursing personnel's hands." The most recent MDS (minimum data set), a comprehensive assessment of the resident performed by qualified facility staff, dated 11/22/05, documented no behavioral issues regarding resident 6. This MDS also documented that resident 6 had full loss of voluntary movement of her neck, arms, hands, legs, and feet. Two nurses and the social worker were interviewed regarding resident 6 on 1/24/06. The social worker was interviewed at 10:30 AM and was asked what behaviors were exhibited by resident 6. The social worker responded "She use to. She use to push away. She would push her arms at the staff and turn away being resistive to care - not anything really." When asked why she was on Zyprexa, the social worker stated "for her agitation". When asked to define resident 6's agitation, the social worker stated, "resisting care and pushing away." The first nurse was interviewed at 11:15 AM and was asked what behaviors were exhibited by resident 6. This nurse stated that she worked with resident 6 once a week, but had not noticed any behaviors. The second nurse was interviewed at 11:20 AM and was asked what behaviors were exhibited by resident 6. This nurse responded that resident 6 had been "agitated in the past, but is better now on Zyprexa." The nurse continued to say that resident 6 "use to strike out and try and scratch during cares, but is better on Zyprexa. If not, we would have to use 2 people."	F 329	We will be in Substantial Compliance by March 15, 2006.	

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F 329	Continued From page 9 There medical record for resident 6 did not contain documentation to warrant the use of an antipsychotic considering the physical capabilities of resident 6 and the lack of behaviors noted. There was no documentation to evidence that the facility had attempted to taper or discontinue the Zyprexa since it was initially started on 11/1/04.	F 329		
F 431 SS=D	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility was using medications that were not labeled in accordance with currently accepted professional principles. Additionally, based on observation , it was determined that the facility was using medications that were not dated when they were opened. Findings include: 1. On 1/24/06 at 1:59 PM, the initial observation of the medication fridge was completed. At that time it was observed that the facility had multiple vials of insulin opened in the drawer. None of the opened insulin vials were labeled as to when the vial was opened, or when it was to be discarded.	F 431	F 431 483.60 (d) LABELING OF DRUGS AND BIOLOGICALS A Mandatory Inservice will be held February 23, 2006, to review with all nurses the Mandatory Procedure of recording date/time when any vial is open, whether it be a medication or NS. The night nurses will check every night when reordering medications, that all opened vials have a sticker showing the date and time opened. They will throw away any opened vial that has expired. The DON will do a monthly QA when she coordinates the Pharmacy Review. All QA's will be discussed in the Monthly Comprehensive QA meetings. We will be in Substantial Compliance by March 15, 2006.	

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F 431	Continued From page 10 2. On 1/24/06 at 2:01 PM, RN 1 was interviewed about the procedure for opening/labeling insulin vials. The RN stated that the facility goes through the insulin very fast, so no labeling was necessary. She further stated that the vials were always opened "...right around the same time..." as the date they were received. 3. 1/25/06 at 10:06 AM, the medication refrigerator was inspected again. There were 14 vials of insulin in the fridge at that time. Out of the 14 vials, 12 were opened and not labeled or dated. 4. 1/25/06 at 3:06 PM, the medication refrigerator was inspected again. There were 9 vials of Humalog Insulin that were not labeled. There were 6 vials of Lantus Insulin that were not labeled. 5. In the 2005 Physicians' Desk Reference 59th edition, page718, the following reference for the storage of Lantus Insulin states: "...Once a vial is opened, you can keep it in the refrigerator.....but the opened vial must be used within 28 days....". The facility staff must label the opened vials with date and time in order to ensure that the vial will be used within the 28 day time frame.	F 431		
F 432 SS=D	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.	F 432	F 432 483.60 (e) STORAGE OF DRUGS AND BIOLOGICALS A Mandatory Inservice will be held February 23, 2006, to review with all nurses that all medications and insulin syringes need to be locked up at all times when the nurse is away from her cart.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465057	A. BUILDING _____ B. WING _____	01/26/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR CORNERS REGIONAL CARE CTR	818 NORTH 400 WEST BLANDING, UT 84511

