| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 095014 | A. BUILDING _____ B. WING _____ | 05/05/2008 |

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| L 000 | Initial Comments<br><br>An annual licensure survey was conducted on April 28 through May 5, 2008. The following deficiencies were based on record review, observations, and staff interviews. The sample included 30 residents based on a census of 244 residents on the first day of survey and 33 supplemental residents. | L 000 | | |
| L 051 | 3210.4 Nursing Facilities<br><br>A charge nurse shall be responsible for the following:<br><br>(a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;<br><br>(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;<br><br>(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;<br><br>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;<br><br>(e)Supervising and evaluating each nursing employee on the unit; and<br><br>(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:<br><br>Based on observation, record review and staff interviews for four (4) of 30 sampled residents and one (1) supplemental resident, it was | L 051 | 1. Residents #6 ,18 and 21 were receiving appropriate care and/ or medications as ordered by the physicians plan of care. The nursing staff reassessed residents #6 and 18 and the care plans were updated to reflect the appropriate changes. A care plan on 9 or more meds was developed for resident #21, and the dietary department was re-notified regarding the isolation which had already been discontinued by nursing; however, unable to address alteration in skin for this resident as the resident was not in the facility. Resident #22 record revealed accurate documentation in the nursing notes. Staff have been re-educated regarding documentation on the behavior monitoring record. Residents #28 and 29 were closed records. Resident #52 was reassessed by the nursing management team in consultations with the physicians. Treatment order was obtained and record was modified to reflect the treatment as ordered. | |

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christine D. Page TITLE: Administrator (X6) DATE: 6/28/08

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| L 051 | Continued From page 1<br><br>determined that the charge nurse failed to: continue the skin integrity care plan for one (1) resident, accurately document the status of one (1) resident's skin on readmission, develop a care plan with potential for adverse drug interactions involving nine (9) or more medications, revise the care plan to accurately reflect the current status of the skin and discontinue isolation practices as per physician's orders for one (1) resident, document one (1) resident's behaviors on the monthly behavior monitoring flow record, document allergy and treatment on the discharge summary for one (1) resident, document the disposition of the body after pronouncement for one (1) resident and failed to discontinue a wound treatment before initiating another wound treatment for one (1) resident. Residents #6, 18, 21, 22, 28, 29 and S2.<br><br>The findings include:<br><br>1. The charge nurse failed to continue the skin integrity care plan for Resident #6.<br>Care plan #16 "Resident has surgical wound(s) R/T PVD (related to Peripheral Vascular Disease). Measurements: 2x3x0 cm Location: Left bka (below knee amputation) and small 1x1x0 cm front side of left stump. Start date 1-2-08 [January 2, 2008]."<br><br>This care plan was discontinued on February 2, 2008 [with the comment] "Resident's surgical wound has healed without complication." This was the only care plan in the resident's record related to skin integrity.<br><br>"Altered Skin Integrity Assessment Forms" in chart for Left stump below knee amputation(BKA) wound type surgical origin date 01/02/08 [January 02, 2008] included weekly documentation of | L 051 | 2. The care plans for residents with alteration in skin integrity was reviewed. A list of residents on 9 or more medications was obtained from the pharmacist and the care plans for those residents were reviewed. A review of residents on isolation was done. The nursing management team reviewed all residents on behavior monitoring. A review of closed records including discharge summaries and /or residents who expired was completed. No other residents were affected by this practice.<br><br>3. Nursing staff was re-educated regarding documentation requirements. This included care planning, infection control procedures, admission, readmission, behavioral monitoring, allergies and disposition of a body.<br><br>4. The nursing management team monitors the care plan; audits closed records, and completes a comprehensive medical record audit monthly. This information is reported at the QA/QI meetings. | |

