Plan of Correction with additions Reviewed with Joanne Aldrich RN accepted 11/19/07 10:44 AM Karla Hobbs



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535050 | A. BUILDING _____ B. WING _____ | 10/18/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MORNING STAR CARE CENTER | P O BOX 859 FORT WASHAKIE, WY 82514 |

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| F 170 SS=B | 483.10(i)(1) MAIL<br><br>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on confidential resident interview and staff interview, the facility failed to ensure mail was delivered to residents on Saturdays. The findings were:<br><br>Confidential interview with eleven residents on 10/16/07 at 11:30 AM revealed residents did not receive mail on Saturdays. Interview with the nursing home administrator on 10/18/07 at 9:55 AM confirmed residents did not receive mail on Saturdays because there was no management staff member present on the weekends to pick the mail up from the post office. She also confirmed mail is delivered to the post office box on Saturdays. | F 170 | F170: The facility strives to ensure Resident Rights.<br>The Activity department Mail will be picked up at the Post Office on Saturdays.<br>The activity department Mail will be delivered to the Residents in the facility on Saturdays.<br><br>Audits will be completed on Mondays by the Administrator and/or designee to ensure mail was picked up and delivered on Saturday.<br><br>Audits will be taken to the QAAC (Quality Assurance and Assessment Committee) at least quarterly. | 12-1-07 |
| F 176 SS=D | 483.10(n) SELF ADMINISTRATION OF DRUGS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and medical record review, the facility failed to ensure one (#34) of nine sample residents and one non-sample resident (#17) were evaluated for self administration of medications. The findings | F 176 | F176: The facility strives to assess Residents for self-administration of drugs.<br><br>Residents #17 and #34 will be assessed for self administering of drugs.<br>Education of nursing staff on self Administration of medication will be done by SDC | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 11-8-07

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 176 | Continued From page 1<br>were:<br><br>1. Observation on 10/15/07 at 5:55 PM revealed licensed practical nurse (LPN) #1 placed a medication cup containing the medications oxybutynin, acidophilus, morphine sulfate, and clonazepam on the table in front of resident #17. Observation revealed the LPN did not stay to ensure the resident took the medications. Review of the medical record revealed the resident was not assessed for self administration of pre-poured medications.<br><br>2. Observation in the dining room on 10/15/07 at 5:45 PM revealed a medication cup containing a white liquid was on the dining room table next to resident #34. At 7:15 PM (one hour and 30 minutes later) the resident left the dining room; however, the cup with the medication remained on the table. Interview with LPN #2 on 10/15/07 at 7:21 PM revealed the white substance was milk of magnesia and should have been administered to resident #34. The LPN said the milk of magnesia should not have been left on the table.<br><br>Review of the resident's medical record showed a physician's order for milk of magnesia three times a day; however, there was no evidence the resident was assessed for his/her ability to safely self administer medications.<br><br>3. Interview with the director of nursing (DON) on 10/18/07 at 9:30 AM revealed she was unsure if the facility had a policy on self administration of medications. She also confirmed there was no assessment completed for self administration of medications for resident #1 or resident #34. | F 176 | F176 cont'd:<br>All Residents will be assessed by nursing for self administering of drugs at admission and quarterly care plan.<br><br>Audits of completion of assessments will be completed by the Health Information Manager or designee to assure completion of assessments each month.<br><br>Audits will be taken to the QAAC at least quarterly.<br><br>10-1-07 | |
| F 226 | 483.13(c) STAFF TREATMENT OF RESIDENTS | F 226 | | |

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| F 226 SS=E | Continued From page 2 | F 226 | | |

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on review of personnel files, policy and procedure review, and staff interview, the facility failed to follow its abuse policy and procedures regarding screening for five (#1, #2, #3, #4, #5) of five personnel files reviewed. The findings were:

1. Review of the facility's policy and procedures "Background Screening Investigations" (10/99) showed the facility would conduct "...employment background checks, reference checks, and criminal conviction checks..." Review of five personnel files (#1, #2, #3, #4, #5) revealed no evidence of employment or reference checks. During an interview on 10/17/07 at 5:20 PM, the administrator stated there were no reference checks because "staff [in the facility] knew them."

