STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A051	A. BUILDING _____ B. WING _____	09/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK HEALTH CENTER	3520 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84106

(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=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 upon observation, interview and record review, it was determined that the facility did not provide an environment that maintained each resident's dignity for 2 of 14 sample residents and 6 of 7 residents in a confidential interview. Specifically, alert residents stated they were not treated with respect by nursing staff, one alert resident stated he was not treated with respect regarding his incontinence, one alert resident who did not speak was observed to be treated as a behavior problem without regard for her individual needs, alert residents stated call lights were answered too slowly, a nurse-surveyor observed a call light for 10 minutes before a staff member responded. Resident Identifiers: 1 and 10. Findings included: 1. Resident 10 was admitted to the facility 4/16/02 with diagnoses that included deafness, aphasia, and hemiparesis. Resident 10's Minimum Data Set (MDS) assessment, dated 4/19/06, revealed resident 10 did not speak but was understood. The MDS assessment, dated 7/19/06, revealed the resident could communicate well enough to be understood and could understand others. The Interdisciplinary Team (IDT) had documented both MDS assessments that resident 10 had	F 241	1. Resident #10 will have a speech evaluation completed to determine if a communication board would be an appropriate device for her. In the meantime a wipe board will be attached to resident #10's wheelchair to facilitate communication. An inservice will be held with all staff to instruct them on using the wipe board as the primary means of communication with resident #10. In addition, all staff will be inserviced on behavior managements techniques with particular emphasize on managing negative behaviors without being disrespectful to the resident as well as making sure that staff asks her what she needs/want. Also, nursing staff will be inserviced to give resident #10 her medications as soon as possible when resident #10 indicates that she is ready for the medications. They will also let her know that, by using the communication board, she will be next to receive medications. 2. The facility has installed audible indicators in the nursing station call light panel to alert staff when call lights in bedrooms are turned on. All C.N.A.s and nurses will be inserviced on answering call lights they may hear/see in a timely manner, as well as all other staff will be instructed to check on any call lights they may hear/see to offer assistance to the resident or locate a C.N.A. or nurse that can provide the assistance when necessary.	11-10-06

10/19/06 POC acceptable Completion date 11/10/06 Ubuenbuhk RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamara R Besch	Assistant Administrator	10/11/06

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.

Utah Department of Health
761396

OCT 13 2006

Bureau of Health Facility Licensing, 1
Certification and Resident Assessment

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F 241	Continued From page 1 exhibited repetitive anxious concerns and repetitive concerns regarding her health. On 9/11/06 at 4:30 PM, a confidential resident group interview was being conducted in the main activity room at the facility. At that time, resident 10 pushed open the double doors and rushed into the room. A facility staff entered right behind resident 10, grabbed the resident's wheelchair hand grips and pulled the chair backwards. After briefly tugging back and forth, resident 10 was pulled backwards out of the activity room. Fifteen minutes later, resident 10 entered the activity room and pulled her wheelchair up with the other residents in the group. Resident 10 sat alert and quiet through the remainder of the meeting. On 9/12/06 during observation of medication pass with Charge Nurse 1, the surveyor observed resident 10 wheel herself up close to the nurse at the medication cart. Without addressing resident 10, Charge Nurse 1 pushed the resident back from the cart and continued to prepare another resident's medications. Charge Nurse 1 stated to the surveyor that resident 10 was "very invasive" and did not need extra medication and had no special problem at that moment. Charge Nurse 1 stated that it was part of resident 10's regular clinical behavior. Charge Nurse 1 did not write resident 10 a note or attempt to let her know she could be next. Resident 10 would not leave the medication cart until she was given her medications. Charge nurse 1 wrote a statement to the surveyors on 9/13/06. Charge nurse 1 documented that resident 10 had come "crashing into" the medication cart and the resident was	F 241	Cont. from page 1 The C.N.A. Coordinator will perform random timed tests (5x weekly) to assure that lights are answered in a timely manner. Employee #1 has been counseled with regards to behaviors that may be irritating or disrespectful to residents. Also, employee #1 will not be assigned to provide cares for Resident #1. The facility cannot address the statement resulting from the resident group meeting of "a particular nursing assistant with whom they had difficulty communicating with" as we do not know who the nursing assistant is. However, the Resident Services director will conduct interviews to see if any residents have communication problems with any staff and results from the interview will be addressed. Inservices will be conducted by the Director of Nursing and Resident Services Director. This is to be monitored for compliance by the Director of Nursing and the Assistant Director of Nursing. Continued compliance will be integrated in Quality Assurance meeting by completion date and will be reviewed quarterly	11-10-06