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| L 051 | Continued From page 2<br>surgical wound from January 11, 2008 through April 21, 2008. The treatment sheet indicated that the last time the dressing change was done was April 30, 2008.<br><br>"Altered Skin Integrity Assessment Forms" in the chart for a Left " BK Ulcer " Stage II Origin date 1/11/08 [January 11, 2008] included weekly documentation from January 11, 2008 through April 14, 2008. The documentation indicated "closed" on April 14, 2008.<br><br>A face-to-face interview was conducted with Employees #17 and 20 on April 30, 2008 at approximately 12:01 PM. He/She acknowledged that the care plan had been discontinued on February 8, 2008. The record was reviewed on April 30, 2008.<br><br>2. The charge nurse failed to accurately document the status of Resident #18's skin on readmission to the facility.<br><br>A nurse' s note dated April 14, 2008 at 10:00 PM revealed, "Head to toe skin assessment done TX (treatment) to open area RT (right) Ischium continues ..." The resident was transferred to the hospital on April 15, 2008.<br><br>Resident #18 was readmitted to the facility on April 21, 2008. The readmission nurses' note dated April 21, 2008 at 9:00 PM included the following, "...healed scar on both side of buttocks (95%) ..."<br><br>A nurse's note dated April 23, 2008 at 7:00 AM included, " Resident readmitted on 4/21/08 ... Resident has (R) ischium ulcer 4 x 3 x 0 x 0 cm, a stage III pressure ulcer ... (L) Ischium 1 x 1 x 0 x 0 cm, a stage III pressure ulcer ..." | L 051 | | |

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| L 051 | Continued From page 3<br><br>A face-to-face interview was conducted with Employee #20 on April 30, 2008. He/She stated that the right ischium pressure sore was not healed when the resident was readmitted and that the left ischium pressure sore was first observed on readmission to the facility. Employee #20 acknowledged that the readmission assessment of the skin was wrong.<br>The record was reviewed on April 30, 2008.<br><br>3. The charge nurse failed to develop a care plan with the potential for adverse drug interactions involving nine (9) or more medications, revise the care plan to accurately reflect the current status of Resident #21's skin and discontinue isolation practices as per physician's orders.<br><br>A. A review of Resident #21's record revealed a physician's order form signed and dated February 8, 2008 which listed 13 medications. The following medications were ordered for administration: Docusate Sodium 100mg capsule, Guaifenesin Oral Syrup 100mg/5ml, Heparin Sodium 10,000 u/ml, Hydralazine 10 mg tablet, Nephrocaps capsules, Novolin R 100u.ml, Oxycodone w/APAP 5-325mg tablet, Phoslo 667mg gelcap, Renagel 800mg tablet, Sensipar 60mg tablet, Sertraline 100mg tablet, Simvastin 20mg tablet and Xalatan eye drops.<br><br>According to the quarterly "Minimum Data Set", completed February 7, 2008 revealed, Section O1, "Number of Medications" documents that the resident takes 13 medications.<br><br>A review of the care plan section of the record lacked evidence that a care plan was developed with appropriate goals and approaches for potential adverse drug interactions involving nine | L 051 | | |

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| L 051 | Continued From page 4<br>(9) or more medications.<br><br>A face-to-face interview was conducted with Employee #25 on April 28, 2008 at 3:15 PM. He/she acknowledged a care plan for Resident #21 was not initiated.<br><br>B. The charge nurse failed to accurately reflect the current status of Resident #21's skin on the "decubiti" care plan.<br><br>A review of the care plan entitled "decubiti" included revisions as follows: "2/13/08 skin continues to be free of open areas ..."<br><br>A review of the "Altered Skin Integrity Assessment" forms revealed the following: "Location of Wound: Sacral. Date of Origin: 12/14/07. The forms included weekly assessments of the sacral pressure sore from December 14, 2007 through April 25, 2008."<br><br>A face-to-face interview was conducted with Employee #25 on May 1, 2008 at 3:15 PM. He/She acknowledged that the entry on the care plan was inaccurate.<br><br>C. The charge nurse failed to discontinue isolation practices for Resident #21 as per physician's orders.<br><br>On April 28, 2008 at 9:30 AM, the door to Resident #21's room had a sign which instructed visitors to report to the nurses' station. There were paper products from the breakfast meal in the resident's room.<br><br>A face-to-face interview was conducted with Employee #25 on May 5, 2008 at approximately 9:45 AM. He/She stated, "[Resident] is not on it | L 051 | | |