2. Further review of the policy showed "...for any individual applying for position as a certified nursing assistant [CNA], the state nurse aide registry for each state in which the applicant has worked will be contacted to determine if any findings of abuse, neglect, mistreatment of individuals, and/or theft of property have been entered into the applicant's file." Review of personnel file #2 revealed the employee was a CNA. However, there lacked evidence the nurse aide registry was contacted. During an interview on 10/17/07 at 6:15 PM, the administrator stated the director of nursing (DON) "...goes online and

F226: The facility strives to ensure appropriate treatment of Residents.

Documentation for files for employees #1, #2, #3,#4, #5 will include the reference checks. by SDC

Documentation from the state nurse aide registry for employee #2 will be included in the personnel file. by SDC

Documentation from the state Board of Nursing for employee #5 will be included in the personnel file. by SDC

Documentation for the circumstances for employee #1 will be included in the personnel file. by DON and Administrator

All employees will have documentation on the personnel files to indicate references, registry certification and licenses are in good standing. Audits of personnel files prior to employment will be completed by the Administrator and/or designee to ensure documentation is included in the files. 12-1-07

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| F 226 | Continued From page 3<br>checks the Board of Nursing" but did not document her findings.<br><br>3. The policy also documented "...for any licensed professional individual applying for a position that may involve direct contact with residents, his/her respective licensing board will be contacted.." Review of personnel file #5 revealed the employee was a licensed practical nurse. However, there lacked evidence the Board of Nursing was contacted. During an interview on 10/17/07 at 6:15 PM, the administrator stated the DON "...goes online and checks the Board of Nursing" but did not document her findings.<br><br>4. Finally, according to the policy, "...should the background investigation disclose any...information indicating that the individual has been convicted of abuse, neglect, mistreatment of individuals...the applicant will not be employed..." and "...prior convictions of offenses other than abuse, neglect, mistreatment of individuals, and/or theft of property may not necessarily disqualify an applicant from employment...Serious consideration will be given to the position applied for, the seriousness of the offense, and how recent the offense was committed." Review of employee file #1 showed the employee was hired in a position which would have direct resident contact. The application in the file was incomplete; there was no education or prior employment listed. In addition, the file lacked evidence of employment or reference checks. The file also contained court documentation of a conviction of "battery, domestic violence". The personnel file lacked evidence the nature of the conviction was further investigated to determine if this applicant should be hired. During an interview on 10/17/07 at 5:20 | F 226 | F226 cont'd:<br>Audits will be taken to the QAAC meeting at least quarterly<br><br>12-1-07 | |

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| F 226 | Continued From page 4<br>PM, the administrator stated she knew the circumstances behind the conviction, but it was not documented in the file. | F 226 | 241 Education of Staff Regarding dignity with catheter bags being covered by will be done by SDC / | |
| F 241 SS=D | 483.15(a) DIGNITY<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and medical record review, the facility failed to ensure dignity was provided and maintained for one (#23) of 3 sample residents and one (#10) non sample resident who had indwelling urinary catheters. The findings were:<br><br>1. Periodic observation on 10/15/07, 10/16/07, and 10/17/07 revealed resident #23 had an indwelling urinary catheter bag which was not covered while the resident was in the dining room for meals. Interview with the director of nursing (DON) on 10/18/07 at 9:30 AM revealed she was unsure why the catheter bag was not covered.<br><br>2. Periodic observation on 10/15/07, 10/16/07, and 10/17/07 revealed resident #10 had an indwelling urinary catheter bag which was not covered while the resident was in the dining room for meals and while s/he was in other public areas. Interview with the DON on 10/18/07 at 9:30 AM revealed she was unsure why the catheter bag was not covered but stated it should be. | F 241 | F241: The facility strives ensure dignity for each Resident. Resident #23 and Resident #10 will have the catheter bag covered.<br><br>All catheter bags will be audited by DON or designee to ensure appropriate covering.<br><br>Audits will be completed on a monthly basis to ensure appropriate coverings.<br><br>Audits will be taken to the QAAC meeting at least quarterly. | 12-1-07 |
| F 253 SS=D | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE | F 253 | | |