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F 241	Continued From page 2	F 241		

pushed back to prevent her from injuring herself, the nurse or the surveyor. Charge nurse 1 wrote that the surveyor had a questioning look on her face so the nurse "explained [resident 10] can be very invasive as part of her clinical behavior" which was being tracked. Charge nurse 1 stated that resident 10 could not hear what was said about her and could not read lips so there was no issue of failing to treat the resident with dignity.

Resident 10's behaviors were being tracked by nursing in the Medication Administration Record, but no behavior interventions were documented.

On 9/14/06 at 2:00 PM and at 2:30 PM, resident 10's family members were interviewed individually. Resident 10's family members stated that resident 10 had always been extremely out going, very caring, very interested in other people and very stubborn when she wanted something. The family members stated that resident 10 continued to have those same characteristics at the facility.

Resident 10's family members stated that the resident was able to communicate her needs effectively to the staff. They stated she motioned washing her hair when she wanted her hair washed and she shook her hands to let them know she wanted something. When asked about a communication board or notebook, a family member stated that resident 10 had a notebook that was used mostly by the facility.

Resident 10's family members were not aware surveyors had witnessed the interactions with resident 10 at the medication cart. While talking about the resident, a family member stated that

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F 241	Continued From page 3 resident 10 was very anxious about getting her medications on time because the resident was afraid of having another seizure. The family member stated that resident 10 had suffered a seizure a long time ago after missing her medications, and that she was still afraid of a recurrence. On 9/14/06 at 9:40 AM, an interview was conducted with the resident service director (RSD). The RSD stated resident 10 was very stubborn and had behaviors of taking cokes from other residents. The RSD stated staff communicated with resident 10 by writing to her in a notebook kept in a drawer in the resident's room. Resident 10's notebook was reviewed 9/14/06. The notebook was spiral bound, 8 inches by 11 1/2 inches, and thin - about 200 pages. Few pages were dated, but notes began before December 2005 and the notebook was not more than half filled. Some of the notes made by staff to resident 10 included the following: (Each of the following notes took one full page in the notebook.) "You have to stay in your room until everybody else is done eating. You can eat after that Your (sic) a big bully and very rude You know that you can grab from others - you are stronger than they are If you don't stop you will (be) staying in your room most of the day" "You listen to me (underlined) Don't steal It's that easy I dont (sic)believe your (sic) sorry You know why? Because you keep stealing See," "I don't know what you want. So please stop yelling."	F 241		

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F 241	Continued From page 4 "You cannot change the channel when other people are in the middle of a program. How rude is that of you!! When others are not in the middle of a show then you can watch what you want Ok If you go back in and try and change the channel you will have to come back to your room Do you understand" "You just had 2. NO! (underlined) maybe later" There were no notes asking resident 10 how she felt or what she wanted. 2. On 9/11/06 at 4:00 PM, a confidential group interview was held at the facility with alert and oriented residents. Six of the 7 participating residents in the group interview said they had to wait too long a time for their call lights to be answered. One resident stated, "I have waited a half hour." Another resident stated, "I have waited one hour." Six of 7 residents stated they had a concern with a particular nursing assistant with whom they had difficulty communicating. They stated the nursing assistant couldn't always understand them, would get frustrated, and leave without providing the assistance they needed. During the group interview, one resident stated that on 9/10/06 she had turned on her call light. The resident stated that nursing assistant 3 entered her room, turned off the light, and left the room without speaking to her. The resident stated she turned the light back on and the nursing assistant returned to turn it off without helping her. The resident stated she had been furious and had reported the incident to the Charge Nurse. 3. On 9/13/06, an interview was conducted with	F 241		