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| L 051 | Continued From page 5<br>[isolation] anymore."<br><br>A physician's order dated April 14, 2008 at 11:45 AM read, "D/C (discontinue) MRSA (Methicillin Resistant Staphylococcus Aureus) isolation."<br><br>The charge nurse failed to discontinue isolation practices although a physician's order directed to discontinue isolation. The record was reviewed on May 1, 2008.<br><br>4. The charge nurse failed to document all behaviors for Resident #22 on the "Monthly Behavior Monitoring Flow Record."<br><br>A review of the nurses' notes revealed the following:<br>April 12, 2008 at 3:30 PM, " ...Eloped from the unit ..."<br>April 17, 2008 at 8:20 PM, " From 6:30 PM [he/she] is very agitated and abusive and several times walking out of the unit, but caregivers have been following [him/her] ..."<br>April 18, 2008 at 4:20 PM, " Resident left the unit unescorted ..."<br><br>The "Monthly Behavior Flow Record" was reviewed for April 2008. The following behaviors were identified on the form: "Behavior #1 - Attempted elopement (leaving the unit unescorted) and Behavior #2 - Verbally abusive towards staff and residents." The aforementioned incidents on April 12, 17 and 18, 2008 were not entered on the Monthly Behavior Flow Record.<br><br>A face-to-face interview was conducted with Employee #21 on May 1, 2008 at 3:45 PM. He/she acknowledged the absence of the behaviors on the "Monthly Behavior Flow | L 051 | | |

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| L 051 | Continued From page 6<br><br>Record."<br>The record was reviewed on April 30, 2008.<br><br>5. The charge nurse failed to document the resident's allergy to nuts and a wet-to-dry treatment to the abdomen on the "Discharge Summary" for Resident #28.<br><br>A review of the " Interdisciplinary Discharge Summary" revealed, "...discharge date March 14, 2008 ..."<br><br>A telephone order dated March 13, 2008 at 12 Noon directed, "Discharge Orders ...Allergy- Latex and nuts, cephalosporin and erythromycin ... home health aide and home health PT [physical therapy] and OT [occupational therapy]"<br><br>A. The " Physician's Order Sheet and Plan on Care" dated February 21, 2008 and signed by the physician on February 29, 2008 revealed, "Allergy history: Latex and nuts..."<br><br>The " Interdisciplinary Discharge Summary" lacked evidence that the allergy to nuts was transcribed to the final summary of the resident' s status.<br><br>B. A physician's order dated and signed by the physician on February 29, 2008 directed, "Wet to dry dressing of surgical wound daily" .<br><br>A review of the March 2008 Treatment Administration Record revealed that the wet to dry dressing was signed as being administered from March 1 through March 13, 2008. March 14, 2008 was not signed documenting that the treatment was not administered. Additionally, there was no discontinuation order in the record for the wet to dry dressing. | L 051 | | |

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| L 051 | Continued From page 7<br><br>The "Interdisciplinary Discharge Summary" and the discharge orders lacked evidence that the wet to dry dressing of the surgical wound was transcribed to the final summary of the resident's status.<br><br>A face-to-face interview was conducted on April 30, 2008 at 9:30 AM with Employee #4. He/she acknowledged that Resident #28's allergy to nuts and the wet to dry dressing were not documented on the " Interdisciplinary Discharge Summary" and the wet to dry dressing was not documented on the discharge orders. The record was reviewed on April 30, 2008.<br><br>6. The charge nurse failed to document in the nurses notes the disposition of the Resident #29's body.<br><br>A review of the "Discharge Summary" signed as completed by the physician on March 12, 2008 revealed,"...Expired, Date: February 11, 2008 at 11:00 PM, Released to: Funeral Home... Reason for Discharge: Expired..."<br><br>A review of the nurses' notes dated February 11, 2008 at 11:15 PM documented, "...called stat and responded to room 172, assessment done skin very warm but no pulse, no respiration. O2 (oxygen) started and CPR (cardiopulmonary resuscitation) initiated... 911 was called and they responded and did EKG [electrocardiogram]. 11:30 PM they said they will not take him/her to hospital and we will call the police office. Which they did. Police officer arrived. Doctor [name] notified and RP [responsible party] number given to doctor [name] and he/she left a message on his/her answering machine at 11:50 PM..."<br>The nurses' notes lacked documented evidence | L 051 | | |