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| F 253 | Continued From page 5<br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to assure the walls, floors, and furniture were maintained in a clean manner in the dining room and activity room. The findings were:<br><br>1. Observation of the dining room on 10/15/07 at 6 PM and again on 10/17/07 at 11:10 AM revealed numerous splatters of dried debris on the lower half of the east and south walls. In addition, the walls that separated the assisted dining room from the main dining room also contained numerous splatters. The corners of the floors (where the walls and floor join) contained a build-up of black residue. The black residue was the thickest (about 2 inches wide) underneath the baseboard heaters on the north and west walls. In addition, the legs of the ten dining room tables, five stools, and ten dining room chairs all contained dried splatters of debris and dirt.<br><br>2. Observation on 10/18/07 at 9 AM of the activity room revealed the bottom third of the east and west walls contained splatters of dried debris.<br><br>3. On 10/17/07 at 11:25 AM, the administrator confirmed there were splatters on the walls and furniture. The administrator stated the black residue was probably wax build-up, which could be stripped and cleaned. The administrator was unsure when the floors were last stripped. On 10/18/07 at 9:53 AM the housekeeping | F 253 | F253: The facility strives to maintain a sanitary, orderly and comfortable interior.<br><br>All observed walls will cleaned and/or renovated to remove any splatters.<br><br>The dining room furniture will be cleaned to remove observed splatters<br><br>Build up of wax around observed floor edges will be removed.<br><br>A schedule for striping/waxing and cleaning walls floors will be developed by maintenance and/or housekeeping. Activity room will be painted<br>Audits will be completed by the Administrator and/or designee to ensure striping/waxing have been completed per schedule.<br><br>Audits will be taken to the QAAC meeting at least quarterly. | 12-1-07 |

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| F 253 | Continued From page 6<br>supervisor stated the maintenance department was responsible for stripping the floors. She was unable to say when the walls were last cleaned, nor could she produce a cleaning schedule for the walls. On 10/18/07 at 9:55 AM, the maintenance assistant stated the floors had not been stripped in at least one year, but probably was done two years ago. | F 253 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>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.<br><br>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).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to develop a care plan that addressed elopement precautions and safety measures for one (#39) of one sample resident | F 279 | F279: The facility strives too review the Resident care plan.<br><br>All Residents being admitted to facility will be assessed for potential elopement.<br><br>All Residents will be assessed for potential elopement at their quarterly care plan meeting.<br><br>Audits will be completed for admission and quarterly assessments by the Health Information Manager or designee monthly.<br><br>Audits will be taken to the QAAC meeting at least quarterly.<br><br>Resident #39 is no longer living at facility | 12-1-07 |

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| F 279 | Continued From page 7<br>who eloped from the facility. The findings were:<br><br>Refer to F323 in regard to the lack of care planning for resident #39 who eloped from the facility on 8/7/07, 8/24/07, and 8/29/07. | F 279 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and medical record review, the facility failed to ensure staff updated the care plan for one (#23) of ten sample residents. The findings were:<br><br>1. Periodic observation on 10/15/07, 10/16/07, and 10/17/07 revealed resident #23 had an | F 280 | F280: The facility strives to up date Resident care plans.<br><br>Care plan for Resident #23 will be up-dated. by nursing<br><br>Nursing staff will be inserviced by SDC regarding the need to up date care plans. MDS Coordinator will review care plans with each new physician order to ensure care plans are updated.<br><br>Each record will be reviewed at Resident quarterly care plan meeting. 12-1-07<br><br>Results of the review will be brought to the QAAC meeting at least quarterly.<br><br>F282: The facility strives to follow the comprehensive plan of care.<br><br>The call light for Resident #8 will be placed within the Resident's reach; Resident #1 will be toileted every two hours. | |

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| F 280 | Continued From page 8<br>indwelling urinary catheter. Interview with the director of nursing on 10/18/07 at 9:30 AM revealed she thought the resident's catheter was inserted on 10/15/07. Review of the nursing care plan and the certified nurse aide care plan on 10/18/07 revealed the plans were not updated to reflect the insertion or care of a urinary catheter. | F 280 | F282 cont'd:<br>Staff will be inserviced by SDC pertaining to following the Residents comprehensive plans of care. | |
| F 282 SS=D | 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to assure care was provided in accordance with the written plan of care for two (#1, #8) of nine open sample residents. The findings were:<br><br>1. Review of the 12/28/06 admission Minimum Data Set (MDS) assessment showed resident #8 had fallen in the past 31-180 days. Review of the 12/26/06 Resident Assessment Protocol (RAP) summary for falls showed one strategy was to keep the call light in reach. Review of the 10/2/07 care plan showed "...keep call light in reach." Observation on 10/16/07 at 9 AM revealed certified nurse aide (CNA) #3 transferred the resident into bed. The CNA did not assure the call light was in reach of the resident. In fact, the call light was in the top drawer of the nightstand with the drawer closed. On 10/18/07 at 8:15 AM the director of nursing (DON) stated the call light should be in reach. | F 282 | Audits will be completed by the DON and/or designee to ensure comprehensive plans of care are followed for each Resident.<br><br>Audits will be taken to the QAAC meeting at least quarterly. | 12-1-07 |

