STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A061	A. BUILDING ______ B. WING ______	02/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPANISH FORK NURSING AND REHAB	46 NORTH 100 EAST SPANISH FORK, UT 84660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review the facility did not notify the physician of injuries that occurred for of 2 of 8 sampled residents that had the potential for requiring physician intervention. (Resident	F 157		5/1/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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identifier: 2 and CL 8 [closed record])

Findings included:

1. Resident 2 was admitted on 10/22/05 with diagnoses that includes: Parkinson's disease, arthritis, insomnia, constipation, anxiety and benign prostatic hypertrophy.

A review of resident 2's medical record was completed on 2/21/07.

On 4/23/06 at 1:15 AM, the resident was found in his room on floor. The resident was assessed for injuries and complained of pain on his left side. It was documented that the resident was helped back into bed. The resident was reminded to use his call light. Additionally, on 4/23/06 at 9:30 AM, it was documented in resident 2's Nurses' Progress notes that X rays were done on his ribs. The results of the x-ray showed that the resident had 3 fractures ribs on his left side. It was documented on the incident report that it was not necessary to notify the physician.

On 6/9/06 at 2:00 AM, it was documented that resident 2 was found on the floor by his table and stated that he was lost. It was documented that the bed alarm was not working. Resident 2 was placed in a geriatric chair. The resident sustained two small cuts to his head on the right lobe. The wounds were cleaned with peroxide and the resident's head was wrapped with sterile gauze and an ace wrap. Ice was applied to the wound. It was documented on the incident report that it was not necessary to notify the physician.

On 6/19/06 at 1:35 AM, it was documented that a thump was heard. Staff went into resident 2's

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F 157	Continued From page 2 bedroom and found him on the right side of the bed on the floor with his head against the bed. The bed alarm was reset. Resident 2 was assisted back to bed. There was some redness and swelling to the back of resident 2's neck. It was passed onto day shift about the bed alarm functioning improperly and resident 2's fall. It was documented on the incident report that it was not necessary to notify the physician. On 8/13/06 at 12:15 AM, it was documented that staff heard resident 2 fall and went into resident 2's room. Resident 2 was lying on the floor. His head was on the side table. The resident had an open wound on the top and back of his head that was bleeding. First aid was administered and an ambulance was called. The bed alarm did not go off. Additionally, resident 2's Nurses' Progress Notes dated 8/13/06 at 3:00 AM documented that resident 2 returned from the hospital emergency room by ambulance with staples placed in his head. It was documented on the incident report that it was not necessary to notify the physician. On 8/31/06 at 8:25 PM, it was documented that resident 2 was in bathroom on the toilet left alone. When staff went into check on him they found resident 2 on the ground on his side. The top of resident 2's head was bleeding. It was documented on the incident report that it was not necessary to notify the physician. On 11/4/06 at 3:00 AM, it was documented that resident 2's bedside alarm was going off and that the resident was found sitting on floor beside his bed." Resident 2 had a skin abrasion on his back. It was documented on the incident report that it was not necessary to notify the physician.	F 157		

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On 12/20/06 at 11:50 AM, it was documented that resident 2 fell in the doorway of the dining room possibly hitting his head on door or the doorframe. Resident 2 sustained a 2" cut on the right side of his head. First aid was administered. It was documented on the incident report that it was not necessary to notify the physician.

2. CL 8 was admitted to the facility on 7/2/04 with diagnoses that included cerebral vascular disease, depression, renal insufficiency and gastrointestinal bleed. CL 8 passed away on 11/29/06.

A review of CL 8's medical record revealed that between September of 2006 through November of 2006 CL 8 was disimpacted of fecal matter 5 times. There was no documentation in the record that the physician had been notified. While standing medications were prescribed and given for constipation, there was no documentation that the PRN (as needed) medication for constipation were administered. A care plan pertaining to bowel elimination was found on the chart. It was not followed.

A review of CL 8 medical record was completed on 2/20/07.

CL 8's nursing notes from September 2006, October 2006 and November of 2006 were reviewed. The following was documented:

On 9/4/06, "Resident assisted digitally to have XL (extra large) BM (bowel movement). Cursing @ nurse entire time." There was no documentation in the nurse's notes that the physician was notified.

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F 157	Continued From page 4 On 9/19/06, " c/o 'bum' hurting. Digitally removed XL hard brown BM this AM (morning)." There was no documentation in the nurse's notes that the physician was notified. On 9/27/06, "Resident manually eliminated of XL soft brown stool. Hemorrhoids bleeding." There was no documentation in the nurse's notes that the physician was notified. On 10/28/06, "2000 (8:00 PM) Digital disimpaction of large amount hard dk (dark) brown stool." There was no documentation in the nurse's notes that the physician was notified. On 11/17/06, "Res(ident) c/o 'hurting all over' disimpacted Lg BM...." There was no documentation in the nurse's notes that the physician was notified.	F 157		
F 164 SS=E	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164		5/1/07

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F 164	Continued From page 5 and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to provide privacy for 2 out of 8 sample residents and 1 supplemental resident (SR) when providing personal care. (Resident identifiers: 3, 4, and SR 15.) Findings included: 1. During tour of the facility on 2/12/07 at 12:50 PM, the hall door and the bathroom door was open to resident bedroom 1. A staff person was assisting SR 15 with using the toilet in the bathroom. As the staff assisted SR 15 to stand up the resident's naked backside was in view from the hallway. SR 15 was assisted from the bathroom and resident 3 was assisted into the bathroom. The staff person assisted resident 3 to remove his pants. Resident 3 's naked backside was in full view from the hallway. 2. On 2/15/07 at 1:08 PM, the facilities Activities Director was observed to assist SR 15 in the resident's bathroom. The Activities Director assisted SR 15 to stand up from the toilet. While the Activities Director was placing an	F 164		

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F 164	Continued From page 6 incontinence brief on SR 15, the resident's naked backside was in full view from the hallway. 3. On 2/14/07 at 3:50 PM, CNA (certified nursing assistant) 1 and CNA 2 were observed to change resident 4's brief while resident 4 was laying in his bed. Resident 4's roommate was in his bed awake facing resident 4 during the incontinence brief change. The two CNAs did not pull the privacy curtain and resident 4's roommate observed the brief change.	F 164		
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 observations and interview, the facility did not ensure that results of the most recent State conducted survey of the facility was readily available to residents and ensure their right to examine the results of the facility survey and plan of correction. Findings included: During 2 different observations on 2/13/07, the most recent state survey from 2006 was not	F 167		5/1/07

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F 167	Continued From page 7 found. At approximately 4:00 PM on 2/13/07, the medical records person was asked where the survey results from 2006 were located. She stated that the survey results were kept in a binder on a book shelf located in front of the nurses' station. The 2006 survey, however, was not found. At approximately 5:00 PM on 2/13/07, the Administrator was asked where the survey from 2006 was located. He stated that the survey was kept in a binder on the book shelf located in front of the nurses' station. When he was informed that the survey was not found on the book shelf earlier, the Administrator went to the book shelf and looked for the 2006 survey. The Administrator was unable to locate the 2006 survey and stated that he did not know what happened to it.	F 167		
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, it was determined that the facility assessed a resident as not being a safe candidate for administering his own medications, then allowed the resident to administer his own medication. The facility did not monitor for drug safety for 1 of 8 sampled residents. (Resident identifier: 5)	F 176		5/1/07

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F 176	Continued From page 8 Findings included: Resident 5 was admitted to the facility on 1/23/07 with diagnoses that included insulin dependent diabetes mellitus, renal failure, schizophrenia, hypertension and bipolar disease. On 2/13/07 at 7:45 AM, licensed practical nurse (LPN) 1, was observed preparing resident 5's morning medications. She stated that resident 5 had given "himself his insulin yesterday in his penis." A few minutes later, LPN 1 gave resident 5 an insulin syringe filled with 20 units of Lantus insulin. Resident 5 was observed to give himself an injection of the insulin in the right upper quadrant of his abdomen. Resident 5's medical record was reviewed on 2/13/07. It was documented in the physician's orders dated 1/25/07 that resident 5 was to be administered Lantus insulin 20 units subcutaneus injection every morning. The following was documented in resident 5's nursing notes dated 2/12/07: "Resident observed while giving himself 20 units Lantus Insulin. At first was about to give injection in his abdomen, hesitated for approx. 15 seconds, then gave himself the injection in the head of his penis. No apparent acute distress seen during the procedure, resident stated "...it didn't hurt as bad as I thought it would." On 2/13/07 resident 5's "Self-Administration of Medication Assessment" dated 1/23/07 was reviewed. It was documented on the assessment that resident 5 was "not a candidate for safe	F 176		

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F 176	Continued From page 9 self-administration of medications."	F 176		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility did not provide documentation of medical necessity for siderails, for 1 of 8 residents. (Resident identifier: 6) Findings included: 1. Resident 6 was admitted to the facility on 12/29/06 with diagnoses that included hypertension, blindness, arthritis and dementia. Resident 6 was observed in bed on 2/14/07 at 1:21 PM, with full siderails up on both sides of the bed. The resident was yelling over and over the following: "Come in here," and "Take me down to the girls." At one point, resident 6 had both legs through the siderails up to mid-thigh. The resident independently removed her legs from between the side rails and sat up in bed and continued to yell. Resident 6's verbalizations could be heard at the nurses' station. However, at this time no staff was at the nurses' station nor was there any staff in the hallway. At 1:27 PM, the Administrator was informed that resident 6 was in need of assistance and came into the resident's room. Resident 6 was calling out, moving about the bed with full side rails up for a total of 6 minutes	F 221		5/1/07

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F 221	Continued From page 10	F 221		

before she received assistance from staff.

On 2/14/07 at 2:00 PM, the director of nursing (DON) was interviewed. She stated that every time resident 6 is in bed for more than 15 minutes she will start yelling out and shaking the side rails. The DON stated that she has seen resident 6 with her legs through the side rails but has never seen her entangled in the side rails or fall over the side rails. The DON stated that resident 6 is very "antsy". The DON also stated that resident 6 can be heard at the nurses' station by staff when she calls out but they did not hear her today because staff opted to have their lunch in another area.

Review of resident 6's medical record was completed on 2/20/07.

On 2/14/07, a review of resident 6's nurses' notes was completed. The following was documented in a nursing note dated 12/29/07. "...Returns to room and placed in bed (with) rail up for safety. Asks to have rail down because of nerves (and) request granted. Res(ident) would not stay in bed so rail back up... Res is blind but has very good hearing - most comments she makes are very confused..."

No documentation of evaluation of need for side rails, entrapment risk, care planning, nor doctors orders could be found in resident's medical records. However, a "Side Rail Approval by Resident or Surrogate" form, signed by a family member was found in the resident's chart. Above the family members signature the following was printed on the form: "Resident displays no behaviors that would make the bed a safety issue."

F 241	483.15(a) DIGNITY	F 241		5/1/07

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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, it was determined the facility did not provide 1 supplemental resident (SR) a dignified environment; thus, placing the resident at risk for diminished self-esteem and self worth. (Resident identifier: SR 16)

Findings included:

SR 16 was admitted to the facility on 9/15/03 with diagnoses that included dementia, hypertension, glaucoma, hypothyroidism and congestive heart failure.

On 2/12/07 at 3:32 PM, the following observations were made in the dining room:

SR 16 was sitting in a geriatric chair (recliner) and was covered with a thin white blanket. SR 16 was wearing a dressing gown and had fidgeted with the blanket. SR 16's knees were pulled up towards her head exposing the resident's incontinent pad and bare hips. Three other residents were in the dining room. At 3:35 PM, a staff person entered the dining room and assisted another resident out of the room. SR 16 put her legs down but her gown and blanket were still up around her waist and hips exposing her incontinence brief. At 3:36 PM, a male resident walked through the dining room. At 3:45 PM, a female resident entered the room and sat down.