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F 241	Continued From page 5	F 241		

nursing assistant 3. Nursing assistant 3 stated that he recalled the incident. The nursing assistant stated there was no other staff available to help answer the call lights at the time. Nursing assistant 3 stated several residents needed his assistance at the same time. The nursing assistant stated that he was rushing to do all he could do to triage the residents' needs and help them all.. Nursing assistant 3 stated he had to attend to the other residents before he could help this resident.

4. On 9/11/06 at 3:25 PM, the call light was observed to be on over the door to room 113 but did not sound at the nurses station. At 3:35 PM, another call light sounded from the bathroom for room 117. A nurse called over the intercom for someone to answer the lights. Two nursing assistants responded to answer the call lights. The call light for room 113 was answered at 3:35 PM, after 10 minutes.

5. Resident 1 was admitted to the facility with diagnoses including diabetes, hypertension, arthritis, and depression.

An individual interview with resident 1 was conducted on 9/11/06 at 3:35 P.M. At that time he stated that he has had to wait up to "45 minutes" for staff to answer his call light.and that he had timed the instance. Further, he stated he had to wait for staff to answer his call light on more than this occasion.

During this interview with Resident 1 on 9/11/06, he was asked, "Tell me how you feel about the staff members at this facility. Do they treat you with respect?" Resident 1 stated, in response to

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F 241	Continued From page 6 the question, "Not in some ways." He said that there was a Certified Nurse Aide (CNA 1) whose behavior "irritates" him. He indicated that the aide complained when Resident 1 was incontinent. An informal interview was conducted with resident 1 on 9/13/06 at 1:10 P.M. Resident 1 stated that, "every time" he needed the bed changed, CNA 1 stated to the resident "The bed is wet again!"	F 241		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility did not maintain a safe, clean, homelike environment. Specifically, many doors throughout the facility had nail holes or scratches, some floors had scratches or were uneven, one attic access had rough edges and lacked molding, call light covers were missing outside some rooms, and the parking area contained a large hole in the asphalt as well as many cigarette butts. Findings included: The facility contained many doors that were in disrepair: Room 104 had 6 closet doors that displayed	F 252	All nail holes in resident closet doors filled with wood putty, sanded, stained and varnished. The scratches on the hallway door to room 117 will have the same repair completed. Room 121-attic access door will have wood trim installed around the perimeter, trim and door will be painted the same color to match existing ceiling color. All missing window screens: screens have been ordered and will be all be replaced by completion date. Room 120– scratch on the bathroom vanity will be filled, stained and varnished. A new light cover will be put in place. Room 118-The crack in the tile floor will be repaired by taking up the cracked tile, repairing the sub floor and installing new floor tile. Room 115-New floor tiles will be installed to replace existing cracked tiles. Room 109 & 119-Call light covers in the common hallway have been ordered and will be installed. Room 113-sink faucet has been repaired. The hump in the hallway floor between 116 and 115 will be repaired by taking up the carpet, inspecting the subfloor and taking necessary actions to even out the subfloor. Carpet to be replaced at completion of repair.	11-10-06