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| F 282 | Continued From page 9 | F 282 | | |

2. Review of the 1/18/07 bowel and bladder assessment for resident #1 revealed s/he should be offered and assisted to the bathroom every two hours to help increase and maintain his/her continence. Review of the 10/2/07 care plan revealed the resident was to be offered and assisted to the bathroom every two hours. Interview with certified nurse aide (CNA) #1 on 10/16/07 at 11 AM revealed the resident was to be toileted every two hours to maintain his/her continence. However, observation on 10/16/07 from 7/30 AM until 10:25 AM (2 hours and 55 minutes) revealed the resident was not offered or assisted to the bathroom during that time.

F 283 SS=D 483.20(l)(1)&(2) DISCHARGE SUMMARY

When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to develop a discharge summary for one (#39) of one sample resident who was discharged to another facility. The findings were:

Review of the closed medical record showed resident #39 was discharged to a psychiatric hospital on 9/1/07. Further medical record review revealed a discharge report; however, the section

F 283: The facility strives to ensure discharge planning is completed. Recapitulation will be completed on Resident #39 by interdisciplinary care team. Each Resident with a planned discharge will have a discharge summary completed.

Prior to discharge, the summary will be reviewed by the interdisciplinary care team to ensure completion. 12-1-07

F 283

Results of the reviews will be taken to QAAC at least quarterly.

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| F 283 | Continued From page 10<br>titled "Recapitulation of resident's stay; including post-discharge plan of care which will assist the resident to adjust to his/her new living environment" was blank. Interview on 10/18/07 at 8:10 AM with RN #1 confirmed a discharge summary, including a recapitulation of the resident's stay, was not done. The RN said "It fell through the cracks." | F 283 | | |
| F 309 SS=D | 483.25 QUALITY OF CARE<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and medical record review, the facility failed to ensure staff administered medications and provided testing as ordered to manage two (#4, #18) of two sample residents who required insulin to treat diabetes. The findings were:<br><br>1. Review of the 10/07 physician's order recapitulation for resident #4 revealed s/he had diagnoses including diabetes. Review of the 10/1/07 physician's order revealed the resident was on sliding scale regular insulin for management of his/her diabetes. Review of the 10/07 Medication Administration Record (MAR) and the blood glucose data sheet revealed there was no evidence the resident had his/her blood sugar test performed or received the corresponding dose of insulin on 10/5/07 (Friday) | F 309 | F309 The facility strives to provide the highest practicable well-being for the Residents.<br><br>Residents #4 and #18 will have the results of the blood sugar testing and insulin dosage documented in the record. by nursing<br><br>All nurses will be inserviced by Staff Development for procedure of recording the blood sugar and insulin dosage.<br>of MARS<br>Audits will be completed by the Health Information Manager and/or designee weekly for one month then randomly thereafter for six months to ensure the recording is being done.<br><br>Audits will be taken to the QAAC meeting at least quarterly. | 12-1-07 |