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| L 051 | Continued From page 8<br>as to what was done with Resident #29's body after the emergency respondents did not take him/her with them and failed to document in the record the date and time that the body was released to the funeral home.<br>A face-to-face interview was conducted on April 29, 2008 at approximately 3:30 PM with Employee #15. He/She brought the surveyor a record book that documented the release of all expired bodies from the facility. According to this book Resident #29 was pronounced at 11:30 PM on February 11, 2008 and was picked up by the funeral home at 1:30 PM on February 12, 2008. He/She further acknowledged that this record book was not a part of the resident's clinical record. The record was reviewed on April 29, 2008.<br><br>7. The charge nurse failed to discontinue a wound treatment before initiating another wound treatment for the same area for Resident S2.<br><br>According to re-admission orders dated March 14, 2008, signed by the physician May 1, 2008, directed, ""Wash LT (left) heel with soap and water, pat dry, apply A & D ointment and monitor daily."<br><br>According to a physician's telephone order dated March 24, 2008 and signed by the physician on April 1, 2008, "Apply Acticoat to LT heel daily after cleansing with wound cleanser and patting dry. Cover with coversite"<br><br>A review of the March 2008 MAR revealed the following orders:<br>"Wash LT (left) heel with soap and water, pat dry, apply A & D ointment and monitor daily." The order was initiated on March 14, 2008. | L 051 | | |

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| L 051 | Continued From page 9<br>"Apply Acticoat to LT heel daily after cleansing with wound cleanser and patting dry. Cover with coversite" The order was initiated March 24, 2008.<br><br>Both wound treatments were signed as administered concurrently from March 24 through March 31, 2008. A face-to-face interview was conducted on May 1, 2008 at 8:35 AM with Employee #26. He/she acknowledged that he/she had incorrectly initialed that both wound treatments were administered. The record was reviewed May 1, 2008. | L 051 | | |
| L 052 | 3211.1 Nursing Facilities<br><br>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:<br><br>(a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;<br><br>(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:<br><br>(c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;<br><br>(d) Protection from accident, injury, and infection;<br><br>(e)Encouragement, assistance, and training in self-care and group activities;<br><br>(f)Encouragement and assistance to: | L 052 | 1. Resident #7 was seen immediately by the Psychiatrist and it was determined that the plan of care was appropriate. Resident #8's physician was contacted and he indicated that the resident was to be seen prn (as necessary) by the urologist an appointment has been scheduled. Additionally, the nursing staff had already discontinued the isolation as ordered; however, dietary was re-notified regarding the discontinuance of the isolation. Resident's #16, A1 and # 18's is community acquired pressure sores were re-assessed by the nursing management team in consultation with the physicians. The residents are currently receiving treatment of the areas as ordered by the physicians. As indicated in the report resident #21 had no complaints of pain, however unable to retrospectively correct medication administration as resident was not in the facility upon receipt of the survey (2567). | |

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| L 052 | Continued From page 10<br>(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;<br><br>(2)Use the dining room if he or she is able; and<br><br>(3)Participate in meaningful social and recreational activities; with eating;<br><br>(g)Prompt, unhurried assistance if he or she requires or request help with eating;<br><br>(h)Prescribed adaptive self-help devices to assist him or her in eating independently;<br><br>(i)Assistance, if needed, with daily hygiene, including oral acre; and<br><br>j)Prompt response to an activated call bell or call for help.<br><br>This Statute is not met as evidenced by:<br><br>Based on record review and staff interviews for four (4) of 30 sampled residents and one (1) supplemental resident, it was determined that facility staff failed: to follow up on a psychiatric consultation for one (1) resident, to follow-up on a urology consult and discontinue isolation practices for one (1) resident, to ensure one (1) resident had orders for the treatment of bilateral ischium pressure sores on readmission to the facility, to follow proper infection control procedures during pressure ulcer treatment for two (2) residents, and to ensure that one (1) resident had sufficient pain medication for administration as ordered. Residents # 7, 8,16, 21, and A1.<br><br>The findings include: | L 052 | 2. A review of the residents requiring psychiatric evaluations and outside urology appointment was conducted. A review of residents on isolation was also done. The wound care nurse and nursing management reviewed all residents with alteration in skin integrity to ensure that all residents had appropriate orders with independent supplies A review of residents receiving pain medication was conducted. No other residents were found to be affected by this practice.<br><br>3. The Medical Director met with and/ or contacted all members of the medical staff and reviewed regulatory compliance and facility requirements as it pertains to the care of the residents. The licensed nursing staff will be re-educated on use of isolation. All nursing staff will be re-educated on proper infection control procedures and on physicians' orders for residents upon admissions and re-admissions. An interim narcotic box has been put in place to ensure the resident receives pain medications in a timely manner.<br><br>4. The Medical Director and/or members of the medical team conducts audits of the physician requirements. Additionally, nursing and medical records audits the clinical record. This information is presented at the QA/QI meetings. | 6/19/08 |