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F 252	Continued From page 7 numerous nail holes. Room 107 had 6 closet doors that displayed numerous nail holes. Room 108 had 3 closet doors that displayed numerous nail holes. Room 109 had 4 closet doors that displayed numerous nail holes. Room 110 had 4 closet doors that displayed numerous nail holes. Room 111 had 3 closet doors that displayed numerous nail holes. Room 113 had 2 closet doors that displayed numerous nail holes. Room 116 had 2 closet doors that displayed numerous nail holes. Room 117 had 5 closet doors that displayed numerous nail holes, and the door to the hallway contained 2 prominent scratches that were approximately 1 inch wide and ran along the entire width of the door. Room 118 had 1 closet door that displayed numerous nail holes. Room 119 had 4 closet doors that displayed numerous nail holes. Room 120 had 4 closet doors that displayed numerous nail holes. Room 120 had 4 closet doors that displayed numerous nail holes. Room 121 had 6 closet doors that displayed numerous nail holes. During an interview with the Maintenance Supervisor on 09/12/06, he stated that the nail holes in closet doors were due to latches for locks that had been removed. Inspection of the resident rooms and bathrooms also revealed the following problems:	F 252	Cont. from page 7 Laundry room vent has been covered with screen material. The parking lot holes will be patched/repaired. The air conditioner grill in the smoking area has been repaired. The outdoor resident smoking area will be monitored/swept twice a day, a.m. and p.m., respectively. The maintenance department will monitor and determine if more times throughout the day are needed. The Maintenance Supervisor will add to his Preventative Maintenance monthly inspection the following: check finish of all doors, check placement of window screen, operation of sink faucets and finishes on vanity cabinets and light covers in resident rooms and bathrooms and flooring condition in resident rooms. Call light covers will be checked during monthly inspection of call lights. This is plan of correction will be completed and monitored for compliance by the Maintenance Supervisor and Assistant Administrator. Continued compliance will be integrated in Quality Assurance meeting by completion date and will be reviewed quarterly.	

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F 252	Continued From page 8 Room 121 contained an attic access door above the resident's bed. The ceiling edges were rough and lacked molding. The trap door was painted a different color than the ceiling. The window screen in this room was also missing. The bathroom vanity in room 120 had a scratch in the finish that was 1 foot x 1 inch. The light cover in this bathroom contained a 3 inch x 1 inch hole. The floor in room 118 had a 2 foot long crack just beneath the window. The floor in room 115 has a 1.5 foot crack in the floor at the entryway. Rooms 109 & 119 were missing call light covers in the common hallway, leaving the bulbs exposed. The call light cover at the bedside in room 116 was missing. The sink in room 113 would not turn off. The window screen in the resident's room was torn. The hallway floor between rooms 116 and 115 had an uneven hump that projected approximately one quarter of an inch higher than the rest of the floor. During an interview with the Maintenance Supervisor on 09/14/06, he stated that this problem was "structural, probably a beam". One laundry room vent that was one foot in diameter, was missing a screen. The parking area contained many large potholes, the largest measured approximately 8 feet x 10	F 252		

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F 252	Continued From page 9 feet. The outdoor resident smoking area contained an air conditioner grill that had been pushed in. The area around the smoking area contained 28 cigarette butts on 9/11/06. During an interview with the Maintenance Supervisor on 09/12/06, he stated that the butts were swept every weekday. Another inspection was conducted on 9/14/06, and the same area contained 24 cigarette butts, and there were also several butts on the ground in the smoking area on this date.	F 252	All reviews for residents 4,5,7 and 8 have been placed in the chart. Quarterly reviews were completed by the facility, but were not in the chart as they were on the desk of the person responsible for MDS encoding and transmission. The facility will change its process to include placing a copy of the completed, handwritten review in the chart until the encoded review can take its place. A shift of responsibilities will take place to assure that MDS documents are encoded and transmitted in a timely manner. To be completed and monitored by the Assistant Administrator and Medical Records. Continued compliance will be integrated in Quality Assurance meeting by completion date and will be reviewed quarterly	11-10-06
F 276 SS=B	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility did not complete quarterly Minimum Data Set (MDS) assessments every three months for 4 of 14 sample residents. Residents: 4, 5, 7 and 8. Findings included: 1. Resident 4 was admitted to the facility 10/6/04. Resident 4's medical record was reviewed on 9/11/06. Resident 4's most recent MDS assessment was dated 4/12/06. There had not been a quarterly MDS assessment documented in resident 4's record for 5 months.	F 276		