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| F 309 | Continued From page 11<br>and 10/7/07 (Sunday) at 5 AM, and on 10/8/07 (Monday) at 11:30 AM. Interview with the director of nursing (DON) on 10/18/07 at 9:30 AM revealed she was unsure why the diabetic test and insulin administration did not take place unless the resident was out of the building for dialysis during those times. However, review of the medical record revealed the resident received dialysis on Tuesdays, Thursdays and Saturdays.<br><br>2. Review of the 10/07 physician's order recapitulation for resident #18 revealed s/he had diagnoses including diabetes. Review of the 8/27/07 physician's order revealed blood sugar diagnostic testing was ordered twice daily; once fasting in the morning and once two hours after eating a meal. Review of the 10/07 MAR and the blood glucose data sheet revealed the blood sugar testing was not performed on 10/4/07, 10/5/07, and 10/7/07 at 5 AM. Interview with the DON on 10/18/07 at 9:30 AM revealed she was unsure why the diabetic test was not performed on those dates and times. | F 309 | F311: The facility strives to maintain or improve activities of daily living for each Resident.<br><br>The staff assisting Resident #8 will be inserviced by the SDC to follow the activities of daily living (ADL) plan pertaining to toileting.<br><br>All nursing staff will be inserviced by the SDC regarding the ADL plan requirement for each Resident.<br><br>Audits will be completed by the SDC each week for one month then randomly each month for six months. | |
| F 311 SS=D | 483.25(a)(2) ACTIVITIES OF DAILY LIVING<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to provide services to maintain the ability to use the toilet for one (#8) of five sample residents who had that ability. The findings were:<br><br>Observation on 10/16/07 at 9 AM revealed CNA | F 311 | Audits will be taken to the QAAC meeting at least quarterly. | 12-1-07 |

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| F 311 | Continued From page 12<br>#3 transferred resident #8 into bed without taking the resident to the toilet first. The CNA then checked the resident for incontinence once the resident was in bed.<br>The 3/30/07 and 9/22/07 bowel and bladder assessment revealed the resident would be checked every two to three hours and changed as needed. The 10/2/07 care plan showed staff should check and change the resident every two hours. The October 1-15, 2007 activities of daily living sheets showed the resident did not use the toilet.<br>On 10/18/07 at 8:15 AM the director of nursing (DON) was asked why this resident did not use the toilet since s/he was a one person transfer. The DON replied the resident was on hospice. The DON then looked through the medical record and stated that the resident was able to use the toilet, and staff should be putting the resident on the toilet. | F 311 | F315 The facility strives to ensure appropriate use of catheters.<br><br>Resident #23 will be assessed for catheter placement. ung appropriate physician order obtained<br>Nursing staff will be inserviced by SDC regarding appropriate assessment and documentation for catheter placement.<br><br>All Residents will be assessed and documentation present prior to catheter placement. Audits will be completed monthly for six months by Health Information Manager to ensure assessment and documentation is present.<br><br>Audits will be taken to QAAC at least quarterly. | 10-1-07 |
| F 315<br>SS=D | 483.25(d) URINARY INCONTINENCE<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and medical record review, the facility failed to ensure there was a medical reason for insertion of an | F 315 | | |

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| F 315 | Continued From page 13<br>indwelling catheter for one (#23) of three sample residents who had catheters. The findings were:<br><br>1. Periodic observation on 10/15/07, 10/16/07, and 10/17/07 revealed resident #23 had an indwelling urinary catheter. Review of the physician's orders revealed there was no order for the catheter. In addition, review of the medical record revealed there was no evidence of medical signs and symptoms that indicated there was medical necessity for the indwelling catheter. Interview with the director of nursing (DON) on 10/18/07 at 9:30 AM revealed she thought the resident's catheter was inserted on 10/15/07. Interview further revealed she was not aware there was no physician's order and no evidence of medical necessity for the catheter in the medical record. | F 315 | F323: The facility strives to ensure Residents environment remains as free of accident hazards as is possible. Resident #39 is no longer living @ facility. All admission will have a risk for elopement assessment completed at or before time of admission.<br><br>All current Residents will have a risk for elopement assessment completed. by social services | |
| F 323 SS=D | 483.25(h) ACCIDENTS AND SUPERVISION<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to assure one (#39) of one sample resident who eloped from the facility received adequate supervision to keep the resident safe and minimize the risk for subsequent elopements. The findings were:<br><br>1. Review of the admission face sheet showed | F 323 | All Residents will be reviewed for risk of elopement at the time of the quarterly care plan. Documentation of reviews of elopement assessments will be kept at each care plan meeting.<br><br>All staff will be inserviced by SDC regarding the requirement of keeping the bathing room doors locked at all times.<br><br>Audits will be completed by Charge Nurses, Supervisory staff and CNA staff daily for two weeks to ensure doors are locked. Audits | |