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| L 052 | Continued From page 11<br><br>1. Facility staff failed to reschedule a psychiatric consultation for Resident #7.<br><br>A review of the resident's record revealed the following doctor's orders:<br><br>A telephone order dated December 28, 2007 directed,"...Psychiatry consult due to patient agitation ..."<br><br>A telephone order dated February 16, 2008 directed,"...Psychiatry consult due to patient status." The physician's progress note dated March 1, 2008 revealed the following "Psych. [Psychiatry] consult: attempt to see Resident. Resident currently at the hospital. Will follow after discharge from hospital."<br><br>Facility staff failed to reschedule Resident #7 for psychiatry evaluation after March 1, 2008.<br><br>A face-to-face interview was conducted with Employee #21 on May 2, 2008 at approximately 3:30 PM. He/she acknowledged that the facility staff failed to reschedule the resident for the psychiatry consultation after March 1, 2008. The record was reviewed on May 2, 2008.<br><br>2. Facility staff failed to follow-up on a urology consult and discontinue isolation practices for Resident #8.<br><br>A. Facility staff failed to follow up on a urology consult for Resident #8. | L 052 | | |

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| L 052 | Continued From page 12<br><br>According to the urologist's consult dated February 27, 2008, "Patient has had the catheter changed monthly per recommendation. ... Continue with catheter change ... See q (every) 4-6 weeks or PRN."<br><br>Further review of the record revealed that no appointment was scheduled for the resident between February 27 and April 29, 2008.<br><br>A face-to-face interview conducted with Employee #17 at approximately 9:05 AM on April 30, 2008. He/she acknowledged that the appointment was not scheduled. He/she stated, "We did not think he/she needed to return because the order said prn and [the resident] did not have any problems." The record was reviewed on April 29, 2008.<br><br>B. The facility staff failed to discontinue isolation practices for Resident #8.<br><br>On May 1, 2008 at approximately 9:30AM Resident # 8 was observed eating with plastic utensils from a paper food container on a paper tray.<br><br>A face-to-face interview was conducted with Employee #20 at approximately 10:00 AM on May 1, 2008. He/she was asked if the resident was on isolation, and if not why was he/she being served with paper ware. Employee #20 stated that the resident had been on isolation but it has been discontinued. The employee added, "I don't understand. I discontinued the isolation myself | L 052 | | |

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| L 052 | Continued From page 13<br>last week. Anyhow, I will do it again." Approximately five (5) minutes later Employee #20 displayed a form addressed to the Dietary Department regarding the discontinuation of isolation for the resident. The employee stated, "I am taking this downstairs myself this time."<br><br>A review of the record revealed a physician's telephone order dated April 23, 2008 and signed on April 25, 2008 which directed, "Discontinue Isolation."<br>The record was reviewed on April 29, 2008.<br><br>3. Facility staff failed to follow proper infection control procedures during pressure ulcer treatments for Resident #16 and A1.<br><br>On April 29, 2008 at approximately 10:35 AM a pressure ulcer treatment was observed for Resident #16 and at approximately 11:00 AM a pressure ulcer treatment was observed for Resident A1.<br><br>Employee #20 rolled the treatment cart to the entry of Resident #16's room. He/she entered the room with wound care supplies that included: a bottle of Septicare wound cleanser, Polysporin powder, and a pack of 4x4 gauze sponges. The supplies were placed on the resident's over bed table. The table was covered with a protective barrier prior to placing the supplies on the table.<br><br>Employee #20 failed to cleanse the outside of the bottle of Septicare wound cleanser and Polysporin powder after completion of Resident | L 052 | | |