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F 432	Continued From page 11 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation of the medication pass, it was determined that the facility did not store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys. Specifically, during two observed medication passes, medications were not properly locked in the medication cart while the staff nurse was away from the medication cart. Findings include: On 1/24/06 at 7:36 AM, a facility staff LPN 1 (licensed practical nurse), was observed during the medication pass by a nurse surveyor. The first residents medication pass consisted of: 1. Pioglitazone 30 milligrams 2. Glipizide 5 milligrams 3. Aspirin 81 milligrams 4. Metronidazole 500 milligrams 5. Calcium 600 milligrams 6. Lortab 5 milligrams 7. Vitamin C 500 milligrams 8. Calcium carbonate one tab	F 432	New policy will be instated that all stock meds need to be dispensed from inside the medication cart and should not be placed on top of the cart during medication administration. All syringes need to be left inside the medication cart until the time of medication administration. Never leave the medication cart unattended without making sure all medications are inside and the cart is locked. 5 monthly random medication administration QA's will be done by DON and ADON to monitor proper medication administration and to ensure all drugs and medical supplies are locked up properly. All QA's will be discussed in the Monthly Comprehensive QA meeting. We will be in Substantial Compliance by March 15, 2006.	

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F 432	Continued From page 12	F 432		

9. Ceravite one tab
10. Lactulose 30 milliters

When LPN 1 went to administer the resident his/her medication, the following medications and medical supplies: insulin needles, a bottle of vitamin c, a bottle of calcium, a bottle of Asprin, a bottle of Tums, and a bottle of multivitamins were left unlocked and unattended, on top of the medication cart while LPN 1 was away from the cart, administering medications to the resident.

At 8:02 AM during the observation of another staff nurse conducting a medication pass, an observation was made of the following medications and medical equipment sitting on top of LPN 1's medication cart, while she was away from the medication cart, administering medications to a resident; insulin needles, a bottle of vitamin C, a bottle of calcium, a bottle of Asprin, a bottle of Tums, and a bottle of multivitamins.

At 8:30 AM, during the observation of another staff nurse during the medication pass , it was observed that there were still medications, and medical supplies left unattended and unlocked on top of LPN 1's cart. The medications consisted of: a bottle of multivitamins, a bottle of calcium, a bottle of Tums, a bottle of Asprin and insulin needles. LPN 1 was away from the cart, administering medications to a resident, and not within view of the cart.

On 01/25/06 at 7:45 AM, an observation was made of a facility staff RN (Registered nurse) during the medication pass.

During the observation of the medication pass,

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F 432	Continued From page 13 the facility staff RN would set up each medication then hand the medication container to the nurse surveyor to read the medication label, before administering them to a resident. When the facility staff RN was setting up a residents medications, she punched out a medication called Avandament 2 milligrams from a cassette, she then proceeded to hand the nurse surveyor the cassette of Avandament, then stated she wold be right back. The staff RN left the dining room. The cassette of Avandament was left with the nurse surveyor, and a bottle of calcium was left on top of the medication cart. The facility RN was not in view of the medication cart. The two medications went unattended and unlocked until the facility RN returned about a minute later.	F 432		
F 467 SS=E	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that outside ventilation, by mechanical means was available in all bathrooms. This failure was found throughout the facility and created unpleasant odors in the area, especially the 100 hall. Findings include:	F 467	F 467 483.70 (h) (2) OTHER ENVIRONMENTAL CONDITIONS- VENTILATION As we went through the facility, we found that all the bathrooms had ventilation capabilities when the lights were on, but not all of the fans worked. Maintenance will go throughout the facility and check to see which fans are not working or are dirty. They will fix, clean, and lubricate all fans as manufacturer specifies. Odor neutralizer in all halls will be turned up and odor neutralizer dispensers will be added to bathrooms with chronic odor problems not fixed by properly working ventilators. Maintenance will do a monthly QA to keep on top of ventilation problems. See Attachment E. All QA issues will be discussed in the Monthly Comprehensive QA Meetings and all staff will monitor for odor problems ongoing. We will be in Substantial Compliance by March 15, 2006.	