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F 241	Continued From page 12 At 3:56 PM, the MRP (Medical records person) entered the room and assisted a male resident who had fallen. While in the dining room the MRP adjusted SR 16's gown and blanket so that the resident's hips and brief were covered.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interview, group interview and record review, it was determined that for 2 of 8 sample residents and 2 supplemental residents (SR), the facility did not provide an ongoing program of activities designed to meet the comprehensive assessment, the interests and the physical, mental and psychosocial well being of each resident. (Resident identifiers: 2, 4 and SR 16, 17) Findings included: 1. Resident 4 was admitted to the facility on 10/2/05 with diagnoses that included Alzheimer's disease, diabetes mellitus, obesity, depression, and peripheral edema. On 2/13/07, from 7:00 AM through 1:00 PM, resident 4 was observed sitting in a geri-chair (recliner) in the dining room. From 7:00 AM until 8:00 AM, the resident was in his gerichair sitting quietly. The television was on. From approximately 8:00 AM to 9:00 AM, resident 4	F 248		5/1/07

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was fed breakfast by the MRP (medical records person). At approximately 9:15 AM, resident 4 was taken to the bathroom and toileted. From 9:30 AM until 10:55 AM, resident 4 was in his geri-chair with the television on. At approximately 12 :00 noon, resident 4 was fed lunch. At 1:00 PM, resident 4 was still in the gerichair in the dining room. Sometime after 1:00 PM, the resident was taken to bed. At approximately 4:30 PM, the resident was brought back into the dining room for the evening meal.

The "Activity Calendar" for 2/13/07 was reviewed. (Note: Most group activities are held in the facility dining room.) At 9:00 AM, beauty time was scheduled. Three female residents were observed in the dining room getting a manicure. The television was on. At 10:30 AM, Bingo was scheduled. No activity took place.

On 2/14/07 from 7:00 AM until 12:30 PM, resident 4 was observed sitting in a geri-chair in the dining room. At 8:10 AM, the resident was being fed breakfast by the MRP. At approximately 9:30 AM, an "Andy Williams Christmas Special" was playing on the television. At 10:30 AM, Relief Society was held. Resident 4 remained sitting in his geri-chair. At approximately 12:00 noon lunch was served. At 12:30 PM, resident 4 was taken to his room and put to bed.

A review of resident 4's medical record was completed on 2/20/07.

Resident 4's quarterly MDS (minimum data set) dated 1/24/07 was reviewed. It was documented that resident 4 was severely impaired for daily decision-making, that he needed total assistance with activities of daily living and was incontinent of

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F 248	Continued From page 14 bowel and bladder. In the activities section, it was documented that resident 4 spends from 1/3rd to 2/3rd's of his time involved with activities. No preferences for activities were documented in this MDS. Resident 4's annual 10/25/06 MDS was reviewed. It was documented under general activity preferences that resident 4 likes music, watching television, spiritual activities and walking/wheeling out doors. Resident 4's care plan for activities was reviewed. It was documented in the "Goals" section that "Res. (resident) will show some response to sensory activities during 1:1 visits at least two times per week. Res. will be passively involved in at least three activities per week. In the "Approach" section the following was documented: "Provide prompts and cues during activity to help focus attention. Praise participation. Provide 1:1 sensory activities including taste, smell, touch and sound. Establish eye contact before speaking. Sit res. in social area for passive participation in group activity. Resident 4's activity log for February 2007 was reviewed. A 1:1 visit was recorded as being done on 2/1/07, 2/12/07 and on 2/13/07. There was no documentation that on the weekends of 2/03/07-2/04/07 and 2/10/07-2/11/07 that resident 4 was involved in any activities. On 2/15/07 at approximately 9:15 AM, the facility's activity director was interviewed. When asked when the 1 to 1 activities take place with the individual residents, she stated that she does 1 to 1 with the residents when doing her CNA duties.	F 248		

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F 248	Continued From page 15 On 2/14/07 at 3:53 PM CNA 1 was interviewed. CNA 1 stated that she works every Saturday. She stated that she does not do the activities on Saturday because she is the only CNA working from 6:00 AM to 3:00 PM shift and does not have enough time. 2. Resident SR 17 was admitted to the facility on 1/2/07 with diagnoses that included Parkinson's disease, Alzheimer's disease, macular degeneration, benign prostate hypertrophy, hypothyroidism and depression. On 2/12/07 at 3:30 PM through 4:30 PM, SR 17 was observed sitting in a geri chair in the facility's dining room. The television was on. On 2/13/07 from between 7:00 AM through approximately 1:00 PM, SR 17 was observed numerous times in the dining room in his geri-chair. From approximately 8:00 AM to 9:00 AM, SR 17 was fed breakfast by the activities director. From approximately 9:30 AM until 10:55 AM, SR 17 was in his geri-chair with the television on in the dining room. At approximately 12 :00 noon, SR 17 was fed lunch. The "Activity Calendar" for 2/13/07 was reviewed. (Note: Most group activities are held in the facility dining room.) At 9:00 AM, beauty time was scheduled. Three female residents were observed in the dining room getting a manicure. The television was on. At 10:30 AM, Bingo was scheduled. No activity took place. On 2/14/07 from 7:00 AM until 12:30 PM, SR 17 was observed sitting in a geri-chair in the dining room. At 8:00 AM, the resident was being fed	F 248		

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breakfast by the activities director. At approximately 9:30 AM, an "Andy Williams Christmas Special" was playing on the television. At 10:30 AM, Relief Society was held. SR 17 remained sitting in his geri-chair. At approximately 12:00 noon lunch was served.

A review of SR 17's medical record was completed on 2/20/07.

SR 17's admission 1/15/07 MDS was reviewed. It was documented that SR 17 has moderately impaired cognitive skills, is difficult to understand when talking and has difficultly understanding others, needs total assistance with activities of daily living, his vision is severely impaired and is incontinent of bladder. In the activities section, it was documented that SR 17 spends from 1/3rd to 2/3rd of his time involved with activities and that SR 17 preferrers music, spiritual activities, walking/wheeling outdoors, watching TV and talking or conversing.

SR 17's care plan for activities was reviewed. It was documented in the "Goals" section that "SR 17 will remain attentive for at least 15 minutes during leisure activities per week". In the "Approach" section the following was documented: "Provide prompts and cues during activity to help focus attention. Praise participation. Invite and assist to group activities. Involve in current preferred activities: music, and singing, family visits. Provide adaptation to activities as needed: adapt activities for vision impairment."

SR 17's activity log for February 2007 was reviewed. There was no documentation that on the weekends of 2/03/07-2/04/07 and

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F 248	Continued From page 17 2/10/07-2/11/07 that SR 17 was involved in any activities. 3. Resident 2 was a 92 year old male admitted on 10/22/05 with diagnoses that included Parkinson's disease, arthritis, insomnia, constipation, anxiety and benign prostate hypertrophy. On 2/13/07 from 6:40 AM through 4:30 PM, resident 2 was observed. From 6:40 AM until 7:30 AM, the resident was in the dining room in a geri-chair sleeping quietly. The television was on. At 7:34 AM, resident 2 stood up from his geri-chair, attempted to remove his pants and was redirected by staff. Resident 2 then urinated. The urine soaked through the resident's pants. The activities director assisted resident 2 to the bathroom. After using the bathroom, resident 2 was returned to the gerichair. From approximately 8:00 AM to 9:00 AM, resident 2 was fed breakfast by a CNA. From 9:30 AM until 10:55 AM, resident 2 was in his gerichair with the television on in the dining room. At approximately 12:00 noon, resident 2 was fed lunch. At 1:00 PM, resident 2 was in the gerichair in the dining room and the television was on. The "Activity Calendar" for 2/13/07 was reviewed. (Note: Most group activities are held in the facility dining room.) At 9:00 AM, beauty time was scheduled. Three female residents were observed in the dining room getting a manicure. The television was on. At 10:30 AM, Bingo was scheduled. No activity took place. On 2/14/07 from 7:00 AM until 12:30 PM, resident 2 was observed sitting in a gerichair in the dining room. At approximately 8:00 AM, the resident was being fed breakfast by a staff person. At approximately 9:30 AM, an "Andy Williams	F 248		

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F 248	Continued From page 18 Christmas Special" was playing on the television. At 10:30 AM, Relief Society was held. Resident 2 remained sitting in his gerichair. At approximately 12:00 PM, resident 2 was fed lunch by a staff person. At 12:35 PM, resident 2 was sitting in his geri-chair with an empty lap tray in front of him. At 1:15 PM, the DON assisted resident 2 out of the dining room. They walked down the hall and back to the geri-chair. At 2:30 PM, resident 2 was observed in the dining room in a gerichair. At 3:22 PM, another resident came out of the dining room saying resident 2 "is trying to walk without his walker". The MRP entered the dining room with resident 2's walker in hand (which was out in the hall) and assisted the resident down the hall. At 3:40 PM, a resident came down the hall and said resident 2, "is walking down the hall with out his walker". The DON went down the hall and assisted resident 2 to the nurse's station and sat the resident down in a chair. The DON then asked the MRP where resident 2's walker was. The MRP said it was in his room with him. At 3:46 PM, a resident was assisting resident 2, by holding onto his hands as he walked into the dining room. The resident sat resident 2 down in a geri-atric chair and told him to get comfortable and put the legs up. At 4:16 PM, with no staff present, resident 2 was observed ambulating in dining room with an unsteady gait, reaching for the wall. Resident 2 approached the door way and stood for approximately 1 minute, then turned toward a table, reached out with his arms and grabbed the table. Resident 2 then sat down on a chair for approximately 1 minute. Then stood up and walked to a chair on the other side of the table. Resident 2 sat down for approximately 1 minute then stood up and ambulated to the doorway and held onto the doorjamb. At 4:21 PM, a surveyor alerted the LPN that resident 2 needed	F 248		

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assistance.

A review of resident 2 medical record was completed on 2/21/07.

Resident 2's annual MDS (Minimum Data Set) assessment dated 11/04/06 was reviewed. It was documented that resident 2 was severely impaired for daily decision-making, his vision is highly impaired, that he needed assistance with activities of daily living and was incontinent of bladder. In the activities section, it was documented that resident 2 spends from 1/3rd to 2/3rd of his time involved with activities and that resident 2 prefers music, spiritual activities trips/shopping, walking/wheeling outdoors and talking or conversing.

Resident 2's care plan for activities was reviewed. It was documented in the "Problem/Need" section that Resident 2 is unable to structure his time, has short and long term memory loss, has difficulty with decision making and needs prompts to choose activities. In the "Goal" section the only goal documented was: "Resident will remain attentive for at least 15 minutes during leisure activities per week". In the "Approach" section the only approach documented was: "Monitor for falls".

Resident 2's activity log for February 2007 was reviewed. The log documented type of participation but not length of time. There was no documentation that on the weekends of 2/03/07-2/04/07 and 2/10/07-2/11/07 that resident 4 was involved in any activities.

