STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345123	A. BUILDING _____ B. WING _____	05/20/2011

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(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to accurately transcribe a medication order for one (1) of thirteen (13) residents reviewed for medications administered as ordered by the physician (Resident # 15). The findings are: Resident #15 was readmitted to the facility on 05/15/11 with diagnoses including a history of pulmonary embolism and dyspnea. Review of Resident #15's hospital patient discharge medication list dated 05/15/11 and used by the facility to transcribe medications onto the facility's Treatment Administration Record (TAR) revealed the following medication order; Xopenex 0.63 milligram (mg)/3 milliliters (ml) Nebulizer every eight (8) hours as needed (PRN) in nebulizer. Review of Resident #15's TAR for May, 2011 revealed the following order; Xopenex 0.63 mg/3ml nebulizer treatment scheduled at 6:00 a.m., 2:00 p.m. and 10:00 p.m. Documentation on the TAR revealed Resident #15 received a nebulizer treatment on 05/15/11 at 10:00 p.m., 5/16/11 at 6:00 a.m. and 2:00 p.m., 5/17/11 at 2:00 p.m., 5/18/11 at 6:00 a.m. and 5/19/11 at	F 281	A surveyor alleged that staff had made a transcription error related to a nebulizer treatment ordered on resident #15. Corrective action was accomplished by the DON speaking to the resident's Physician about the alleged error. He told the DON that both ways may be correct, but since he was not the hospital physician who wrote the order, he would need to speak with that physician prior to writing another order. An order was written on 5-24-11 to give the nebulizer treatment routinely. All nursing staff involved was counseled to clarify any unclear orders. All staff involved was educated to read orders, transcribe the orders, and clarify as needed and to have another staff member verify that the transcribed order is correct. The nursing staff directly involved also was required to complete a Silver Chair in-service on correctly completing a medication pass. All licensed nurses are currently required to complete a Silver Chair med pass in-service annually. For those that have the potential to be affected, nursing staff was in-serviced on transcribing orders, having another nurse verify the orders and clarifying any unclear orders during an	6/14/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Cechran, NHA | TITLE: NHA | (X6) DATE: 06/15/2011

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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F 281	Continued From page 1 6:00 a.m. and 2:00 p.m. An interview was conducted on 05/19/11 at 3:00 p.m. with Licensed Nurse (LN) #2 who transcribed Resident #15's admission orders on 05/15/11. LN #2 reviewed the order and confirmed the Xopenex should be given PRN. LN #2 further stated the order was confusing and she did not call the facility physician for clarification. On 5/20/11 at 10:10 a.m. the Director of Nursing (DON) was interviewed and confirmed the order for Xopenex was transcribed incorrectly and should have been clarified with the physician.	F 281	in-service on 5-25-11. An audit of all residents with Nebulizer treatments has been accomplished to determine if there were any orders that had not been clarified. The systemic measures the facility has put into place to ensure that corrective action is achieved and sustained is: Administrative Nursing staff will audit telephone orders daily for nebulizer treatments for four (4) weeks and orders of new admissions with nebulizer treatments for four (4) weeks to determine if the nebulizer orders are clear. After four (4) weeks of monitoring the daily telephone and new admission nebulizer orders and if errors are not occurring, orders will be audited monthly. If any of the orders are unclear, they will be clarified. Education sheets and counseling will be used to educate the staff member responsible for the unclear order. The Director of Nursing or her designee will report on the implemented plan and the effectiveness of the corrective action at the monthly and quarterly QA meetings and plan revisions will be made as needed.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain 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 staff interviews, documentation and record reviews the facility failed to manage and implement planned measures for adequate bowel elimination patterns for two (2) of twelve (12) sampled residents. (Resident #s 6 and 7). The findings are: The facility's undated Physician's standing orders specified:	F 309	F 309 The surveyors alleged that the facility did not provide the necessary care and services to attain or maintain the highest practicable well-being of the residents involved, Residents # 6 and # 7 by allegedly failing to provide intervention for these two (2) residents after nine (9) consecutive shifts of no bowel movement (BM). For the two identified residents, the Care Tracker records have been reviewed each	6/14/2011