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F 276	Continued From page 10 2. Resident 7 was admitted to the facility 3/29/04. Resident 7's medical record was reviewed on 9/11/06. Resident 7's most recent MDS assessment was dated 4/5/06. There had not been a quarterly MDS assessment documented in resident 7's record for more than 5 months. 3. Resident 8 was admitted to the facility 2/10/06. Resident 8's medical record was reviewed on 9/12/06. Resident 8's most recent MDS assessment was dated 5/24/06. There had not been a quarterly MDS assessment documented in resident 8's record for more than 3 months. 4. Resident 5 was admitted to the facility on 4/20/03 with diagnoses including: dementia, hypertension, diabetes mellitis, and Alzheimer's. Resident 5's medical record was reviewed on 9/11/06. The most recent MDS (Minimum Data Set) in the record was dated 4/26/06. There had not been a quarterly review documented in the resident's chart for over four months.	F 276		

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F 287 SS=C	483.20(f) AUTOMATED DATA PROCESSING Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment. Annual assessment updates. Significant change in status assessments. Quarterly review assessments. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, if there is no admission assessment. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment. Annual assessment. Significant change in status assessment. Significant correction of prior full assessment. Significant correction of prior quarterly assessment. Quarterly review. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, for an initial transmission of MDS data on a resident that does	F 287	All encoding and transmission of required assessments and tracking forms will be completed in a timely manner to meet regulations as set forth by CMS. This will be accomplished by: MDS coordinator will be inserviced in the required time frames and the importance of timeliness as well as the MDS coordinator's duties will be restructured to allow for adequate time to complete the duty of encoding and transmission of MDS material. Assessments will be transmitted at least bimonthly. State reports will be accessed to verify that all transmitted material corresponds to facility census and resident roster. All discharged residents noted in tag that are missing a discharge tracking form will have one completed and transmitted. The facility will enlist the help of the EDI coordinator at the Dept of Health if necessary to clear off any old discharges that still show on our roster. The plan of correction will be completed and monitored by the MDS coordinator and the Administrator. Continued compliance will be integrated in Quality Assurance meeting by completion date and will be reviewed quarterly	11-10-06

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	46A051	A. BUILDING _____ B. WING _____	09/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK HEALTH CENTER	3520 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84106

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F 287	Continued From page 12 not have an admission assessment. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review at the State office of the Center for Medicare and Medicaid Services (CMS), it was determined the facility had not encoded MDS (Minimum Data Set) assessments within 7 days after they were due. The facility had not been transmitting MDS information within 30 days after it was due and / or completed for 13 of 14 sample residents and for an additional 42 previous and current residents. Sample Resident Identifiers: 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, CL1, CL2, SR3, SR4, SR5, SR6, SR7, and SR8. Findings included: On 9/7/06, the Resident Assessment Section (RAS) nurse who worked with the facility was interviewed at the Utah State Department of Health, as part of the pre survey information gathering. The RAS nurse stated that there was a concern regarding the residents' MDS assessments completed by the facility. On 9/11/06 at 7:10 AM, survey began at the facility. Initial review of the active medical records for 12 sample residents' medical records revealed 5 past due MDS assessments were missing from the records (see F 275 and F 276).	F 287		