4. SR 16 was admitted to the facility on 9/15/03 with diagnoses that included dementia,

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F 248	Continued From page 20 hypertension, glaucoma, hypothyroidism and congestive heart failure. On 2/13/07 from 7:00 AM through 4:30 PM, SR 16 was observed. From 7:00 AM until 7:30 AM, the resident was quietly sitting in a gerichair in the dining room. The television was on. At 7:30 AM, SR 16's geri-chair was wheeled into the hall. The activities director and combed and curled the resident's hair. SR 16 was then returned to the dining room. From approximately 8:00 AM to 9:00 AM, SR 16 was fed breakfast by the acitivies director. From 9:30 AM until 10:55 AM, resident 2 was observed in her geri-chair in the dining room with the television on. At approximately 12:00 PM, SR 16 was fed lunch. At 1:00 PM, SR 16 was in the geri-chair in the dining room. The televsion was on. The "Activity Calendar" for 2/13/07 was reviewed. (Note: Most group activities are held in the facility dining room.) At 9:00 AM, beauty time was scheduled. Three other female residents were observed in the dining room getting a manicure. At 10:30 AM, Bingo was scheduled. No activity took place. The television remained on until lunch time. On 2/14/07 from 7:00 AM until 12:30 PM, SR 16 was observed sitting in a gerichair in the dining room. At approximately 8:00 AM, the resident was being fed breakfast by the activities director. At approximately 9:30 AM, an "Andy Williams Christmas Special" was playing on the television. At 10:30 AM, Relief Society was held. SR 16 remained sitting in her gerichair. At approximately 12:00 PM, SR 16 was fed lunch by the activities director. At 2:30 PM, SR 16 was observed in the dining room in a gerichair. At 3:22 PM, SR 16 was	F 248		

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F 248	Continued From page 21 observed in the dining room in a gerichair. The television was on. At 3:46 PM, SR 16 was observed in the dining room in a geri-chair. A review of SR 16 medical record was completed on 2/21/07. SR 16's annual MDS assessment dated 12/18/06 was reviewed. It was documented that SR 16 was severely impaired for daily decision-making, that she needed total assistance with activities of daily living and was incontinent of bladder. In the activities section, it was documented that SR 16 spends from 1/3rd to 2/3rd of his time involved with activities. SR 16's care plan for activities was reviewed. In the "Goal" section the following was documented: "Resident will accept participation in two 1 to 1 contacts each week". In the "Approach" the following was documented: "Offer 1 to 1 contacts weekly focus on sensory stim (stimulation)". SR 16's activity log for February 2007 was reviewed. A 1:1 visit was recorded as being done on 2/1/07 and on 2/13/07. There was no documentation that on the weekends of 2/03/07-2/04/07 and 2/10/07-2/11/07 that resident 4 was involved in any activities. On 2/15/07 at approximately 9:15 AM, the facility's activity director was interviewed. When asked when the 1 to 1 activities take place with the individual residents, she stated that she does 1 to 1 with the residents while doing her CNA duties. On 2/14/07 at 3:53 PM, CNA 1 was interviewed. CNA 1 stated that she works every Saturday. She	F 248		

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stated that she does not do the activities on Saturday because she is the only CNA working from 6:00 AM to 3:00 PM shift and does not have enough time.

5. On 2/13/07 at 1:30 PM, the group interview was completed. Three out of 4 people in group expressed a desire to have more activities during the week and on the weekends.

On 2/14/07 at 3:53 PM, CNA 1 was interviewed. CNA 1 stated that she works every Saturday. She stated that she does not do the activities on Saturday because she is the only CNA working from 6:00 AM to 3:00 PM shift and does not have enough time.

On 2/14/07 at 4:50 PM, CNA 3 was interviewed. CNA 3 stated that she and 2 other off duty CNAs threw a pizza party for the residents on a Saturday afternoon because the residents had nothing to do or look forward to on the weekends. She stated that the 3 of them bought pizza and they and the residents watched a movie together. CNA 3 was asked if they follow the "Activity Calendar." CNA 3 stated that she does not understand the activities calendar and that the calendar is "never" followed.

On 2/15/07 at approximately 9:15 AM, the facility's activities director was interviewed. She stated that she has never trained any staff on activities for Saturdays because she "makes it simple" usually a "movie or a tape." When asked if she does any follow-up on Mondays to see if the scheduled Saturday activity was followed she stated, "No." She also stated that she is not only the activities director but also the facility transporter, social services worker, the staff

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F 248	Continued From page 23 person in charge of getting the residents ready when the physician comes to the facility and helps to feed residents during the morning and afternoon meals. The Activities director also stated that she works from 6:00 AM to 3:00 PM Mondays through Friday.	F 248		
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 interviews and reviews of records, the facility did not provide social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, for 1 of 8 sampled residents. (Resident identifier: 7) Findings included: Resident 7 was admitted to the facility on 2/11/05 with diagnoses that included congestive heart failure, chronic paranoid schizophrenia, angina, abdominal pain-chronic cysts, gastroesophageal disease, diverticulitis, hypoxia, irritable bowel disease and fibromyalgia. A review of resident 7's medical record was completed on 2/20/07. Resident 7's medication administration record (MAR) for February of 2006 was reviewed. Resident 7 had physician's orders for the following medications:	F 250		5/1/07

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a. Duragesic patch 75 micrograms, 1 transdermal system every 72 hours, every three days for pain
b. Methadose 10 mg (milligrams), 3 tablets by mouth, three times a day for chronic pain
c. Alieve 220 mg, 2 pills, by mouth, twice a day for knee pain.
d. Tylenol 325 mg 2 tablets, by mouth every 4 hours
e. Imitrex 100 mg 1 @ onset of migraine. May repeat 2 hours later. Maximum 200 mg a day (as needed)

On 2/13/07 at 5:30 PM, the Administrator and Director of Nursing (DON) were interviewed. When asked why resident 7 was on multiple medications for pain, they stated that resident 7 was a "hypochondriac" and a drug seeker. They stated that resident 7 was very aware of what medications she was taking and that she had books in her room about medications. The DON stated that resident 7 was constantly researching different medications and requesting new medications from her physicians. The Administrator and the DON stated that if you discontinued any of her medications she would become very upset. They stated that she was schizophrenic, but stable at this time. The Administrator stated that if her medications were to be changed it might cause her to become mentally unstable. When they were asked if these behaviors of had been brought to the facility's social services consultant's attention, they stated "No". When asked if these behaviors were addressed in a care plan, they stated "No". The Administrator stated that this was "just [name of resident 7] being [name of resident 7]."

On 2/20/07, at approximately 12:00 PM, the medical records person (MRP) and the activities

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F 250	Continued From page 25 director/social services director (AD/SSD) were interviewed. They stated that resident 7 loved to go to doctor appointments. The AD/SSD stated that usually resident 7 liked to sleep late in the mornings and that she kept to herself. She stated that on the days that she had a doctor's appointment, she would get up early, would do her make-up and acted very happy. The MRP stated that frequently resident 7 made her own doctor appointments and then would notify the facility. The MRP also stated that resident 7 would go to the doctor appointments, then refuse treatment and would then request pain medications. When the MRP and AD/SSD were asked if these behaviors were brought to the facility's social services consultant's attention, they stated "No". When asked if these behaviors were addressed in a care plan, they stated, "No". On 2/21/07, a review of resident 7's "Social Services Progress Notes" dated 11/5/06, 8/7/06 and 5/9/06 was completed. It was documented in each of the above listed dates that "She continues to be very delusional, and there are times when it is very difficult to redirect her." There was no documentation that would indicate the facility's social work consultant was working with the facility to address the resident's behaviors of seeking medications and the staff's allegations of the resident being a "Hypochondriac".	F 250		
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	F 253		5/1/07

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F 253	Continued From page 26 by: Based on observation and interview it was determined that the facility did not provide maintenance services necessary to keep the resident living areas in good repair. Findings included: 1. A tour of the facility was conducted on 2/13/07. The following items were observed: Room 2 had an 8 inch tear in the carpet, and scrapes in the base of the sink. Room 4's hall door had numerous, 1 inch to 3 1/2 foot scratches from just above the handle down to the bottom of the door, the closet door had 3 gouges. The telephone table located in the west hall was missing laminate on the side and the corner and wood was exposed. The face of the table drawer was scratched and gouged. The wall in the hall next to room 8 had 8 holes in the wall. Room 7's door knob was loose. Room 9 had several scratches on the west wall by the bed. Room 4's call light panel was falling out of the wall. 2. The following was observed in room 1 on 2/14/07 at 7:25 AM: The bathroom door had many deep gouges in the finish from the bottom of the door up to 13 inches off the floor, the same	F 253		

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F 253	Continued From page 27 door had pieces of wood laminate pulling away from the door and exposing the foam core, the north wall had a 77 inch by 1 inch area were the paint had been scraped off, the outlet on the north wall was dented and very lose, there was peeling paint chips on the floor, the east wall by the bed had an 8 1/2 inch by 3 3/4 inch area that was missing wall board and exposing the plaster, the bathroom sink cabinet doors had scratches on the bottom 6 inches, the door jamb to the bathroom had numerous areas were the paint had worn off exposing the metal. On 2/15/07 at 9:00 AM, the bathroom next to the Administrators's office was observed. The toilet seat and lid had many areas were the finish was worn off making the surface unsanitizable. On 2/15/04 at 12:30 PM, the following items were observed: in the hall across from room 9 behind the chair rail was a 3 inch hole in the wall, between room 9 and the TV room was a 9 1/2 inch by 1 1/4 inch area of missing and peeling paint, the door jambs for rooms 4, 5, 6, 7, 8, 9, 10, 11, 12 and both (west hall) bathrooms have missing paint exposing the metal.	F 253		
F 279 SS=E	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.	F 279		5/1/07

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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 medical record review and interview, it was determined that for 5 of 8 sample residents the facility did not develop comprehensive care plans for each resident based on their individual needs identified by the facility staff.
(Resident identifiers: 2, 3, 4, 5, and 6)

Findings included:

1. Resident 4 was admitted to the facility on 10/2/05 with diagnoses that included Alzheimer disease, diabetes, obesity and peripheral edema.

On 2/12/07 and 2/13/07 at approximately 3:30 PM, resident 4 was observed in bed with eyes closed with full side rails up times 2.

On 2/20/07 a review of resident 4's medical record was completed.

There was no documentation of an evaluation for the need of side rails, no entrapment risk assessment, nor care planning could found in resident 4's medical records.

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On 2/14/07 at 3:30 PM, the director of nursing (DON) was interviewed. The DON stated that resident 4 has full side rails so that he won't fall out of bed.

On 2/14/07 at 3:50 PM, resident 4's buttock was observed during a incontinence brief change. Resident 4 had two .5 cm breaks in the skin on the left upper buttock approximately one inch apart.

A review of resident 4's medical record was completed on 2/20/07.

Resident 4's quarterly MDS (minimum data set) dated 1/24/07 was reviewed. It was documented that resident 4 was severely impaired for daily decision -making, that he needed total assistance with activities of daily living and was incontinent of bowel and bladder.

A care plan for resident 4 pertaining to pressure ulcers dated 10/30/06 was reviewed. The following was documented:
"Problem: Potential for Skin Breakdown R/T incontinence
Goal: Res. will maintain clean and intact skin.
Approach: Provide measures to decrease pressure and irritation to skin: use sheepskin (a pressure relieving device). Keep skin clean and dry. Change incont(inence) pad ASAP (as soon as possible) after voiding or bowel movements. Apply skin barrier cream after incontinence episodes. Keep bed linen clean, dry, and free of wrinkles. Assist res(ident) to turn and reposition every two hours. Position with pads and cushions to prevent pressure.

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A care plan that addressed actual skin breakdown could not be located in resident 4's medical record.

A care plan that addressed skin breakdown due to sitting in a chair for extended periods of time could not be found in resident 4's chart.

A care plan that addressed the use of a Roho cushion could not be found in resident 4's chart. (The operations manual for Roho dry flotation cushioning products was reviewed. On page 3, in the "Precautions" sections the following was documented: "Obstructions: DO NOT place any obstructions between the user and the cushion because it will reduce product effectiveness.)

2. Resident 5 was admitted to the facility on 1/23/07 with diagnoses that included diabetes, renal failure, depression, hypertension, schizophrenia, bipolar and gastroesophageal disease.

Review of resident 5's medical record was completed on 2/20/07.

Resident 5's admission minimum data set (MDS) dated 2/05/07 was reviewed.

Section V-the "Resident Assessment Protocol Summary" was reviewed. In column b- the "Care Planning Decision-check if addressed in care plan" the following categories were hand checked denoting that care plans had been completed for; cognitive loss, activities of daily living, falls and psychotropic drug use. No care plans were found.