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| L 052 | Continued From page 14<br>16's Stage IV buttock pressure ulcer treatment and before placing the bottle in the treatment cart.<br><br>Employee #20 rolled the treatment cart to the entry of Resident A1's room. He/she provided wound care treatment to Resident A1 right buttock and left ankle pressure ulcers with the same wound care supplies used on Resident #16 including: Septicare, Polysporin powder, and the unused pack of 4x4 gauze sponges. A tube of Santyl cream used on Resident A1 was not labeled for the resident' s use.<br><br>Employee #20 failed to cleanse the outside of the bottles of Septicare wound cleanser and Polysporin powder after completion of Resident A1's Stage IV pressure ulcers treatment and before placing the bottles in the treatment cart.<br><br>A face-to-face interview was conducted on May 5, 2007 at approximately 3:00 PM with Employee #20. The nurse acknowledged that he/she failed to cleanse the outside of the bottles of Septicare wound cleanser and Polysporin powder before and after completion of treatments to Resident #16's Stage IV pressure ulcer and A1's Stage IV pressure ulcers and before placing the items in the treatment cart .<br><br>4. Facility staff failed to ensure that Resident #18 had orders for the treatment of bilateral ischium pressure sores on readmission to the facility.<br><br>A nurse's note dated April 14, 2008 at 10:00 PM revealed, "Head to toe skin assessment done TX | L 052 | | |

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| L 052 | Continued From page 15<br><br>(treatment) to open area RT (right) Ischium continues .." The resident was transferred to the hospital on April 15, 2008.<br><br>Resident #18 was readmitted to the facility on April 21, 2008. The readmission nurse's note dated April 21, 2008 at 9:00 PM included the following, "...healed scar on both sides of buttocks (95%) ..."<br><br>A nurse's note dated April 23, 2008 at 7:00 AM included, "Resident readmitted on 4/21/08 ... Resident has (R) ischium ulcer 4 x 3 x 0 x 0 cm, a stage III pressure ulcer ... (L) Ischium 1 x 1 x 0 x 0 cm, a stage III pressure ulcer ..."<br><br>A face-to-face interview was conducted with Employee #20 on April 30, 2008. He/She stated that the right ischium pressure sore was not healed when the resident was readmitted and that the left ischium pressure sore was first observed on readmission to the facility. Employee #20 acknowledged that the readmission assessment of the skin was wrong.<br><br>The readmission orders dated April 21, 2008 were reviewed and did not include treatment orders for the right and left ischium pressure sores.<br><br>The Interim Order Form included orders dated April 23, 2008 at 8:00 AM which directed, "Apply Santyl ointment and Polysporin powder to (R) Ischium daily after cleansing with wound cleanser and patting dry. Cover with Alleryn adhesive. Apply Santyl ointment and Polysporin powder to (L) Ischium daily after cleansing with wound cleanser and patting dry. Cover with Alleryn adhesive." The record was reviewed on April 30, 2008. | L 052 | | |

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| L 052 | Continued From page 16<br><br>5. Facility staff failed to ensure that Resident #21 had sufficient pain medication for administration as ordered.<br><br>A physician's order dated January 29, 2008, signed by the physician on February 7, 2008, directed, "Oxycodone w/APAP 5-325 mg PO (by mouth) every evening at 6 PM for pain."<br><br>The February 2008 Medication Administration Record (MAR) revealed that Oxycodone was not administered for 10 days from February 8 through 18, 2008. There were nurses' initials circled for February 8 through 17, 2008 and there was no entry on the MAR for February 18, 2008. Written on the back of the MAR for February 8 through 17, 2008 was "On Order" and "Not Given." There was no explanation for the omission for February 18, 2008. Oxycodone was administered on February 19, 2008.<br><br>The March 2008 MAR revealed that Oxycodone was not administered for 10 days from March 4 through 12, 2008 and March 22, 2008. The resident was hospitalized from March 13 through 21, 2008. The nurses' initials were circled for March 4 through 12, 2008 and March 22, 2008. Written on the back of the MAR was "On Order" and "Not Given" for the aforementioned dates.<br><br>A face-to-face interview was conducted with the Employee #25 on May 1, 2008 at 3:15 PM. He/She stated, "[Resident] has not complained of pain that I know of." Employee #25 was not aware of the reason for the delay in receiving Oxycodone.<br><br>A telephone interview was conducted with Employee #14 on May 2, 2008 at approximately | L 052 | | |