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| F 323 | Continued From page 14 | F 323 | | |

resident #39 was admitted to the facility on 8/7/07 with diagnoses including alcohol-induced persistent dementia, depressive disorder, and senile dementia. Interview with the social worker on 10/17/07 at 3:30 PM revealed the resident was transferred to the nursing home from a psychiatric facility for a "30 day trial." On 8/7/07 a daily skilled nursing note timed at 6 PM documented the resident was found conversing with people across the street at the gas station. The note further documented the resident was at risk for elopement. The following concerns were identified:

a. On 8/10/07 a social services note documented the resident "currently has an exit alarm due to wandering this is to alert staff that [resident] is outside." The note did not address the 8/7/07 elopement.

b. On 8/24/07 a nurse's note documented the resident eloped from the facility and was picked up by facility staff with a vehicle. The note further documented that as the vehicle slowed down, the resident jumped from the moving vehicle. The police were informed and brought the resident back to the nursing home.

c. On 8/29/07 a note documented by licensed practical nurse (LPN) #3 and timed at 11 PM documented the resident was last seen at 7 PM. At approximately 8:30 PM the nurse went to give the resident his/her medications; however, the resident was not in the facility. The facility grounds were searched and the police were notified. The police found the resident and transported him/her back to the facility.

d. Review of the entire medical record showed no evidence an elopement assessment was performed to determine the supervision needs of the resident to keep him/her safe.

e. Review of the resident's care plan

F323 cont'd:
will be completed weekly for one month and randomly thereafter for three months.

Documentation and audits will be taken to the QAAC meeting at least quarterly. 12-1-07

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| F 323 | Continued From page 15 | F 323 | | |

revealed a problem was added on 8/21/07 (2 weeks after the 8/7/07 elopement) that documented the resident "has been observed to attempt to leave the facility grounds without escort." The care plan did not address the 8/7/07 or 8/24/07 elopement, or the use of an exit alarm. During an interview with the social worker on 10/18/07 at 8:30 AM she said she thought the care plan was updated; however, an updated care plan could not be found.

f. Interview on 10/18/07 at 9:30 AM with LPN #3, who was working on 8/29/07 when the resident eloped, revealed she never saw a care plan that addressed the resident's elopements and approaches to keep the resident safe.

g. Interview with registered nurse (RN) #1 on 10/17/07 at 5 PM revealed the resident frequently went outside to smoke. The RN further said she thought 30 minute checks should have been implemented following the 8/24/07 elopement.

h. During an interview with the social worker on 10/18/07, she said she had reviewed the entire medical record and confirmed an elopement assessment was never performed.

Continued to next page

Based on observation, staff interview, and review of Material Safety Data Sheets (MSDS), the facility failed to assure potentially hazardous materials were properly stored in one of two bathing rooms. The findings were:

Observation on 10/15/07 at 5:15 PM revealed the door to the east bathing room was unlocked. Inside the room was an unlocked cabinet which contained two containers (1 gallon each) of Classic whirlpool disinfectant cleaner. The containers were labeled with "danger..keep out of reach of children." Observation on 10/17/07 at 12:50 PM revealed the door to the east bathing

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| F 323 | Continued From page 16<br>room was wide open and the cabinet doors were open. The chemicals were still in the cabinet.<br>During an interview on 10/18/07 at 10 AM, certified nurse aide (CNA) #4 and the director of nursing (DON) stated the chemicals should be locked up. When asked if the bathing room door or the cabinet should be locked, they replied "both."<br>Review of the Material Safety Data Sheet (MSDS) for Classic whirlpool disinfectant cleaner revealed "...will cause eye irritation and skin irritation with prolonged exposure. Can be harmful if swallowed or if spray mist is inhaled..." | F 323 | | |
| F 329 SS=D | 483.25(l) UNNECESSARY DRUGS<br><br>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.<br><br>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. | F 329 | F329: The facility strives to ensure each Resident's drug regimen is free from unnecessary drugs.<br><br>Resident #8 will be assessed for need of a sleep aide by using a comprehensive sleep assessment. by nursing Need for a sleep aide medication and/or non-pharmacological interventions will be determined upon completion of assessment.<br><br>Resident #18 will be assessed for need of medication for relief from insomnia by using a comprehensive sleep assessment by nursing Need for a sleep aide medication and/or non-pharmacological interventions will be determined upon completion of assessment. | |

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| F 329 | Continued From page 17 | F 329 | | |