On 2/14/07 at 10:45 AM, the medical records person (MRP) was interviewed. She stated that

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the only care plan completed on resident 5 were the initial care plans. The comprehensive care plans should have been completed no later than 2/12/07.

3. Resident 6 was admitted to the facility on 12/29/06 with diagnoses that included hypertension, blindness, arthritis and dementia.

Resident 6 was observed in bed on 2/14/07 at 1:21 PM, with full siderails up on both sides of the bed. The resident was yelling over and over the following: "Come in here," and "Take me down to the girls." At one point, resident 6 had both legs through the siderails up to mid-thigh. The resident independently removed her legs from between the side rails and sat up in bed and continued to yell.

Review of resident 6's medical record was completed on 2/20/07.

Resident 6's admission minimum data set (MDS) dated 1/11/07 was reviewed. It was documented in section B, for Cognitive Patterns, specifically "Cognitive Skills for Daily Decision-making', that resident 6 was severely impaired. It was documented in section P, for Special Treatments and Procedures, specifically "Devices and Restraints" that resident 6 has "Full bed rails on all open sides of bed."

There was no documentation of an evaluation for the need of side rails, no entrapment risk assessment, nor care planning could found in resident 6's medical records.

Section V- the "Resident Assessment Protocol

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Summary" was reviewed. In column b- the "Care Planning Decision-check if addressed in care plan" the following categories were hand checked denoting that care plans had been completed for; cognitive loss, visual function, activities of daily living, urinary incontinence, mood state, falls, nutritional status, pressure ulcers, and psychotropic drug use. Section V was signed by an RN as being completed on 1/11/07. The R2 date is documented as 1/11/07. Per the date of the RN signatures, care plans should have been completed on 1/11/07 or no later than 1/18/07. However, no care plans were found.

On 2/20/07 at 9:45 AM, the MRP was interviewed. She stated that the only care plan completed on resident 6 was a care plan for "Recreation Therapy."

4. Resident 3 was admitted to the facility on 2/19/06 with diagnoses that included hypertension, angina, mental confusion, decreased mobility, peripheral neuropathy, senility and congestive heart failure.

On 2/12/07 at approximately 12:30 PM, resident 3 was observed in bed with full side rails up times 2.

On 2/20/07 a review of resident 3's medical record was completed.

There was no documentation of an evaluation for the need of side rails, no entrapment risk assessment, nor care planning could found in resident 3's medical records.

On 2/12/07 at approximately 12:30 PM, the

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F 279	Continued From page 33 director of nursing (DON) was interviewed. The DON stated that resident 3 has full side rails so that he won't fall out of bed. 5. Resident 2 was admitted on 10/22/05 with diagnoses that included Parkinson disease, arthritis, insomnia, constipation, anxiety and benign prostate hypertrophy. On 2/21/07 a review of resident 2's medical records was completed. A review of resident 2's nurses notes dated 5/16/06 documented "... a bed alarm has been installed to prevent falls when he gets out of bed". Resident 2's care plan dated 11/07/06 did not include the use of a bed alarm. On 2/12/07 during the facility tour, the DON was interviewed she stated that resident 2's has a bed alarm.	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 on observation and interview, it was determined that the facility did not provide services which met professional standards of quality for 1 out of 8 residents. (Resident identifiers: 2) Findings included: Resident 2 was admitted on 10/22/05 with diagnoses that included Parkinson disease,	F 281		5/1/07

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F 281	Continued From page 34 arthritis, insomnia, constipation, anxiety and benign prostate hypertrophy. A review of resident 2's medical record was completed on 2/21/07. Resident 2's Nurses' Progress Notes contained the following statements: 12/20/06 "Had a fall @ (at) 11:50 (AM) bumped head on door frame or edge of door in entry to dining room. 2" cut on rt (right) side of head noted. Cold compress held on cut which stopped bleeding quite quickly. Daughter called and told abt. (about) incident. Steri-strips applied at her request. Resident stated "My head hurts." Ibuprofen given as ordered. Will monitor." "1400 (2:00 PM) Resident denies pain. Steri -strips intact; small amt (amount) sero sanguary (sic) (sanguineous) fluid noted seeping from edge. Will monitor as needed." "2000 (8:00 PM) ..... 0 c/o (no complaint of) pain from fall .... small amount of blood cleansed. Will continue monitor." 12/22/07 "....c/o (complaint of) head pain d/t (due to) previous fall - gave Darvocet 100 - said "feels better" 0500 (5:00 am) c/o more head pain gave Darvocet 100 @ 0510 (5:10 AM) - resting ....." A facility Incident Report completed on resident 2 dated 12/20/07 at 11:00 AM was reviewed. The following statement was located in the "Description of incident" section on the form: "..... Fell in doorway of dining room hitting head on door or door frame, uncertain which. Approx. (approximate) 2" cut on rt (right) side of head VS (vital signs) WNL (within normal limits) BP (blood pressure)/154/67 T (temperature) 98 (heart rate) 71 O2 (oxygen) 92% RA (on room air)." Located on the same form on the back was a section	F 281		

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F 281	Continued From page 35 labeled "Protocol" . A box was marked next to the statement "Nurses note, chart follow-up next 72 hours" A review of resident 2's nurses notes from 12/20/07 to 12/23/07 was completed. No neurological checks nor additional vital signs were found. On 2/14/07 at 10:15 AM, an interview was conducted with the DON (Director of Nurses). The DON stated that when a resident has a head injury, a neurological check should be completed as part of the initial assessment and then each shift for a couple of days and should be documented in the nurses' notes. The DON reviewed the incident report dated 12/20/06 and the nurses' notes on resident 2. The DON stated that an assessment had been completed but not a neurological assessment and no follow up neurological assessments had been done for resident 2. Per Textbook of Basic Nursing, eighth edition, Rosdahl, Kowalski, copy right 2003 by Lippincott Williams & Wilkins, page 1232, Every client who suffers a blow to the head, no matter how minor it appears needs careful observation until it is certain that the injury has not damaged the brain...observe for the following signs of (increased intracranial pressure): headache, dizziness, visual impairment, hearing loss, nausea, or clear or bloody drainage from the ears, nose or mouth...also observe the client for changes in blood pressure and pupils.	F 281		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain	F 309		5/1/07

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or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility did not provide the care and services necessary to attain or maintain the highest practicable physical well-being for 3 of 8 sample residents.
(Resident identifiers: 1, 2 and CL 8 {closed})

Findings included:

1. CL 8 was admitted to the facility on 7/2/04 with diagnoses that included cerebral vascular disease, depression, renal insufficiency and gastrointestinal bleed. CL 8 passed away on 11/29/06.

A review of CL 8's medical record revealed that between September 2006 through November 2006 CL 8 was disimpacted of fecal matter five times. There was no documentation in the record that the physician had been notified when the disimpaction occurred. While standing medications were prescribed and given for constipation, there was no documentation that the PRN (as needed) medication for constipation were administered to CL 8.

A review of CL 8 medical record was completed on 2/20/07.

CL 8's quarterly minimum data set (MDS), dated

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10/20/06, was reviewed. In section H - "Continence in last 14 days" box 2.d was checked indicating that CL 8 had had a fecal impaction.

CL 8's care plans, dated 7/22/06, were reviewed. The following was documented:

"Alteration in Bowel Elimination: Chronic constipation and evidenced by: bowel movements less than three times per week
Goal: Res. (resident) will have soft formed stool every two days and verbalize freedom from discomfort
Approach: monitor bowel movements every shift, and record and check for impaction as needed. Assist or cue res. to toilet at the same time every day (every AM and every meal). Provide adequate time and privacy for elimination. Monitor for abdominal distention, bowel sounds, palpable mass in abdomen, Res. report of abdominal pressure or fullness. Encourage feber (sic) (fiber) and fluid intake. Offer prune juice as needed."

CL 8's nursing notes from September 2006, October 2006 and November of 2006 were reviewed. The following was documented:

1. On 9/4/06, "Resident assisted digitally to have XL (extra large) BM (bowel movement). Cursing @ nurse entire time." There was no documentation in the nurse's notes that the physician was notified.

2. On 9/19/06, " c/o 'bum' hurting. Digitally removed XL hard brown BM this AM (morning)." There was no documentation in the nurse's notes that the physician was notified.

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3. On 9/27/06, "Resident manually eliminated of XL soft brown stool. Hemorrhoids bleeding." There was no documentation in the nurse's notes that the physician was notified.

4. On 10/28/06, "2000 (8:00 PM) Digital disimpaction of large amount hard dk (dark) brown stool." There was no documentation in the nurse's notes that the physician was notified.

5. On 11/17/06, "Res(ident) c/o 'hurting all over' disimpacted Lg BM...." There was no documentation in the nurse's notes that the physician was notified.

CL 8's physician orders for September 2006, October 2006 and November of 2006 were reviewed. It was documented that CL 8 was ordered Colace 100 mg (milligrams), by mouth, three times a day and Reglan 10 mg, by mouth, three times a day. (Colace is a stool softener and Reglan increases gastric motility). In addition, Milk of Magnesia (MOM) and Dulcolax suppository were ordered for constipation on an as needed basis.

CL 8's medication administration record (MAR) from September 2006, October 2006 and November of 2006 were reviewed.

It was documented in the September 2006 MAR that CL 8 was administered Colace 100 mg three times a day and Reglan 10 mg three times a day. The MOM and Dulcolax suppository were not initialed as being administered.

It was documented in the October 2006 MAR that CL 8 was administered Colace 100 mg three times a day and Reglan 10 mg three times a day.

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F 309	Continued From page 39 The MOM and Dulcolax suppository were not initialed as being administered. It was documented in the November 2006 MAR that CL 8 was administered Colace 100 mg three times a day and Reglan 10 mg three times a day until 11/23/06. The MOM and Dulcolax suppository were not initialed as being administered. CL 8's "CNA (certified nursing assistant) ADL (activities of daily living) Record" forms from September 2006, October 2006 and November of 2006 were reviewed. For the month of September 2006, it was documented in the "bowel movement" section that CL 8 had an extra large BM on 9/4/06 (was disimpacted by nurse), on 9/6/06, twelve days later on 9/19/06 (was disimpacted by nurse), on 9/21/06 and 8 days later a large BM on 9/29/06. It was documented in the bowel function section that on 9/3/06, 9/4/06 through 9/8/06, 9/10/06, 9/11/06, 9/13/06 through 9/30/06 that the resident was continent. For the month of October 2006, it was documented in the "bowel movement" section that CL 8 had a medium size BM on 10/19/06. There was no other documentation found in the "bowel movement" section nor the bowel function section. For the month of November 2006, it was documented in the "bowel movement" section that CL 8 had a medium size BM on 11/4/06, ten days later on 11/14/06 an extra large BM, two days later 11/17/06 a large size BM (was disimpacted by nurse) and 6 days later on	F 309		

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11/24/06 an XL BM. It was documented in the bowel function section that on 9/1/06 through 9/6/06, on 9/8/06 through 9/12/06, 9/13/06 through 9/16/06 and 9/18/06 through 9/24/06 that the resident was continent.

On 2/20/07 at 11:15 AM, licensed practical nurse (LPN) 3 was interviewed. LPN 3 stated that the facility did not have a bowel protocol. She stated that the CNAs "just come and tell the nurses when they haven't had a bowel movement in a while." LPN 3 stated that the CNAs have an ADL form that they were to record cares and bowel movements. LPN 3 was shown CL 8's October 2006 CNA ADL form that only documented a BM on 10/19/06. LPN 3 stated she was unaware that the CNA's had only documented 1 BM for the month of October 2006.

2. Resident 1 was admitted to the facility 1/28/05 with diagnoses which included schizoaffective disorder, dementia, osteoporosis unspecified, constipation and depression.