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F 287	Continued From page 13 On 9/12/06, survey requested the CMS State "Roster Report" of MDS transmissions received from the facility at the Utah State Department of Health. The Roster Report revealed: Resident 1's 6/14/06 MDS assessment was transmitted 8/29/06, 6 weeks late. Resident 2's 8/2/06 MDS assessment was transmitted 9/12/06, 2 weeks late. Resident 3's 7/26/06 MDS assessment was transmitted 9/12/06, 3 weeks late. Resident 4's 7/12/06 MDS assessment was transmitted 9/12/06, 4 weeks late. Resident 5's 7/26/06 MDS assessment was transmitted 9/1206, 2 weeks late. Resident 6's 6/7/06 MDS assessment was transmitted 8/29/06, 7 weeks late. Resident 7's 7/5/06 MDS assessment was transmitted 9/12/06, 5 weeks late. Resident 9's 6/7/06 MDS assessment was transmitted 8/29/06, 7 weeks late. Resident 10's 7/19/06 MDS assessment was transmitted 9/12/06, 3 weeks late. Resident 11's 5/17/06 MDS assessment was transmitted 6/25/06, 1 week late. Resident 12's 7/5/06 MDS assessment was transmitted 9/12/06, 5 weeks late. Resident CL1's 7/5/06 MDS assessment was transmitted 9/12/06, 5 weeks late. In addition, resident CL1 was discharged from the facility on 8/3/06 and should have had a MDS Discharge Tracking transmitted by 9/1/06. As of 9/12/06, no Discharge Tracking had been transmitted for resident CL1. Resident CL2's 5/10/06 MDS assessment was	F 287		

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F 287	Continued From page 14 transmitted 8/29/06, 10 weeks late. In addition, resident CL2 was discharged from the facility on 5/17/06 and should have had a MDS Discharge Tracking transmitted by 6/16/06. As of 9/12/06, no Discharge Tracking had been transmitted for resident CL2. In addition, 6 former residents who had been gone from the facility for a year or more were still on record as residing at this facility because MDS Discharge Tracking had not been transmitted for them. The former residents were: SR 3, whose last MDS transmission was dated 9/15/04. SR 4, whose last MDS transmission was dated 3/22/04. SR 5, whose last MDS transmission was dated 7/26/05. SR 6, whose last MDS transmission was dated 3/22/04. SR 7, whose last MDS transmission was dated 1/10/05. SR 8, whose last MDS transmission was dated 5/19/04. The 9/12/06 CMS State Roster Report for the facility included records of MDS for 59 residents. Fifty-five of the 59 MDS assessments were transmitted after the 30-day deadline for transmitting.	F 287		

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F 323 SS=D	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 upon observation, interview, and document review, it was determined that the facility did not provide residents an accident free environment. Specifically, the high voltage Power Room and the housekeeping closet were unlocked and accessible to residents. During an inspection of the facility on 9/11, 13 and 14, the door to the Power Room was unlocked. An interview was conducted with the Maintenance Supervisor on 9/14/06. He stated that the Power Room contained two high voltage "transformers". The Surveyor stated that access of the Power Room to residents was a safety issue and the Maintenance Supervisor stated, "I think so, too" . On 9/11, 13, 14/06 the door to the housekeeping closet was unlocked, leaving the hazardous contents of the closet accessible to residents. This closet contained Glass Cleaner Concentrate and Disinfectant Cleaner. The Maintenance Supervisor was informed of the hazard and he subsequently provided the Material Safety Data Sheet (MSDS) for both substances. The "Disinfectant Cleaner" MSDS stated that the compound contained two hazardous ingredients: "Didecyl dimethyl ammonium chloride" and "n-Alkyl dimethyl benzyl ammonium chloride". The MSDS further stated that if contact with the compound occurs through exposure to eyes, skin,	F 323	The power room door has a key pad installed on it. All staff will be inserviced in the importance of using the key pad to lock the door when leaving the power room. The chemicals stored in the hopper room have been removed, all housekeeping staff have will be inserviced on the safety concern of storing chemicals in areas that are accessible to residents. They will also be instructed to keep chemicals locked up so that residents cannot access them. The maintenance supervisor and assistant maintenance person will perform random checks 5x weekly to assure that the door remains locked to prevent access by residents and that chemicals are stored under lock and key. The above will be monitored for compliance by the Assistant Administrator. Continued compliance will be integrated in Quality Assurance meeting by completion date and will be reviewed quarterly.	11-10-06