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review and staff interview, the facility failed to assure the drug regimen was free of unnecessary medications for 2 (#8, #18) of 10 sample residents. In addition, the facility failed to ensure staff identified and assessed the potential side effects of psychotropic medications for one (#1) of five sample residents who received psychotropic medications. The findings were:

1. Review of physician's orders dated 2/21/07 showed resident #8 had an order for 10 mg of Ambien at bedtime. Review of the medication administration records (MARs) revealed the resident received it each night, except it was held nine times in August, three times in September, and three times in October. The following concerns were noted:

a. Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, depression, etc. In fact, review of the medical record showed no evidence the resident had insomnia.

b. Review of physician's orders showed on 2/21/07 at 1:10 PM the physician ordered 0.5mg of lorazepam every six hours, as needed for agitation. Hospice notes showed that on 2/21/07 the resident was "restless." Nursing notes dated 2/21/07 showed the lorazepam was held and the physician was called for an alternate medication due to an allergy. On 2/21/07 at 3:45 PM the physician phoned in the alternate medication

F329 cont'd:
Resident #1 will have ~~an~~ assessment completed to determine if the medication is causing side effects by utilizing. The physician will be contacted with the results of the assessment.

All Residents will have appropriate assessments completed regarding drug regimen appropriateness. The assessments will be reviewed quarterly at care plan meetings to determine if assessments are completed appropriately and/or additional assessments are necessary; if any change in medication is needed. 12-1-07

Documentation of review of assessments will be completed at each care plan meeting.

Documentation will be taken to the QAAC meeting at least quarterly.

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which was 10mg of Ambien at bedtime; the medication was ordered routinely. The medical record lacked evidence the resident required the use of a hypnotic nightly. Furthermore, there lacked evidence other non-pharmacological interventions were tried first.

c. There was no evidence that a dose reduction had been attempted since the initiation of the medication on 2/21/07.

d. On 10/18/07 at 8:15 AM, the director of nursing (DON) and social services director looked through the medical record and stated there was no assessment for the use of the Ambien. The social services director stated she thought the resident received the medication because of "hospice." On 10/18/07 at 8:55 AM the hospice registered nurse (RN) stated the resident probably received the Ambien because of "history of joint pain and not sleeping." The RN stated she was not the case manager at the time the Ambien was ordered and she was not sure of the rationale.

Continued on next page

2. Review of the 8/24/07 physician's orders for resident #18 revealed Benadryl 25 mg was ordered as needed for insomnia. Review of the 10/07 MAR revealed the resident received the medication four times from 10/1/07 to 10/16/07. The following concerns were noted:

a. Review of the medical record revealed there was no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, depression, or other reasons.

b. Review of the medical record revealed there was no evidence any non-pharmacological interventions were attempted prior to utilization of

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the medication.

c. According to the "Geriatric Dosage Handbook" by Semla, Beizer, and Higbee, 12th Edition, 2007, page 438, under special geriatric considerations the use of Benadryl as a sleep aid "is discouraged due to its anticholinergic (side effects including dry mouth and blurred vision) effects in the elderly.

d. Interview with the DON on 10/18/07 at 9:30 AM revealed she was unsure why the resident was not assessed for insomnia and why no non-pharmacological interventions were attempted.

3. Observation on 10/15/07 at 4:25 PM and periodic observations on 10/16/07, and 10/17/07 revealed resident #1 was exhibiting tongue thrusting and repetitive chewing movements on a frequent basis. Review of the psychotropic drug side effect monitor policy utilized by the facility revealed the definition of tardive dyskinesia was involuntary movements such as thrusting and chewing movements. According to "Taber's Cyclopedic Medical Dictionary," 20th Edition, 2001, pages 649 and 650, tardive dyskinesia "is a neurological syndrome marked by slow, rhythmical, automatic stereotyped movements... These occur as an undesired effect of therapy with certain psychotropic drugs, ...." Review of the medical record revealed the resident had a history of receiving the antipsychotic, Zyprexa, the anti anxiety drug, Ativan, and the antipsychotic, Abilify. Review of the 10/07 MAR revealed the resident currently received Abilify routinely and Ativan as needed. The following concerns were identified:

a. Review of the entire medical record revealed there was no evidence the tongue thrusting and chewing motions were identified as