Resident 1's medical record review was completed on 2/21/07.

It was documented in resident 1's physician's telephone order, dated 11/21/06 that resident 1 was a ordered a urinalysis. On 11/29/06, 8 days later the urinalysis (UA) was collected. On 11/30/06, the results were found to be positive for a urinary tract infection (UTI). Three days later on 12/2/06 at 7:25 PM, the physician ordered Cipro to treat the UTI. Four days later resident 1's MAR (medication administration record) documented that on 12/6/06 at 5:00 PM, resident 1's ten day course of Cipro was initiated. A total of 15 days passed between the initial order for a UA and for

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F 309	Continued From page 41 treatment to begin. In addition, on 12/2/06, the urine culture and sensitivities report were received and revealed that the organism causing resident 1's UTI was resistant to ciprofloxacin (Cipro). Resident 1's Nurses' Progress Notes dated 12/8/06 were reviewed. On 12/8/06 at 5:20 PM, two days after antibiotic therapy was initiated, resident 1 was found to have a temperature of 101.7 and was refusing to eat. 3. Resident 2 was admitted on 10/22/05, with diagnoses which included Parkinson's disease, arthritis, insomnia, constipation, anxiety and benign prostate hypertrophy. A review of resident 2's medical record was completed on 2/21/07. Resident 2's Nurses' Progress notes were reviewed. On 8/16/06, it was documented that resident 2 "continues to have frequency of urination and c/o (complaint of) not going." The 8/16/06 nursing note documented 10 days earlier, on 8/6/06, resident 2 had a urinalysis completed for a "possible UTI". A nursing note dated 8/17/06 documented that resident 2's ten day course of Cipro was initiated. A total of 11 days passed between the urinalysis and for treatment to begin.	F 309		
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		5/1/07

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F 314	Continued From page 42 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that for 1 of 8 sample residents, the facility did not ensure that the resident who was at risk for developing pressure sores received the necessary treatment and services to prevent a pressure sore from recurring. (Resident identifier: 4) Findings included: 1. Resident 4 was admitted to the facility on 10/2/05 with diagnoses that included Alzheimer's disease, diabetes mellitus, obesity, depression, and peripheral edema. On 2/14/07 at 3:50 PM, resident 4's buttock was observed during a incontinence brief change. Resident 4 had two .5 cm breaks in the skin on the left upper buttock approximately one inch apart. On 2/13/07, from 7:00 AM through 1:00 PM, and again on 2/14/07, from 7:00 AM until 12:30 PM, resident 4 was observed sitting in a geri-chair (recliner). On each day, approximately every two hours, staff were observed to assist resident 4 with toileting, but then returned the resident to the same position in his geri-chair. This was a total of 5 to 6 hours each day that the resident was not repositioned to relieve pressure areas to prevent breakdown. Resident 4's geri-chair was observed	F 314		

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to have a sheep skin that covered the back, arms, and seat. Beneath the sheep skin, and covering the seat section of the chair, was a folded cloth incontinence pad. Beneath the folded incontinence pad was a "Roho" cushion. (A Roho cushion is a dry flotation cushioning product intended to protect skin and aid in the prevention of tissue/skin breakdown.)

A review of resident 4's medical record was completed on 2/20/07.

Resident 4's quarterly MDS (minimum data set), dated 1/24/07, was reviewed. It was documented that resident 4 was severely impaired for daily decision making, that he needed total assistance with activities of daily living and was incontinent of bowel and bladder.

A care plan for resident 4, pertaining to pressure ulcers, dated 10/30/06, was reviewed. The following was documented:
"Problem: Potential for Skin Breakdown R/T incontinence
Goal: Res. will maintain clean and intact skin.
Approach: Provide measures to decrease pressure and irritation to skin: use sheepskin (a pressure relieving device). Keep skin clean and dry. Change incont(inence) pad ASAP (as soon as possible) after voiding or bowel movements. Apply skin barrier cream after incontinence episodes. Keep bed linen clean, dry, and free of wrinkles. Assist res(ident) to turn and reposition every two hours. Position with pads and cushions to prevent pressure.

A care plan that addressed actual skin breakdown could not be located in resident 4's medical record.

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F 314	Continued From page 44 Resident 4's care plan did not address the use of a Roho cushion. The operations manual for Roho dry flotation cushioning products was reviewed. On page 3, in the "Precautions" sections the following was documented: "Obstructions: DO NOT place any obstructions between the user and the cushion because it will reduce product effectiveness.	F 314		
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 record review, it was determined that the facility did not provide, for 1 of 8 sampled residents, an environment as free of accident hazards as possible. Specifically, facility staff had not evaluated a resident's safety when siderails were used and the resident had a known behavior of placing her legs through the siderails. (Resident identifier: 6) Findings included: 1. Resident 6 was readmitted to the facility on 12/29/06, with diagnoses that included hypertension, blindness, arthritis and dementia. Resident 6 was observed in bed on 2/14/07 at 1:21 PM, with full siderails up on both sides of the bed. The resident was yelling over and over the following: "Come in here," and "Take me down to	F 323		5/1/07

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F 323	Continued From page 45 the girls." At one point, resident 6 had both legs through the siderail up to mid-thigh. The resident was observed to independently remove her legs from between the siderail and sat up in bed and continued to yell. Resident 6's verbalizations could be heard at the nurses' station. However, at this time no staff were at the nurses' station nor were any staff in the hallway. At 1:27 PM, the surveyor requested the Administrator assist resident 6. Resident 6 was calling out, moving about the bed with full siderails up for a total of 6 minutes before she received assistance from staff. On 2/14/07 at 2:00 PM, the Director of Nursing (DON) was interviewed. She stated that every time resident 6 was in bed for more than 15 minutes she would start yelling out and shaking the siderails. The DON stated that she had seen resident 6 with her legs through the siderails but that she had never seen the resident entangled in the siderails or fall over the siderails. The DON stated that resident 6 was very "antsy". The DON also stated that resident 6 could be heard at the nurses' station by staff when she called out but staff did not hear her calling, when the observed incident occurred, because the staff were having their lunch in another area. Review of resident 6's medical record was completed on 2/20/07. On 2/14/07, a review of resident 6's nurses' notes was completed. The following was documented in a nursing note dated 12/29/06. "...Returns to room and placed in bed (with) rail up for safety. Asks to have rail down because of nerves (and) request granted. Res(ident) would not stay in bed so rail back up... Res is blind but has very good	F 323		

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F 323	Continued From page 46 hearing - most comments she makes are very confused..." No documentation of evaluation of need for side rails, entrapment risk, care planning, nor doctors orders could be found in resident 6's medical records. However, a "Side Rail Approval by Resident or Surrogate" form, signed by a family member was found in the resident's chart. Above the family members signature the following was printed on the form: "Resident displays no behaviors that would make the bed a safety issue."	F 323		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and clinical record review, it was determined that the facility failed to provide the necessary supervision, to plan care delivery and to implement procedures to prevent 1 of 8 sampled residents from having accidents and receiving injuries. Specifically between 3/24/06 and 2/21/07, the resident had 25 documented falls, eight of which resulted in injury. Outside medical services were required for 2 of the falls. (Resident identifier: 2) Findings included: Resident 2 was a 92 year old male admitted on 10/22/05 with diagnoses that included Parkinson's disease, arthritis, insomnia, constipation, anxiety and benign prostate hypertrophy. Also, it was	F 324		5/1/07

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documented in resident 2's MDS that his vision was "highly impaired."

I. Summary of incidents:

A review of Resident 2's incident reports was completed on 2/20/07. Per the incident reports, resident 2 had 15 documented falls that occurred in his bedroom, 5 documented falls that occurred in the facility's dining room, and 5 documented falls that occurred in the hallway or in a bathroom.

Per documentation, resident 2 sustained injuries in 8 of the falls. Two of the 8 falls, which resulted in injuries, required outside medical services.

There was no evidence that the facility utilized information documented on incident reports to track, and ultimately develop strategies to prevent resident 2 from falling. Except for the implementation of a bed alarm, there was no documentation that plans of care were revised or procedures were implemented, when resident 2 continued to have falls.

II. Observations:

On 2/12/07 at 3:32 PM, resident 2 was observed sitting in a geri-chair (recliner), in the dining room, with the television on. No staff was present. At 3:35 PM, a staff person entered the room and left. At 3:52 PM, resident 2 pushed the footrest of the geri-chair down with his legs and stood up. The resident took several steps. His gait was unsteady. Resident 2 fell down and rolled onto his side. The surveyors notified the Director of Nursing (DON). The DON responded and assessed resident 2 for injuries then assisted him back into the geri-chair. The DON then left the

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F 324	Continued From page 48 room. The footrest was put in the up position. At 4:13 PM, with the footrest in the up position, resident 2 was observed to stand up. He lost his balance and fell backward into the chair. At 4:15 PM, a resident walked into the dining room and told resident 2 not to get up. On 2/14/07 at 12:35 PM, resident 2 was sitting in a geri-chair in the dining room. The resident's walker was not in the room. At 12:56 PM, resident 2's walker was located in the hall south of the dining room. At 1:15 PM, the DON obtained resident 2's walker from the hall and assisted resident 2 out of the dining room. At 1:45 PM, resident 2 was standing in the dining room in front of a regular chair trying to move his feet. The resident's walker was to his right, within reach. No facility staff was present. At 1:50 PM, a staff person entered and assisted another resident from the room. Resident 2 was still standing in front of the chair, trying to move his feet. His walker was remained to his right. At 1:55 PM, the MRP (medical records person) entered the dining room, walked past resident 2 and said "Hi". The MRP repositioned another resident and left the room. Resident 2 was still standing in front of the chair, trying to move his feet. At 1:57 PM, resident 2 moved the walker to his left side and continued to try to move his feet. At 2:00 PM, a staff person entered with another resident and then left. At 2:02 PM, a staff person entered the dining room and assisted resident 2 to sit down in the chair. Resident 2 had been standing in front of the chair for a total of 17 minutes before he received any assistance. In that time, three staff members entered and exited the room without offering assistance to resident 2. At 2:30 PM, resident 2 was observed in the dining room in a geri-chair. The resident's walker was in	F 324		

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the hall east of the dining room. At 3:22 PM, another resident came out of the dining room and stated, "(Resident 2) is trying to walk without his walker." The MRP entered the dining room, bringing with her resident 2's walker, which had been in the hall. The MRP assisted the resident down the hall. At 3:40 PM, a resident came down the hall and said, "(Resident 2) is walking down the hall with out his walker." The DON went to assist resident 2 to a chair at the nurse's station. The DON asked the MRP where resident 2's walker was. The MRP said it had been in his room with him. At 3:46 PM, a resident was assisting resident 2, by holding onto his hands as he walked into the dining room. The resident sat resident 2 down in a geri-chair and told him to get comfortable and put the footrest up on the chair. At 4:16 PM, with no staff present, resident 2 was observed ambulating in dining room with an unsteady gait, reaching for the wall. Resident 2 approached the door way and stood for approximately 1 minute, then turned toward a table, reached out with his arms and grabbed the table. Resident 2 then sat down on a chair for approximately 1 minute then stood and walked to a chair on the other side of the table. Resident 2 sat down for approximately 1 minute then stood up and ambulated to the doorway, held onto the doorjamb. At 4:21 PM, a surveyor alerted the LPN that resident 2 needed assistance.

III. Interview
An interview was conducted on 2/15/07 at 1:20 PM, with the DON. The DON stated the facility used the incident reports and nurses notes to record and evaluate resident falls. The DON stated that she knew that resident 2 had fallen often but they did not want to take the "resident's independence away". The DON stated the alarm

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on resident 2's bed was so staff would know when he got up. She stated staff would then take him to the bathroom. The DON stated that staff have discussed issues, such as falls, in the IDT meetings and that they would make a plan of action. She stated the plan of action would be documented in the IDT notes. The DON stated they did not have a system to actually track and evaluate patterns of injuries. She stated that she knew resident 2's main problem was falls, but staff cannot always be there.