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F 323	Continued From page 16 or ingestion, to "call a physician". The "Glass Cleaner Concentrate" MSDS stated that the compound contained three hazardous ingredients: "2-Butoxyethanol", "2-Propanol", and "Nonylphenolpolyethoxyethanol". The MSDS further stated to "call a physician" in the event of exposure via the eyes, ingestion, or inhalation.	F 323		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based upon observation and interview, it was determined that the facility did not ensure a medication error rate of less than 5%. Specifically, out of 55 opportunities for error, 3 errors were observed. One nurse confirmed during interview that 3 medications were not administered during the observation. (Resident Identifiers: Supplemental Residents 1 & 2). Findings included: 1. On 9/12/06, Charge Nurse 2 was observed during morning medication administrations. Each medication ordered for Supplemental Resident #1 (SR 1) was removed from the medication card and placed in the medication cup. The nurse than presented the cup to SR 1. SR 1 took the cup and, while placing the mediations into her	F 332	Charge nurse 2 has been inserviced on the importance of completing a visual check of the resident and surrounding area to assure that all medications have been taken. This will be accomplished by closer observation, taking care to observe the resident from all angles to complete the visual check. The Director of Nursing or Assistant Director of Nursing will perform random medication pass observations (1x weekly) to assure compliance. This plan of correction will be completed and monitored by Director of Nursing. Continued compliance will be integrated in Quality Assurance meeting by completion date and will be reviewed quarterly.	11-10-06

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F 332	Continued From page 17 mouth, dropped two medications into her lap. She then swallowed the rest of the medications. Charge Nurse 2 then handed her a glass of water, and SR 1 drank the water. Charge Nurse 2 walked away from the resident. The Surveyor asked Charge Nurse 2, "Are you done giving her medications" to her? Charge Nurse 2 stated that she was finished. The Surveyor and Charge Nurse went back to SR 1 and found the two dropped medications in her lap. Charge Nurse 2 stated that one medication was her Lasix and the other medication was her Aspirin. SR 1 was to receive Lasix 20 milligrams and Aspirin 81 milligrams every morning. SR 1 subsequently received her omitted medications. 2. On 9/12/06, Charge Nurse 2 was observed placing each ordered medication for Supplemental Resident 2 (SR 2) into his medication cup. She then presented the cup to SR 2. SR 2 took the cup and, while placing the medications into his mouth, dropped one onto the floor. He then took the other medications and drank some water. Charge Nurse 2 walked away toward her medication cart. The Surveyor asked her at that time, "are you done giving him his medications?" Charge Nurse 2 stated that she was. Together the Surveyor and Charge Nurse 2 found the dropped medication on the floor beside the SR 2. Charge Nurse 2 picked up the medication and stated, "That's his Wellbutrin". SR 2 subsequently received his medication as ordered.	F 332		

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F 518 SS=E	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based upon staff interviews, it was found that the facility did not sufficiently train staff to respond in the event of emergency. Specifically, two of four staff members interviewed could not adequately describe actions to be taken in the event of an emergency. Findings included: 1. On 9/12/06, Charge Nurse1 was interviewed. She was asked to identify the location of the fire alarm pull stations and fire extinguishers. She stated indicated that she did not know, and stated, "Sorry, I should know that". 2. On 9/12/06 CNA 2 was interviewed. She stated that she did not know where the fire alarm pull stations or fire extinguishers were. She further stated she did not know how to pull the fire alarm, "I have to tell the truth, I don't know".	F 518	Charge nurse 1 and C.N.A. 2 have been inserviced as to the operation and location of fire alarm pull stations and fire extinguishers. To assure compliance in emergency training, the maintenance supervisor will receive notification from the Asst. Administrator of new hires so that he can complete training of emergency procedures in a timely manner. In addition, a check list will be developed to document that the training has occurred. This document will be placed in the employee's personnel folder. All employees knowledge of emergency procedures will be reviewed at least biannually by the maintenance supervisor. This plan of correction will be completed by the Maintenance Supervisor. The above will be monitored for compliance by the Assistant Administrator. Continued compliance will be integrated in Quality Assurance meeting by completion date and will be reviewed quarterly.	11-10-06