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F 309	Continued From page 2 1. MOM (Milk of Magnesia) 1 ounce on third day if no bowel movement. 2. If (resident) hasn't had a bowel movement for four (4) consecutive days may give small ready to use enema or soap suds enema. 3. For severe constipation remove digitally followed with soap suds enema to be done by Registered Nurse or Licensed Practical Nurse. 4. May use glycerin suppository as needed for constipation. 1. Resident #6 was admitted to the facility on 5/30/08 with diagnoses that included constipation and dementia. The most recent Minimum Data Set (MDS) dated 5/2/11 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident required extensive assistance with Activities of Daily Living (ADLs) and was always incontinent of bowel. Resident #6's bowel elimination records were reviewed and revealed the following: a. Starting 4/19/11 and continuing for four (4) days / twelve (12) shifts no bowel movements were documented. b. Starting 4/27/11 and continuing for seven (7) days / twenty-one (21) shifts no bowel movements were documented. A review of nursing notes for Resident #6 for the periods of 4/19/11 through 4/22/11 and 4/27/11 through 5/4/11 revealed no documentation of assessment for constipation or implementation of the facility's standing orders for constipation.	F 309	9 shifts since survey and the residents have had a BM within the nine shift (9) perimeters. These two residents will continue to be monitored each 9 shifts for at least the next 3 months and then randomly. An in-service was held on 5-25-11 for all nursing staff to provide information on how to monitor for BM's in the future. For those residents who may be affected by the alleged deficient practice, the facility staff will monitor all residents by reviewing the Care Tracker each day after 3:30 PM and monitor each for the previous nine shifts to determine who has had no BM in the last nine shifts. The facilities policies of using our standing orders will be followed. The measures that will be put into place to prevent the alleged practice from reoccurring are: 1) We reviewed our Care Tracker Policy of pulling the BM records for nine shifts and found that they were being pulled too early in the day and the Care Tracker was unable to pull the ninth shift. 2) The nursing staff was educated to pull the report at the end of the first medication pass on the second shift.	

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F 309	Continued From page 3 The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 4/11 and 5/11 were reviewed and revealed an original physician order dated 12/18/10 for Senna (laxative) one (1) tablet daily and Dulcolax (suppository) 10mg (milligrams) for constipation dated 4/19/10. Further review of the MAR and physician orders revealed no additional orders and/or interventions to address the two (2) episodes of constipation. On 5/18/10 at 3:15 p.m. the Director of Nursing (DON) was interviewed and reported that residents' bowel elimination patterns were monitored by the evening shift staff who ran a report of residents who had not experienced a bowel movement in the last nine (9) shifts (three [3] days). She specified the licensed nurse was responsible for assessing the resident and implementing interventions that included the standing orders. She specified that routine bowel elimination medications superseded the facility's standing orders for residents who experienced no bowel movement in nine (9) shifts. She stated she would expect the licensed nurse to perform a rectal exam on the resident and notify the physician for further orders if the resident experienced pain. The DON confirmed the license nurse would document such measures in the medical record and added this was the facility's only system for monitoring a resident's bowel elimination patters. On 5/19/11 at 2:50 p.m. the medical doctor was interviewed and reported that if Resident #6 went nine (9) shifts without a bowel movement she would expect licensed nursing staff to complete a	F 309	3) The ADON or her designee will pull the reports after 3:30 PM daily. 4) Any resident who has not had a BM in the previous nine (9) shifts will be given Milk of Magnesia as our policy dictates and our policy will be followed as written. 5) The action taken will be documented on the Care Tracker nine shift BM report as has been done in the past and the BM sheets will be placed in a notebook at each nurses' station and in a notebook in the ADON's office. The ADON or her designee will pull the no BM in 9 Shifts Report. The ADON or Designee will pull the detailed report every 2 to 3 days but will not print the report unless an issue that needs attention is noted on the report. The facility plans to monitor its performance by the ADON providing a report to the DON on a weekly basis and the DON or her designee will report on the system at the monthly and quarterly QA meetings and the plan will be revised as needed.	