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F 467	Continued From page 14 1. On 1/23/06 at 4:30 PM, the initial tour of the facility was performed, during which time the 100 hall was observed to have a very strong urine odor which lingered until 6:00 PM when surveyors left the building. 2. Bathrooms located on the 200 and 300 halls were observed to be without mechanical ventilation. On 1/24/06 a strong urine odor was noticed lingering around resident rooms 208, 212, 200, 312, and 301 at 2:05 PM when the residents were not present. 3. On 1/24/06 at 2:30 PM and at 4:55 PM, the 100 hall was observed to have a strong urine odor. 4. On 1/25/06 at 7:50 AM, 2:15 PM, and 5:03 PM, the 100 hall was observed to have a lingering urine odor.	F 467		

(A)

DRESSING CHANGE (CLEAN)

RESPONSIBILITY: LICENSED NURSE

PHYSICIAN ORDER

Location of wound, type of dressing, frequency.

PURPOSE

1. To protect wound.
2. To prevent irritation.
3. To prevent infection and spread of infection.

RESIDENT RIGHTS

1. Identify resident and explain reason for procedure.
2. Explain benefits of the procedure to the resident.
3. Explain safety measures of the procedure to the resident.
4. Explain the adverse effects and/or complications of the procedure to the resident.
5. Place call light within reach and instruct resident to call for assistance, if needed.
6. Screen and drape resident for maximum privacy. Close door to room.
7. Include resident's family and surrogate health care decision-makers in care planning when possible.

ASSESSMENT

1. General condition of skin.
2. Any pain; report to physician.
3. Status of peripheral circulation.
4. Nutritional status.
5. Hydration/fluid balance.
6. Weight (over/under ideal or usual body weight).
7. Mobility status.

INFECTION CONTROL

1. Observe standard precautions.
2. Wash your hands before and after all procedures. Wear gloves when appropriate.
3. Clean and dry skin well before procedure.
4. Apply preventive measures to maintain skin integrity, if necessary.
5. Dispose of disposable equipment appropriately.
6. Dispose of hazardous materials appropriately.
7. Thoroughly clean all equipment used and return to appropriate storage area.
8. Dispose of soiled linen appropriately.

EQUIPMENT

1. Dressings.
2. Prescribed cleaning solution(s).
3. Medication if prescribed.
4. Red plastic bag for soiled dressing.
5. Adhesive remover if necessary to remove tape residual.
6. Gloves if visible blood is present.

PROCEDURE

1. Wash hands.
2. Take treatment cart to the door of resident's room or take treatment supplies into resident's room.
   NOTE: All dressing changes are to be done in the resident's room (or treatment room, if applicable) not in the hallway.
3. Review orders on the treatment record.
4. Gather required supplies necessary to administer the treatment.
5. Include with supplies a piece of tape approximately 2" long. document date, time and your initial on the tape.
6. Secure/lock cart - leave no solutions/medications on top of cart.
7. Explain procedure to resident.
8. Provide privacy - close door, completely screen resident with privacy curtain, includes closing window curtain if applicable.
9. Position resident exposing only the area to be treated.
10. Wash hands.
11. Place supplies on a clean field.
12. Put on clean gloves.
13. Remove soiled dressing and place in plastic bag.
14. Remove gloves and place in the plastic bag.
15. Put on clean gloves.
16. Clean wound as ordered or with sterile normal saline. Clean from the center of the wound outward, never going back over the area which ahs been cleaned.
    NOTE: If two or more wounds are treated, each wound is treated as a separate wound.

    NOTE: If gloves come in contact with wound during cleansing, they must be changed.
17. Place soiled sponges used for cleaning in plastic bag.
18. Culture wound after cleaning, if applicable.
19. Measure wound accurately, weekly or as condition warrants.
20. Apply correct medication/treatment dressing as ordered.
21. Apply clean dressing as ordered.
22. Place tape with documentation of dressing change on edge of dressing.
23. Remove gloves and place in the plastic bag.
24. Close plastic bag securely with a knot and place in marked red infectious waste bag on treatment cart or take directly to infectious waste container.
25. Wash hands.
26. Complete documentation.