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| L 052 | Continued From page 17<br><br>2:00 PM. He/She stated, "We [pharmacy] received three (3) orders for Percocet (Oxycodone) for [Resident #21] on January 22, February 18 and March 22, 2008. Each order was for a quantity of 15. There is no verification that any other orders for Percocet came in."<br><br>The nursing monthly assessments for pain and nurses' notes were reviewed for February and March 2008. There was no documentation or indication that the resident complained of pain.<br><br>Facility staff failed to ensure that Oxycodone was ordered and received in a timely manner for administration to Resident #21. | L 052 | | |
| L 108 | 3220.2 Nursing Facilities<br><br>The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident.<br><br>This Statute is not met as evidenced by:<br>Based on the observation of a test tray conducted on April 28, 2008, breakfast meal, it was determined that facility staff failed to ensure that cold food did not exceed 45 degrees Fahrenheit (F) and hot foods were served above 140 F at the point of delivery to the resident. The temperatures were measured in the presence of Employee #33.<br><br>The findings include:<br><br>On April 28, 2008, trays were delivered to unit 2 Blue at 9:05 AM. The last tray was passed to the residents at 9:35 AM. The following food temperatures were recorded in the presence of | L 108 | 1. Facility staff reheated food items prior to serving. Facility cannot retrospectively correct the varying temperatures on test tray.<br><br>2. On 4/29/08 a review of the breakfast meal schedule was done to ensure residents trays are passed in a timely manner. No other residents were affected by this practice.<br><br>3. Nursing personnel will be in-serviced on the meal schedule and passing food trays. Administration, Dietary and Nursing management will review the meal delivery process.<br><br>4. The Dining room tray service review will be completed by management staff. This information will be reported at the Quality Improvement meeting. | 6/6/08 |

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| L 108 | Continued From page 18<br>Employee #31 at 9:35 AM:<br><br>Whole Milk - 58.5 F<br>Sausage, mechanical texture - 94.2 F<br>Pureed eggs - 103.7 F<br>Scrambled eggs - 99.1 F<br>Sausage patty - 98.2 F<br>Grits - 136.0 F<br><br>Employee #33 acknowledged the findings at the time of the observations. | L 108 | | |
| L 152 | 3227.3 Nursing Facilities<br><br>Proper storage temperature shall be maintained for each medication according to the manufacturer's direction.<br><br>This Statute is not met as evidenced by:<br>Based on observation and staff interview, it was determined that facility staff failed to store all drugs and biological under proper temperature controls.<br><br>The findings include:<br><br>The facility staff failed to store medications at the proper temperatures.<br><br>The facility ' s policy 4.1 " General Guidelines for Medication Storage " stipulates<br>(9) " Medications requiring " refrigeration " or temperatures between 36° F and 46° F "<br>Are kept in a refrigerator with a thermometer to allow temperature monitoring.<br><br>On April 29, 2008, between 1:00 PM and 3:00 PM, during the inspection of the facility's medication storage areas, nine (9)sealed container were observed stored in the medication | L 152 | 1. The medications requiring refrigeration were placed in the refrigerator immediately.<br><br>2. The medication carts were checked to ensure that medications that required refrigeration were stored according to manufacture's recommendations. No other drug was found to be affected by this practice.<br><br>3. The licensed nursing staff were re-educated regarding storage of drugs and biologicals.<br><br>4. Checking the storage of medications and the medication refrigerator temperatures is a part of the daily nursing rounds and monthly pharmacy inspections. | 6/16/08 |