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F 309	Continued From page 4 rectal exam and notify her if there were concerns. On 5/20/11 at 8:20 a.m. the DON was interviewed and offered no explanation why Resident #6 was not assessed and did not have planned interventions implemented as indicated when the resident went greater than nine (9) shifts without a bowel movement. 2. Resident #7 was admitted on 12/11/09 with diagnoses including Alzheimer's Disease. An annual Minimum Data Set (MDS) dated 11/10/10 indicated Resident #7 had severely impaired cognition and was sometimes understood. The annual MDS further revealed Resident #7 required extensive assistance with transfers, toilet use, and personal hygiene. In addition, the resident was frequently incontinent of urine and continent of bowels. A quarterly MDS dated 04/27/11 indicated Resident #7 had short and long-term memory problems and severely impaired cognitive skills for daily decision making. The quarterly MDS further revealed Resident #7 required extensive assistance with transfers, toilet use, and personal hygiene. In addition, the resident was frequently incontinent of urine and bowel movements. Review of Resident #7's "Resident Bowel and Bladder by Shift Chart" (computer documentation entered by nursing assistants) for 03/19/11 through 04/23/11 revealed, utilized by the facility to monitor residents' bowel movements (BMs), revealed four (4) episodes of more than nine consecutive (9) shifts with no BM: - From 03/19/11 evening shift through 03/24/11 night shift- fourteen (14) shifts	F 309		

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F 309	Continued From page 5 - From 04/04/11 evening shift through 04/09/11 night shift- fourteen (14) shifts - From 04/13/11 night shift through 04/16/11 night shift- ten (10) shifts - From 04/19/11 evening shift through 04/23/11 night shift- eleven (11) shifts Review of daily "No BM in last 9 shifts Cross Tab Reports" (computer summary of data entered by nursing assistants) from 03/19/11 through 04/23/11 revealed no reports were generated for Resident #7 to indicate nine (9) consecutive shifts without a BM for any of the four episodes noted on the "Resident Bowel and Bladder by Shift Chart" for 03/19/11 through 04/23/11. Review of the medical record revealed a Physician's order dated 03/24/11 for Milk of Magnesia (laxative) 30cc's (cubic centimeters) by mouth daily as needed for constipation. Review of Resident #7's Medication Administration Records (MARs) for March and April of 2011 revealed no laxatives were administered nor were Physician's standing orders implemented. Resident #7's nurse's notes from 03/19/11 through 04/23/11 were reviewed and revealed no documentation regarding bowel assessments or implementation of interventions when Resident #7 experienced more than nine shifts with no BM. During an interview on 05/19/11 at 9:40 AM Licensed Nurse (LN) #3 stated residents' BMs were documented in the computer each shift by their assigned nursing assistant (NA). LN #3 further explained the evening shift (3:00 PM to	F 309		

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F 309	Continued From page 6 11:00 PM) LNs print the "No BM in last 9 shifts Cross Tab Reports" daily to determine which residents may need assessment and/or interventions due to no BM in the last nine (9) shifts. An interview with NA #3 on 05/19/11 at 2:30 PM revealed NA staff were responsible for entering BMs in the computer each shift for their assigned residents. NA #3 further stated computer input was reviewed daily and residents' BMs were monitored by the LN staff therefore NA staff were not required to advise the nurse of residents with no BM during their shift. On 5/18/10 at 3:15 PM the Director of Nursing (DON) was interviewed and reported that residents' bowel elimination patterns were monitored by the evening shift staff who ran a report of residents who had not experienced a bowel movement in the last nine (9) shifts. The interview further revealed the facility had no other system in place to monitor residents' bowel movements. The DON reviewed the "No BM in last 9 shifts Cross Tab Reports" from 03/19/11 through 04/23/11 and could not explain why Resident #7 did not print out on the reports for any of the four episodes of no BM in nine (9) shifts for 03/19/11 through 04/23/11.	F 309		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431	On the tour of the facility, the surveyor found one outdated bottle of Lantus Insulin in our medication rooms.	6/14/2011

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F 431	Continued From page 7 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 by: Based on observations, staff interviews, facility policy review and manufacturer's recommendations, the facility failed to remove expired insulin from use in one (1) of two (2) medication refrigerators. The findings are:	F 431	The Lantus Insulin was destroyed while the survey team was in the building. On 5-25-11, all the nursing staff was in-serviced on destroying expired medications. The drug rooms will be monitored for expired drugs monthly by the ADON or her designee. She will report her findings to the DON who will report them at QA monthly and quarterly where the plan will be revised as needed.	