IV. A review of resident 2's medical record was completed on 2/21/07.

A. Resident 2's annual MDS (Minimum Data Set) assessment dated 11/04/06 was reviewed. The following was documented:

Resident 2's cognition is severely impaired
Resident 2 has periods of lethargy and his mental function varies over the course of a day,
Resident 2's vision is highly impaired,
Resident 2 has wandering behaviors,
Resident 2 needs assistance to ambulate; he needs assistance with standing and sitting due to problems with balance,
Resident 2 has an unsteady gait,
Resident 2 is on psychotropic medications
And Resident 2 has history of frequent falls.

B. Resident 2's nursing notes were reviewed.

It was documented on 3/24/06 that resident 2's gait was "unsteady as always". It was documented on 4/26/06 at 10:00 AM, that the resident is "very unsteady on feet." It was documented on 5/9/06 that resident 2 needs one assist for activities of daily living and to ambulate

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F 324	Continued From page 51 along with walker. It was documented on 7/12/06 that resident 2 "Ambulates (with) walker (with) difficulty." It was documented on 8/12/06 that resident 2 ambulates with walker but occasionally forgets and attempts walking alone and that his gait is very unsteady. It was documented on 10/05/06 that resident 2's fall risk is very high. And it was documented on 11/13/06 that resident 2 was wandering through the halls with his walker and his gait was unsteady. C. An Interdisciplinary Team (IDT) note, dated 5/15/06, included documentation that resident 2 had a "New lazer (laser) alarm on bed" and that the alarm "works very well when adjusted properly and resident doesn't play (with) his covers". Resident 2's medical record contained a care plan for falls; however, the addition of the bed alarm was not included. An IDT note, dated 8/16/06, included documentation that staff would "Continue to monitor his (resident 2's) ambulation. Make sure bed alarm is on each night." D. A review of resident 2's incident reports dated between 3/24/06 and 2/12/07 revealed the following: The following incident reports are falls that occurred in resident 2's bedroom. 1. On 3/24/06 at 8:30 PM, it was documented that the resident fell to his knees and broke open a scab on his knee from a previous fall. 2. On 4/3/06 9:30 PM, it was documented that resident 3 was found lying on the floor by the left side of his bed.	F 324		

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3. On 4/13/06 at 3:00 AM, it was noticed that resident 2 had red marks, scrapes and a bruise on his back. It was documented that the resident" appeared to have fallen out of bed and scraped his back."

4. On 4/21/06 at 7:30 PM, resident 2 was found on the floor of his bedroom.

5. On 4/23/06 at 1:15 AM, resident 2 was found in his room on floor. The resident was assessed for injuries and complained of pain on his left side. It was documented that the resident was helped back into bed. The resident was reminded to use his call light.

Additionally, on 4/23/06 at 9:30 AM, it was documented in resident 2's Nurses' Progress notes that X rays were done on residents ribs. The results of the x-ray showed that the resident had 3 fractures ribs on his left side.

6. On 4/25/06 at 2:00 AM, it was documented that resident 2 was found on the floor beside his bed lying on his left hip. Resident complained of lower back pain.

7. On 5/24/06 at 4:50 AM, it was documented that resident 2 was found sitting on his roommate's stereo and wedged between his bed and a chair. Additionally, it was documented in the Nurses' Progress Notes on 5/24/06 at 4:50 AM, that resident 2's bed alarm did not go off and was reset again.

8. On 6/9/06 at 2:00 AM, it was documented that resident 2 was found on the floor by his table and stated that he was lost. It was documented that

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the bed alarm was not working. Resident 2 was placed in a geriatric chair. The resident sustained two small cuts to his head on the right lobe. The wounds were cleaned with peroxide and the resident's head was wrapped with sterile gauze and an ace wrap. Ice was applied to the wound. The physician was not notified.

9. On 6/19/06 at 1:35 AM, it was documented that a thump was heard. Staff went into resident 2's bedroom and found him on the right side of the bed on the floor with his head against the bed. The bed alarm was reset. Resident 2 was assisted back to bed. There was some redness and swelling to the back of resident 2's neck. It was passed onto day shift about the bed alarm functioning improperly and resident 2's fall. The physician was not notified.

10. On 7/22/06 at 1:30 AM, it was documented that resident 2 was found sitting on floor beside bed.

11. On 7/27/06 at 12:05 AM, it was documented that resident 2 was found on his knees by the bed.

12. On 8/5/06 at 2:00 AM, it was documented that resident 2 was found on the floor after the bed alarm went off.

13. On 8/13/06 at 12:15 AM, it was documented that staff heard resident 2 fall and went into resident 2's room. Resident 2 was lying on the floor. His head was on the side table. The resident had an open wound on the top and back of his head that was bleeding. First aid was administered and an ambulance was called. The bed alarm did not go off. Additionally, resident 2's

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Nurses' Progress Notes dated 8/13/06 at 3:00 AM documented that resident 2 returned from the hospital emergency room by ambulance with staples placed in his head.

14. On 11/4/06 at 3:00 AM, it was documented that resident 2's bedside alarm was going off and that the resident was found sitting on floor beside his bed." Resident 2 had a skin abrasion on his back. The physician was not notified.

15. On 1/7/07 at 2:00 AM, it was documented that resident 2 was found on the floor in his bedroom with his head against the bed.

The following incident reports are falls that occurred in the facility dining room.

1. On 5/7/06 at 4:30 PM, it was documented that the cook heard a loud thump in the dining room and ran to tell the nurse. When staff entered the dining room resident 2 was sitting on his walker's seat. When asked what had happened, resident 2 replied that he had fallen on his right side.

2. On 5/19/06 at 7:00 AM, it was documented that resident 2 was ambulating with his walker in the dining room. The resident fell backwards onto his back and bumped his head.

3. On 5/22/06 at 3:30 PM, it was documented that resident 2 was in the dining room and a loud thump was heard. The resident was found lying on his left side on the floor near his walker.

4. On 12/20/06 at 11:50 AM, it was documented that resident 2 fell in the doorway of the dining room possibly hitting his head on door or the door frame. Resident 2 sustained a 2" cut on the right

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side of his head. First aid was administered. It was documented on the form that it was not necessary to notify the physician.

5. On 2/12/07 at 3:30 PM, it was documented that a visitor (a state and federal surveyor) notified nursing staff that resident 2 fell on the floor in dining room. The resident was found on his hands and knees. It was documented in the "Preventive Plan of Action" section that in order to keep this incident from occurring again staff needed to "Keep walker within close reach of res." The incident report also documented ". . . Resident will have good days when ambulation is easier than others. On the days when he is having more difficulty, he should have increased supervision when available."

The following incident reports are falls that occurred in the hallway or bathroom in the facility.

1. On 6/4/06 at 6:45 PM, it was documented that a thump was heard and resident 2 was found on the floor in the hallway. Resident 2 had been ambulating with his walker.

2. On 6/13/06 at 9:00 AM, it was documented that resident 2 was walking in the hallway and lost his balance falling backwards.

3. On 7/13/06 at 3:00 PM, it was documented that resident 2 was ambulating in the hall. He turned and then attempted to sit on his walker. Resident 2 sat too far towards the side of the walker and tipped it over. Resident 2 then fell to the floor hitting the back of his head.

4. On 8/31/06 at 8:25 PM, it was documented that

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F 324	Continued From page 56 resident 2 was in bathroom on the toilet left alone. When staff went into check on him they found resident 2 on the ground on his side. The top of resident 2's head was bleeding. The physician was not notified. 5. On 1/22/07 at 2:25 PM, it was documented that staff heard resident 2 fall and found him on the floor. It was also documented that resident 2 had been napping in his walker seat when he fell.	F 324		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		5/1/07

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F 329	Continued From page 57 Based on interview and review of medical records, it was determined that for 2 of 8 sample residents, the facility did not ensure that the resident's drug regimen was free from unnecessary drugs. Specifically, 2 residents are receiving duplicate therapy. (Resident identifier: 5, 7.) Findings included: 1. Resident 5 was admitted to the facility on 1/23/07 with diagnoses that included diabetes, renal failure, depression, hypertension, schizophrenia, bipolar and gastro-esophageal disease. A review of resident 5's medical record was completed on 2/20/07. Resident 5's physician's orders dated 1/25/07 were reviewed. Resident 5 had orders for the following medications: Ambien 10 milligrams by mouth at bedtime for insomnia Temazepam 30 milligrams 1 by mouth at bedtime for insomnia A monthly consult check list by the facility pharmacist dated 1/31/07 was reviewed. The following was documented pertaining to resident 5's drug regimen: " On 2 sleepers must DC (discontinue) one ...suggest - Temazepam - because on Ativan which is a benzodiazepine best not to give both together unless the Ativan won't work ... " On 2/15/07, the director of nursing (DON) was	F 329		

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interviewed. The DON stated that the facility physician would review the pharmacists's recommendations for resident 5 on his next scheduled visit.

2. Resident 7 was admitted to the facility on 2/11/05 with diagnoses that included congestive heart failure, chronic paranoid schizophrenia, angina, abdominal pain-chronic cysts, gastroesophageal disease, diverticulitis, hypoxia, irritable bowel disease and fibromyalgia.

A review of resident 7's medical record was completed on 2/20/07.

Resident 7's physician's orders dated 1/04/07 were reviewed. Resident 7 had orders for the following medications:

Duragesic patch 75 micrograms, 1 transdermal system every 72 hours, every three days for pain.

Methadose 10 mg (milligrams), 3 tablets by mouth, three times a day for chronic pain.

Resident 7 had a faxed physician's order by another physician dated 1/11/07 for the following medication:

Alieve 220 mg, 2 pills, by mouth, twice a day for knee pain.

On 2/20/07 at 11:20 AM, resident 7's physician was interviewed via the telephone. When asked about resident 7's medications for pain management, the physician stated that resident 7 should not be on the Duragesic patch and the Methadose at the same time. He stated that he was planning to decrease the dosage of the

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F 329	Continued From page 59 Methadose and increase the dosage of the patch. When asked about the Alieve he stated that he had not prescribed it and was not aware that she was on it. Resident 7 had a physician's order for Milk of Magnesia (MOM) 30 cubic centimeters by mouth daily. It was documented on the MAR on 2/2/07 that resident 7 was administered 2 doses of MOM. As per the physician's orders, resident 7 should have only received one dose of MOM.	F 329		
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 on observation, interviews and medical record review, it was determined that the facility did not ensure that it was free of a medication error rate of less than 5%. Medications that were administered to residents during survey observation, were assessed further through medical record review and interviews with medical staff. It was determined during the observed medication pass that for 43 opportunities, 4 medication errors occurred, which represents a facility medication error rate of 9.3%. (Resident identifiers: 7, 17.) Findings included: At 2/13/07 from 6:35 AM until 10:35 AM, the medication administration was observed as 2 different facility nurses prepared and delivered the morning medications. As each medication	F 332		5/1/07

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was put into each individual medication cup the information contained on the medication container was noted. Then, as well as after, the label was also checked against what the MAR (medication administration record) had documented. Later, after the medication administration was completed, the information obtained during the observation was compared with the physician's orders in each resident's medical record.

1. On 2/13/07 at approximately 6:45 AM, resident 17's medications were prepared by being crushed and mixed with strawberry yogurt and delivered by the licensed practical nurse (LPN) passing medications. Eight different medications were observed to be administered, including an enteric coated aspirin, to resident 17.

Later upon review of the physician's orders, it was noted that resident 17 had an order to receive Aspirin enteric coated 81 milligrams every day.