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| L 152 | Continued From page 19<br><br>carts on 1 Green, 2 Green and 3 Orange units. These drugs required refrigeration, but were stored at room temperature. According to the manufacturer's recommendation, Xalantan must be stored under refrigeration until opened for use. According to the manufacturers, Lactinex and Aranesp are to be refrigerated at all times.<br><br>The medications included:<br>Six (6) sealed container of Lactinex packages<br>One (1) sealed container of Aranesp Injection<br>Two (2) sealed containers of Xalatan ophthalmic drops | L 152 | | |
| L 157 | 3227.8 Nursing Facilities<br><br>Each refrigerator that is used for storage of medication shall operate at a temperature between thirty-six degrees (36°F) and forty-six (46°F) Fahrenheit; each refrigerator shall be equipped with a thermometer that is easily readable, accurate and in proper working condition.<br><br>This Statute is not met as evidenced by:<br><br>Based on observation, staff interview and review of facility reports, it was determined that facility staff failed to store refrigerated medication at the proper temperature according to the manufactures' packaging instructions.<br><br>The findings include:<br><br>On April 30, 2008, at between 3:00 PM and 4:00 PM, during the inspection of the facility's medication storage area the medication refrigerators were out of range. The temperature should range between 36° Fahrenheit (F) - 46° F. | L 157 | 1. The engineering staff checked the refrigerators adjusted the thermostat on 3 Blue and changed the refrigerator on 2 Blue.<br><br>2. All medication refrigerators were checked, and no other refrigerator was found to be affected by this practice.<br><br>3. The licensed staff were re-educated on procedures for checking refrigerator temperatures.<br><br>4. Monitoring refrigerator temperatures is part of the engineering inspections. This information will be presented in the QA/QI meetings. | 6/16/08 |

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| L 157 | Continued From page 20<br><br>On unit 2 Blue, the unit inspection reports showed the refrigerator temperatures were as follows: April 30, 2008 - 65° F, February 2008 - 20° F, January 2008 - 25 F , December 2007 - 20° F November 2007- 30° F, September 2007- 34° F and August 2007- 34° F.<br><br>On three Blue, the unit inspection reports showed the refrigerator temperatures were as follows: April 30, 2008 - 65° F, February 2008 - 20° F, January 2008 - 25° F , December 2007 - 20° F November 2007- 30° F, September 2007- 34° F and August 2007- 34° F..<br><br>A face-to-face interview was conducted on May 2, 2008 at 2:00 PM with Employee #25, #22 and 34. He/she acknowledged that the refrigerators were fluctuating and corrected the problem. | L 157 | | |
| L 410 | 3256.1 Nursing Facilities<br><br>Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner.<br>This Statute is not met as evidenced by:<br>Based on observations during the survey period, it was determined that housekeeping and maintenances services were not adequate to ensure that the facility was maintained sanitary manner as evidenced by: marred/scarred furniture and items stored underneath sinks. These observations were made in the presence of Employees #2, 3, 15, 21, 25, 28 and 20.<br><br>The findings include: | L 410 | 1. The marred/scarred chair legs identified on the "newly purchased" furniture on 1 Orange, 2 Orange, and 3 Blue were repaired. The items stored under the sinks on 1 Blue, 2 Blue, 3 Blue, and 3 Green have been removed.<br><br>2. The chairs in the dining rooms and family rooms were reviewed and those identified to be marred/scarred were sanded and re-stained. The sinks located in other areas of the facility were checked and no others areas were noted to have items under them. | |

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| L 410 | Continued From page 21<br><br>1. Marred/scarred chair legs were observed in the following areas:<br>1 Orange: 13 of 13 chairs in the dining room.<br><br>2 Orange: 13 of 13 chairs in the dining room.<br><br>3 Blue: Four (4) of four (4) chairs in the family room.<br><br>2. Items stored underneath sinks were observed in the following areas:<br><br>1 Blue medication room: multiple packages of Styrofoam cups and soufflé cups.<br><br>2 Blue soiled utility room: Christmas wreath, red biohazard bags, five (5) rolls of clear tape, scrub pad, two (2) bottles of cleaning solution, and assorted mop heads.<br><br>2 Blue medication room: Sharp container and ambu-bag.<br><br>3 Blue pantry: box of bibs.<br><br>3 Green soiled utility room: red biohazard bags.<br><br>Employees #2, 3, 15, 21, 25, 28 and 20 acknowledged these findings at the time of the observations. | L 410 | 3. The vendors who supplied the new chairs was contacted regarding the finish on the chairs and it was determined that new chairs of that make will no longer be purchased. The preventive maintenance program is now in place to monitor and inspect all marred/scarred legs of the chairs. The nursing department has identified an alternative storage area for supplies, the environmental services manager in-serviced environmental staff on storage of supplies.<br><br>4. The Director of Engineering and the maintenance team will monitor and conduct audits of the furniture and report to the quality assurance committee. The Environmental management staff will inspect the areas under the sinks and report to the quality assurance committee. | 6/13/08 |