DOCUMENTATION

1. Date, time, dressing change on treatment record.
2. Wound size, site, depth, color, drainage.
3. Progress of healing (or lack of progress).
4. Signature and title of nurse changing dressing.

POSSIBLE RELATED MINIMUM DATA SET TRIGGERS

1. ADL function/rehabilitation potential.
2. Psychosocial well-being.
3. Dehydration/fluid maintenance.
4. Pressure ulcers.

RESIDENT CARE PLAN

PROBLEM

1. Identify the appropriate problem under which to list the dressing change as an approach.
2. Consider listing possible risks and complications.

GOAL

1. List MEASURABLE goal(s) to be accomplished.
2. List target date.

APPROACHES

1. List responsible discipline for each approach.
2. List instructions unique to this resident.
2. List necessary monitoring and observation of the underlying condition.

REFERENCE: WOUND CARE MANUAL

(B)

MAINTENANCE AND HOUSEKEEPING DEPARTMENTS

Quality Assurance problem reporting and communication sheet

(Give to QA coordinator when completed)

DATE	LOCATION OF DEFICIENCY (be specific)	DESCRIPTION OF DEFICIENCY (be specific)	REPORTED BY	DATE CORRECTED M.P. signature	REMARKS (Reason for delay in correcting; etc.)	QA C SIGNATURE

MEAL INSPECTION

Date: _____

Time meal served: _____

Time last meal served to resident: _____

Meal inspected: _____

Cook: _____

Aides: _____

Note: Meal Inspection to be done 1 breakfast / 1 lunch / 1 dinner per month

Foods	S = 3 pts U = 0 pts Serving Temps	Bedside Temps	Taste	Appearance (Garnish)	Diet Card	S = 6 pts U = 0 pts Accuracy with Diet Card	Diet Card Agrees with DR
1. One regular cold food					1.		
2. One vegetable hot food					2.		
3. One ground hot food					3.		
4. One pureed hot food					4.		
5. One entrée hot food					5.		
TOTAL POINTS					**TOTAL POINTS**		

(minus 2 points if no garnish)

1.	Proper handling of foods (plastic gloves)?	Yes	No
2.	Proper scoops and portions of meat?	Yes	No
3.	Double / Large / Small portions accurate?	Yes	No
4.	Dislikes and allergies adhered to?	Yes	No
5.	Proper amounts of milk given to diabetics, low sodium and renals?	Yes	No
6.	Correct condiments given?	Yes	No
7.	Did you observe each area of meal served?	Yes	No
8	Did you interview (5) patients during meal service?	Yes	No

Observations:

Total Points Available: _____

Percentage of Compliance:

Dietary Manager: _____

Administrator: _____

Dietitian: _____

D

4 Corners Care Center

Policy to Monitor Need for Drug Reduction

1- Nurses administer all Psychotropic Medications as ordered, monitor for behaviors and record daily, monitor for side effects and record daily.
2- In Quarterly IDT, Social Services will bring the residents chart and all members will review Psychotropic Medications, Current Behaviors, Need to Add any new Targeted Behaviors, Side effects if any.
3- If there are <10 targeted behaviors or any side effects, the resident will be referred to the APRN or MD for evaluation for med reduction.
4- Social Services will keep a list for APRN to see and evaluate. She will be in charge of all communication with APRN.

(E)

PORTABLE/MOBILE/INSTALLED FANS
CLEANING/SERVICING RECORD

1. Each portable/mobile and installed fan in the facility will be inspected for its condition and serviced quarterly as follows:

   a. Unit will be thoroughly cleaned and oiled per manufactures recommendations.
   b. If unit is defective in any manner that could effect safe operation the unit will be disconnected and removed from service until repairs are completed or the unit is replaced.

SERIAL # OR ASSIGNED #	LOCATION	DATE	MAINTENANCE PERSON SIGNATURE	SERIAL # OR ASSIGNED #	LOCATION	DATE	MAINTENANCE PERSON SIGNATURE

FHW-FCSR 001
REV 3/95