Per the "Fundamentals of Nursing Concepts, Process, and Practice" book sixth edition by Kozier, Erb, Berman and Burke reprinted with corrections February 2000 by Prentice-Hall INC. page 767, it was documented that "Sustained -action, enteric-coated...tablets should not be crushed."

2. On 2/13/07 at approximately 10:35 AM, resident 7's, 7:00 AM medications were prepared and delivered by the director of nursing (DON) to the resident. Ten different medications were observed to be administered to resident 7, including Reglan 10 milligrams by mouth QID (4 times a day) for gastroesophageal disease, Erythromycin 125 milligrams by mouth QID to

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F 332	Continued From page 61 enhance gastric motility and Methadose 30 milligrams by mouth ordered three times a day for chronic pain control. The DON explained that resident 7 occasionally likes to sleep late in the morning and to accommodate the resident the facility holds her 7:00 AM medications until she awakens. On 2/13/07 at 10:50 AM, the DON was interviewed. The DON stated that she possibly shouldn't have given the Reglan at 10:30 AM. She stated that resident 7 should get her Reglan before meals and that she was scheduled to get it again at 12:00 noon. A short time later upon review of the physician's orders, it was noted that resident 7 was also to be administered her Erythromycin and Methadose again at 12:00 noon. Because the Reglan and Erythromycin were to be given before meals to enhance gastric motility and were given at 10:30 AM, two hours after breakfast but an hour and a half before lunch, this was considered to be 2 medications errors. Because the Methadose needs to be given around the clock at 7:00 AM, 12:00 noon and 8:00 PM, to manage chronic pain and because the drug has a cumulative effect and can cause marked sedation this was considered to be a medication error.	F 332		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the	F 334		5/1/07

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benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:

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(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on interview and review of facility records it was determined that the facility; (1) before offering the influenza immunization did not educate each resident or each resident's legal representative regarding the benefits or potential side effects of immunization, (2) did not give the residents' legal representative an opportunity to refuse immunization, (3) there was no documentation on the residents' chart that the resident or the residents' legal representatives were provided education regarding the benefits and potential side effects of the influenza immunizations. Furthermore the facility did not have any policies and procedures for the Pneumococcal/Influenza Vaccinations.
(Resident identifiers: 1, 2, 3, 4, 7.)

Findings included:

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F 334	Continued From page 64 Resident 1, resident 2, resident 3, resident 4, and resident 7 had medical record reviews that were completed by 2/20/07. All 5 residents had documentation in their medical records revealing that they had received the influenza vaccine in November of 2006. All 5 residents had documentation that they had received the pneumococcal vaccination in the past. However, there was no documentation in their medical records that the residents and/or their legal representatives were provided with education regarding the benefits and potential side effects of the influenza vaccine. There was no documentation in the above residents' medical records that the residents and their legal representatives were given an opportunity to refuse the administration of the influenza immunization. On 2/13/07 at 5:00 PM, the Administrator and the director of nursing (DON) were interviewed. The Administrator stated that the residents and families were never told about the side effects or benefits of the vaccinations. The Administrator stated the residents and their families had a right to refuse the vaccinations but that it was not documented. The DON and Administrator stated that there were papers/ forms on admit that were given to the residents but she needed to find the forms. On 2/14/07, the DON and Administrator stated that they had no policies and procedures pertaining to the Pneumococcal/Influenza vaccinations.	F 334		
F 354 SS=D	483.30(b) NURSING SERVICES - REGISTERED NURSE	F 354		5/1/07

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F 354	Continued From page 65 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 an interview with facility staff, observation, and review of the facility's nursing schedule it was determined that the facility did not have a RN (registered nurse) for at least 8 consecutive hours a day, 7 days a week. Findings included: A review of the nursing scheduled showed there was no RN coverage on 2/21/07. On 2/21/07, LPN 1 was interviewed. LPN 1 stated there was no RN scheduled to work on 2/21/07.	F 354		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		5/1/07

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F 371	Continued From page 66 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not store, prepare or serve food under sanitary conditions. Finding included: Initial observations of the kitchen area were conducted on 02/12/07 at 12:30 PM. Additional observations were conducted through 02/21/07. During the initial observation on 2/12/07 at 12:30 PM, the following was observed. The Administrator asked dietary aide 1 for a hair net. Dietary aide 1 stated that they did not have hair nets and that they had ran out several days ago. Dietary aide 1 had long hair pulled up in a pony tail and was wearing a visor with an open area on the top. Dietary aide 1's pony tail extended out of the open area of the visor and hung freely. In the refrigerator was 3 cups of what appeared to be fruit and cottage cheese. The cups were not dated or labeled. The upstairs pantry contained a gallon size bag with what appeared to be heart shaped sugar cookies. The bag was not labeled or dated. The flour bin with flour in it was uncovered. The freezers and food storage areas in the basement were observed on 2/12/07 and on 2/15/07: The bottom drawer on the first freezer in the basement contained over 15 1 lb packages of undated hamburger. The second freezer contained a large bag of what	F 371		

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F 371	Continued From page 67 looked like cooked chicken that was not labeled or dated. It also contained a blue colored bag with what looked like chicken cordon blue that was not labeled or dated. The food storage in the basement contained the following: 2 large packages of what looked like spaghetti noodles with no label, 2 packages of what looked like elbow noodles with no label, a bin with 20 packages of what looked like saltine crackers with no date or label, a bin with 24 packages of what looked like graham crackers with not date or label. Six shelves with food and food service items are sitting on the floor and one shelf with food items on it was 3 inches off the floor. Shelves should be at least 6 inches off floor. Observation of the breakfast tray line on 2/13/07: Dietary aide 1 was wearing an open top visor without a hair net. Dietary aide 1 removed a pan of scrambled eggs from the oven at 8:04 AM and placed them into a cold steam tray and began to serve them. At 8:14 AM the surveyor requested for dietary aide 1 to take the temperatures of the food being served. The scrambled eggs registered at 120 degrees. Dietary aide 1 said "The eggs are probably too cold". Dietary aide 1 served 6 more trays with scrambled eggs on them and did not attempt to bring the scrambled eggs up to temperature. Observation on 2/14/07 at 8:17 AM: Dietary aide 1 was wearing an open top visor without a hair net. Dietary aide 1 was interviewed on 2/14/07 at 8:37 AM. Dietary aide 1 stated that she only takes temperatures of meats that she cooks, like roasts. Dietary aide 1 stated she did not know what temperature the foods should be held at or	F 371		

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F 371	Continued From page 68	F 371		

served at. She stated that the thermometer cover has temperatures on it for cooked meats and she uses those numbers.

Observation on 2/14/07 at 5:05 PM:
Dietary aide 2 was at the stove cooking soup, with no hair covering.

Observation of the breakfast tray line on 2/15/07 at 8:04 AM:
The bin on the shelf above the stove was coated with grease and dirty lint.
There were approximately 20 poached eggs in individual bowls in warming tray waiting to be served. At the request of the surveyor, dietary aide 2 took temperatures of the poached eggs. The temperature of the eggs was 135 degrees Farenheit. Dietary aide 2 then served the poached eggs to the residents.

Observation 2/21/07 at 9:40 AM:
The counter top between stove and hand wash sink had greater then 20 nicks in the formica exposing the brown backing. The counter tops to the left of the metal sink has greater then 15 nicks in the formica exposing the brown backing. The damaged counter top areas render the counters unsanitizable. Also 2 packages of raw pork chops were sitting in the sink.

On 2/21/07 at 9:46 AM, dietary aide 2 was interviewed. Dietary aide 2 stated that he had put the pork chops in the sink 20 minutes ago because he had forgotten to pull them out of the freezer the day before. Dietary aide 2 stated he did not want to put them in the fridge or in water.
On 2/15/07 at 1:30 PM, the following observations of the refrigerator at nurses' station were made:
There was one opened container of strawberry

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F 371	Continued From page 69 Diabetic Boost that had no date when opened. There was one opened carton of Mighty Shake with no open or thaw date. There were two cartons of Mighty Shakes with no thaw date. (The Mighty Shake cartons documented that the shakes "must be used within 14 days of thawing".)	F 371		
F 406 SS=D	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility did not provide specialized mental health rehabilitative services for 1 of 8 sample residents. (Resident indentifier: 1) Findings included: Resident 1 was admitted on 1/28/05 with diagnosis that included schizoaffective disorder, dementia nos, osteoporosis, hypothyroidism, constipation, and depression. Resident 1's medical record review was completed on 2/21/07.	F 406		5/1/07

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Resident 1's PASRR (preadmission screening resident review) dated of 1/28/05 was reviewed. It was documented that resident 1 needed a psychiatric consultation and follow through by (local) mental health agency. The PASRR assessment was completed by a Licensed Clinical Social Worker and signed by a Medical Doctor.

Resident 1's quarterly IDT (interdisciplinary team) care plan review dated 5/15/06 documented a recommendation to check with the medical director about obtaining a psychiatric evaluation.

Resident 1's quarterly IDT care plan review dated 8/16/06 documented that the resident had decline in condition manifested by "psychotic behavior".

An interview was conducted on 2/14/07 at 3:00 PM with the MRP (medical records person). The MRP stated that when resident 1 was admitted the resident was discharged from the care of the State Hospital to the care of the facility's medical director. The MRP stated that the facility consults with the medical director regarding resident 1's mental illness issues and he adjust the residents medications as needed. The MRP stated that resident 1's mental illness symptoms are the same now as they were upon admit. The MRP also stated that resident's mental condition has not declined but is being managed by the medical director. She stated that resident 1 has not been provided outside mental health rehabilitative services while in the facility.

Despite recommendations found on resident 2's PASRR that the resident should be seen for a phychiatric consultation and an IDT note

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F 406	Continued From page 71 documenting that the resident had a mental decline manifested by psychotic behavior the facility did not provide outside mental health rehabilitation services as needed for resident 2.	F 406		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 1 of 8 sample residents, the facility pharmacist did not identify and ensure that a resident's drug regimen was free from unnecessary drugs. Specifically, a resident was on 2 narcotic medications for pain and a high dose of a nonsteroidal anti-inflammatory pain medication. (Resident identifier: 7.) Findings included: 1. Resident 7 was admitted to the facility on 2/11/05 with diagnoses that included congestive heart failure, chronic paranoid schizophrenia, angina, abdominal pain-chronic cysts, gastroesophageal disease, diverticulitis, hypoxia, irritable bowel disease and fibromyalgia.	F 428		5/1/07

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F 428	Continued From page 72	F 428		

A review of resident 7's medical record was completed on 2/20/07.

Resident 7's physician's orders dated 1/04/07 were reviewed. Resident 7 had orders for the following medications:

1. Duragesic patch 75 micrograms, 1 transdermal system every 72 hours, every three days for pain.

2. Methadose 10 mg (milligrams), 3 tablets by mouth, three times a day for chronic pain.

Resident 7 had a faxed physician's order by another physician dated 1/11/07 for the following medication:

3. Alieve 220 mg, 2 pills, by mouth, twice a day for knee pain.

On 2/20/07 at 11:20 AM, resident 7's physician was interviewed via the telephone. When asked about resident 7's medications for pain management, the physician stated that resident 7 should not be on the Duragesic patch and the Methadose at the same time. He stated that he was planning to decrease the dosage of Methadose by titration and increase the dosage of the duragesic patch. When asked about the Alieve he stated that he had not prescribed it and was not aware that it had been prescribed for the resident.