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F 431	Continued From page 8 Review of the facility's "Medication Expiration Timeline," a form used by the facility for guidance in storage and life expectancy of medications indicated once a multi-dose vial of insulin is opened the product is only good for twenty-eight (28) days from the open date. The manufacturer's recommendation for open multi-dose vials of Lantus insulin revealed vials must be discarded 28 days after being opened. On 05/18/11 at 9:40 a.m., the medication refrigerator in the medication room on the A/B hall was observed to contain a 10 ml (milliliter) multi-use vial of Lantus insulin 100 u/ml (units per milliliter) approximately half full. The vial was opened and in the active stock of insulin ready for resident use. The bottle had been labeled with and open date of 04/10/11. On 05/18/11 at 9:40 a.m., Licensed Nurse (LN) # 1 was interviewed. She stated that, per facility policy, insulin should be discarded 28 days after opening. The Director of Nursing (DON) was interviewed on 05/19/11 at 9:30 a.m. She stated the insulin should be discarded 28 days after opening and offered no explanation why the outdated insulin vial remained in use.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	During observation of catheter care, the surveyor alleged that the nursing assistant failed to maintain a sanitary work space by	6/14/2011

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F 441	Continued From page 9 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and policy review the facility failed to follow infection control practices while providing catheter care to one (1) of two (2) sampled residents with an	F 441	placing dirty linens on top of Resident # 2 's over bed table. The nursing assistant was counseled/educated while the survey team was in the building. She has also been observed giving catheter care to resident # 2. For those residents having the potential to be affected by the same deficient practice, an in-service was held on 5-25-11 for all nursing staff including nursing assistants for the purpose of reminding them of the facility's catheter care procedure. Each month four (4) CNA's will be observed while doing catheter care to see that the facility's procedure is followed and that linens are not placed on the over bed table and are put in a plastic bag for disposal in the dirty utility room. These observations will continue until all CNA's have been observed and then will continue randomly. The ADON or designee will monitor the CNA's doing the catheter care. Those CNA's who do not follow the procedures for catheter care will receive education sheets. To ensure that solutions are sustained, the ADON or her designee will report her findings to the DON who will report the findings at QA monthly and quarterly where the plan will be revised as needed.	

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F 441	Continued From page 10 indwelling urinary catheter (Resident #2). The findings are: Resident #2 was originally admitted to the facility on 05/28/10 and readmitted on 03/25/11 with diagnoses including Cerebral Vascular Accident and Urine retention. Review of the admission Minimum Data Set (MDS) dated 04/21/11 assessed the resident as cognitively intact for daily decision making, understood and able to make needs known. Resident #2 required extensive assistance with hygiene, toilet use and had an indwelling urinary catheter. On 05/19/11 at 9:40 a.m., Nursing Assistant (NA) #1 was observed providing catheter care to Resident #2. NA #1 applied a no-rinse cleansing solution to a wet washcloth and proceeded to cleanse the resident's perineal area using appropriate technique. NA #1 then placed the used washcloth directly on the resident's over bed table. NA #1 used a towel to dry the resident's perineal area, picked up the wet washcloth, placed the used towel on the over bed table and placed the washcloth on top of the towel. NA #1 redressed Resident #2, placed the used linens in a plastic bag and removed them from the room. An interview was conducted with NA #1 following the procedure at 9:50 a.m. NA #1 acknowledged she placed the used washcloth and towel on the over bed table without a barrier. NA #1 stated she should have placed the used linens in a plastic bag and not on the over bed table. On 05/20/11 at 9:40 a.m. an interview with the Director of Nursing (DON) revealed NA's are	F 441		

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F 441	Continued From page 11 expected to place used linens in a plastic bag during catheter care. The DON further revealed the NA should not have placed the used washcloth and towel directly on the resident's over bed table.	F 441		