On 2/21/07, the 1/31/07 "Monthly Consultant Checklist" that was completed by the facility's pharmacist was reviewed. On the row labeled with resident 7's name, it was documented in the comments column "none". There was no documentation concerning resident 7's being on 2

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F 428	Continued From page 73 narcotic pain medications and a high dose of Alieve.	F 428		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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	F 431		5/1/07

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F 431	Continued From page 74 by: Based on observation it was determined that the facility did not label drugs and biological used in the facility with the date on which it was opened. Specifically 3 medications were opened and not labeled with the date of opening. Findings included: On 2/15/07 at 1:30 PM, the refrigerator at the Nurses' station was inspected and the following was found: 1 vial of opened Xalatan .005% that had an expiration date of 11/8/06. 1 vial of opened Lantus insulin 100 units per milliliter with no access date("The American Diabetes Association reminds health care professionals that even though each insulin vial is stamped with an expiration date, a slight loss of potency may occur after the vial has been in use for more than 30 days...") 1 vial of opened Mantoux/Tuberculin (Tubersol) with no access date. It was documented on the vial that this medication was good for 30 days after being opened. On 2/15/07 at 1:25 PM, the director of nursing (DON) was interviewed. She stated that the Xalatan should have been dated when it was opened. The DON stated that the Lantus did not have an open date and should have been dated. The DON stated that the Tuberculin vial did not have an open date but she knows that it was accessed more than 30 days ago. She stated that it should have been discarded.	F 431		
F 496	483.75(e)(5)-(7) REQUIRED TRAINING OF	F 496		5/1/07

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F 496 SS=E	Continued From page 75 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 staff interviews, review of employee files and a review of the facility's policies and procedures on abuse, it was determined that the	F 496		

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F 496	Continued From page 76 facility did not implement procedures that included an investigation for a history of abuse, neglect or mistreating residents prior to allowing nursing aides to provide direct care to residents. The facility did not obtain Certified Nurse Aide (CNA) Registry verification for 7 out of 9 nurse aides (NA) or CNA's. Staff identifiers: CNA 1, CNA 3, CNA 4, CNA 5, CNA 6, NA 1 and NA 2. Findings included On 2/12/07, a current list of new employees was obtained from the facility. The files of 5 of the employees were reviewed to determine that the appropriate background information had been obtained. Three of the five employee's records reviewed were for NA's and CNA's. The surveyor verified the date the facility obtained CNA Registry verification and also the date in which each nurse aide began providing direct care to residents. CNA 5 began providing direct care to residents on 6/3/06. Per documentation, the facility did not obtain CNA Registry verification until 2/20/07. NA 1 began providing direct care to residents on 11/3/06. Per documentation, the facility did not obtain CNA Registry verification until 2/20/07. NA 2 began providing direct care to residents on 11/13/06. Per documentation, the facility did not obtain CNA Registry verification until 2/20/07. An interview was held with the Administrator on 2/20/07 at 7:45 AM. The Administrator stated that he did not complete CNA registry checks on on NA 1 & NA 2 or CNA 5.	F 496		

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F 496	Continued From page 77 An interview was held with the Administrator on 2/20/07 at 5:30 PM. The Administrator stated he would pull all current CNA and NA employee files and check for CNA registry checks. On 2/21/07 at 9:30 AM, 6 more CNA employee files were reviewed, 4 of the files did not contain CNA Registry verification. CNA 1 per documentation, the facility did not obtain CNA Registry verification until 2/20/07. CNA 3 per documentation, the facility did not obtain CNA Registry verification until 2/20/07. CNA 4 per documentation, the facility did not obtain CNA Registry verification until 2/20/07. CNA 6 per documentation, the facility did not obtain CNA Registry verification until 2/20/07.	F 496		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility did not maintain clinical records in accordance with accepted professional standards and practices that were	F 514		5/1/07

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complete and accurately documented for 3 of 8 sampled residents. (Resident identifiers: 1, 2 and 7.)

Findings included:

1. Resident 7 was admitted to the facility on 2/11/05 with diagnoses that included chronic paranoid schizophrenia, abdominal pain-chronic cysts, gastroesophageal disease, depression, congestive heart failure, irritable bowel diease and fibromyalgia.

On 2/13/07 at approximately 10:35 AM, resident 7's, 7:00 AM medications were prepared and delivered by the director of nursing to the resident. Ten different medications were observed to be administered to resident 7. The DON explained that resident 7 occasionally likes to sleep late in the morning and to accommodate the resident the facility holds her 7:00 AM medications until she awakens.

On 2/13/07, a review of resident 7's February 2007 MAR (medication administration record) was completed. The DON put her initials in the 7:00 AM boxes on the MAR for the following medications; Lexapro, multivitamin, Aldsactone, Zocor Colace Pepcid Aleve Methadose Reglan and Erythromycin. There was no documentation on the MAR indicating that the above medications were in fact given to the resident at 10:35 AM.

Resident 7's February 2007 MAR documented that resident 7 was to receive Phenergan 25 mg 1 by mouth four times a day as needed. The February 2007 MAR documented nurse's initials that the Phenergan had been administered on the following days and the number of times:

F 514 | F 514

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On 2/1/07- the medication was documented as administered 1 time
On 2/3/07- the medication was documented as administered 1 time
On 2/4/07- the medication was documented as administered 3 times
On 2/5/07- the medication was documented as administered 2 times
On 2/6/07- the medication was documented as administered 3 times
On 2/7/07- the medication was documented as administered 2 times
On 2/8/07- the medication was documented as administered 1 time
On 2/9/07- the medication was documented as administered 1 time
On 2/11/07- the medication was documented as administered 2 times
On 2/12/07- the medication was documented as administered 1 time
On 2/13/07- the medication was documented as administered 2 times

The times the Phenergan was administered were not documented on the MAR. There was no documentation indicating how many hours apart the doses of Phenergan were administered to resident 7.
2. Resident 1 was admitted to the facility on 1/28/05 with diagnoses which included schizoaffective disorder, dementia, osteoporosis unspecified, constipation and depression.

A review of resident 1's medical record was completed on 2/21/07.

Resident 1's January 2007 MAR documented that resident 1 was to receive Tylenol 1000 milligrams

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	46A061	A. BUILDING ______ B. WING ______	02/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPANISH FORK NURSING AND REHAB	46 NORTH 100 EAST SPANISH FORK, UT 84660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 80	F 514		

by mouth every 6 to 8 hours as needed. The January 2007 MAR documented that the Tylenol had been administered on the following days:
1/14/07
1/15/07
1/21/07
1/26/07
1/27/07
1/29/07.
The times the Tylenol was administered were not documented on the MAR. There was no documentation indicating how many hours apart the doses of Tylenol were administered to resident 1.

Resident 1's February 2007 MAR documented that resident 1 was to receive Tylenol 1000 milligrams by mouth every 6 to 8 hours as needed. The February 2007 MAR documented nurse initials that the Tylenol had been administered on the following days:
2/1/07
2/11/07 twice
2/12/07 twice
The times the Tylenol was administered were not documented on the MAR. There was no documentation indicating how many hours apart the doses of Tylenol were administered to resident 1.

3. Resident 2 was admitted on 10/22/05 with diagnoses which included Parkinson disease, arthritis, insomnia, constipation, anxiety and benign prostate hypertrophy.

A review of resident 2's medical record was completed on 2/21/07.

Resident 2's February 2007 MAR documented

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F 514	Continued From page 81 that resident 2 was to receive Ativan 0.5 milligrams by mouth every 6 hours as needed or Ativan 0.5 milligrams 2 by mouth every 6 hours as needed. The boxes on the MAR where the nurse was to initial after administering the medications contained the following time blocks: PRN, 12 to 8, 8 to 4, and 4 to 12. The February 2007 MAR documented nurse initials that the Ativan had been administered on the following days and time blocks: 2/4/07 PRN 2/5/07 4 to 12 (1 ativan) and 4 to 12 (2 ativan) 2/607 4 to 12 2/707 4 to 12 2/8/07 4 to 12 2/9/07 4 to 12 2/10/07 4 to 12 2/11/07 8 to 4 and 4 to 12 2/12/07 4 to 12. The exact times the Ativan was administered were not documented on the MAR. There was no documentation indicating how many hours apart the doses of Ativan were administered to resident 2.	F 514		
F 520 SS=G	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		5/1/07

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F 520	Continued From page 82 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interviews and medical record reviews, it was determined that the facility failed to ensure that the Quality Assessment and Assurance (QAA) committee effectively developed and implemented appropriate plans of action to correct an identified deficiency from the previous recertification survey completed on 3/23/06. In addition, the facility did not maintain a QAA committee that consisted of all required members. Findings included: 1. During the facility's last annual recertification survey, dated 3/23/06, the facility was found to have deficient at 42 Code of Federal Regulations (CFR) 483.25(h)(2), Supervision to prevent accidents. The regulatory non-compliance was cited at a level of Actual Harm. Resident 2 was identified on the 3/23/06 survey as having accidents due to the facility's failure to provide the necessary supervision. Resident 2 was identified on this survey as not receiving the necessary	F 520		

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F 520	Continued From page 83 supervision to prevent accidents. During the current annual recertification survey it was determined between 3/24/06 through 2/21/07, that the facility failed to adequately supervise, plan cares, and implement procedures to prevent resident 2 from having accidents and receiving injuries. Resident 2 had 25 documented falls. Eight of these falls resulted in injury. Outside medical services were required for 2 of the falls. A review of Resident 2's incident reports was completed on 2/20/07. Per the incident reports resident 2 had 15 documented falls that occurred in his bedroom, 5 documented falls that occurred in the facility's dining room, and 5 documented falls that occurred in the hallway and and a bathroom. There was no documentation that these falls were being tracked for quality assurance and care planning. Except for the use of a bed alarm that was utilized starting in May of 2006, there was no documentation that plans of care were revised or procedures were implemented to prevent future falls. Cross-Reference: F-324. On 2/20/06 at 9:00 AM, the medical records person (MRP), who had been designated by the Administrator as the co-chairperson for the QAA committee, was interviewed. The MRP stated that the QAA meetings were held in conjunction with the facility's Interdisciplinary Team (IDT) meetings. She stated that there were no current QAA action plans being implemented by the facility. When asked how action plans would be implemented, she stated that staff would post the	F 520		

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F 520	Continued From page 84 action plans up on the wall at the nurses' station and "hopefully" the staff would implement the plan. When asked how often revisions were made to action plans, the MRP stated the facility "is not looking at it often enough . . . depends on the problem." On 2/20/07 at 10:18 AM, the Administrator was interviewed. The Administrator was asked if the QAA committee had identified concerns with resident 2's safety. He stated the concern had been identified during last year's survey by the survey team. He stated that the committee developed an action plan for resident 2 with the goal of less falls. The Administrator stated the action plan was to do closer monitoring of resident 2, to install a bed alarm and to move the furniture between resident 2's bed and his roommate's bed. When the Administrator was asked for the QAA minutes, he replied,"We use the action plan form as the minutes." The Administrator was unable to produce any QAA minutes/forms. An interview was conducted on 2/15/07 at 1:20 PM, with the Director of Nursing (DON), who had been designated by the Administrator, as the other co-chairperson for the QAA committee. The DON stated the facility did not have a system to "actually track and evaluate patterns of injuries". The DON stated the facility used the incident reports and nurses' notes to record and evaluate falls. She stated she knew that resident 2 has had frequent fall but they did not want to take the resident's "independence" away. The DON stated she knew resident 2's main problem was falling, "but they (staff) cannot always be there". The DON stated that they had discussed issues such as falls in the IDT (interdisciplinary team)	F 520		

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F 520	Continued From page 85 meetings and that they had made a plan of action, which was then documented in the IDT notes. There was no documentation that the committee had identified any quality deficiencies and developed and implemented plans of action to correct quality deficiencies. Additionally, there was no monitoring of the effectiveness of implemented changes that were necessitated by last years survey. 2. On 2/12/07, during entrance, the facility Administrator was interviewed. When asked about the QAA committee meetings and who attended these meetings, the Administrator stated that the facility's designated physician "very seldom" comes. On 2/20/07 at 9:00 AM, the MRP was interviewed. When asked how involved the designated physician has been with past QAA meetings, she stated that he does not attend. She stated that we leave him notes, we fax him and that it was difficult to get his input.	F 520		