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| F 329 | Continued From page 20<br>potential side effects to psychotropic medications.<br>b. Review of the entire medical record revealed there was no evidence there had been an assessment of the repetitive tongue thrusting and chewing motions.<br>c. Interview with the social services director and the director of nursing on 10/18/07 at 11:30 AM revealed they had both noticed the movements "this week" but had done no assessment. Further interview with the social worker revealed she thought the movements occurred because the resident did not wear his/her dentures. | F 329 | | |
| F 364 SS=D | 483.35(d)(1)-(2) FOOD<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and review of policies and procedures, the facility failed during one of one meal observation to assure hot food was served at a proper temperature. The findings were:<br><br>Confidential interview with eleven residents on 10/16/07 at 11:30 AM revealed foods served were not always hot enough.<br><br>Observation during the preparation of lunch on 10/17/07 at 11:43 AM revealed the baked chicken was 170 degrees Fahrenheit (F) when removed from the oven and placed on the steam | F 364 | F364: The facility strives to provide food at temperature pleasing to all Residents.<br><br>The steam table will be set at a temperature to hold the food at a temperature per policy.<br><br>Temperatures of the food will be taken at random each meal by cook when placed on the dishes to be served to the Residents for one week and recorded.<br><br>Temperatures will be taken at random meals three times per week and documented.<br><br>Documentation will be taken to the QAAC meeting at least quarterly. | 10-1-07 |

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| F 364 | Continued From page 21<br>table. At that time the dietary manager commented all food items on the steam table should be "no less than 140 degrees." The following concerns were noted with maintaining proper hot food temperatures:<br>On 10/17/07 at 1:21 PM a test tray showed the baked chicken was 115 degrees F. When tasted, the temperature of the chicken was warm. At 1:26 PM the dietary manager took the temperature of a piece of chicken on the steam table and that temperature was also 115 degrees F.<br>During an interview with the dietary manager on 10/18/07 at 8:50 AM she said the temperature gauge for the steam table well was not set high enough to maintain the temperature of the chicken.<br>Review of the facility policy titled "Food Temperature Record" dated 1/1/90, revealed "Hot food on the steam table should be at least 160 - 165 degrees F and arrive at approximately 140 degrees F when the resident is served."<br>According to the Food Code, U.S. Public Health Service, Food and Drug Administration, 3-501.16: Potentially Hazardous Food, Hot and Cold Holding: "(A) Except during preparation, cooking, or cooling...potentially hazardous food shall be maintained: (1) At 57 degrees C [Celsius] (135 degrees F) or above..." | F 364 | F368: The facility strives to ensure a bedtime snack is offered to all Residents.<br><br>Staff will be inserviced by SDC to offer bedtime snacks to all Residents.<br><br>Charge Nurses will document that staff has offered bedtime snacks to all Residents.<br><br>Documentation will be taken to QAAC meeting at least quarterly. | 12-1-07 |
| F 368<br>SS=E | 483.35(f) FREQUENCY OF MEALS<br><br>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.<br><br>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. | F 368 | | |

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The facility must offer snacks at bedtime daily.

When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

Continue to next page

This REQUIREMENT is not met as evidenced by:
Based on resident and staff interview, policy and procedure review, and review of the bedtime snack list, the facility failed to assure a bedtime snack was offered to each resident residing on two of two nursing wings. The findings were:

The following concerns were noted with offering each resident a bedtime snack:

a. During a confidential interview on 10/17/07 at 5 PM, a resident stated the facility offered snacks during the day, but not at night. The resident stated s/he would like a bedtime snack.

b. Confidential resident interview on 10/16/07 at 9:40 AM revealed at times s/he wanted a bedtime snack; however, s/he had to ask the nursing staff before receiving one.

c. Interview with certified nurse assistant (CNA) #5 on 10/17/07 at 5:12 PM revealed residents who were offered bedtime snacks were "all diabetics and others who request one."

d. Interview with registered nurse #1 on 10/17/07 at 5:15 PM revealed bedtime snacks are offered to "all diabetics and three or four other residents who always want one."

e. Interview with the dietary manager on 10/18/07 at 9:50 AM confirmed residents with a

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| F 368 | Continued From page 23<br>diagnosis of diabetes and a few other residents are offered a bedtime snack. Review of the "HS [bedtime] snack" list at that time confirmed bedtime snacks were prepared for six residents with a diagnosis of diabetes and four other residents. The dietary manager further commented she was unaware that all residents should be offered a bedtime snack.<br><br>Review of the facility policy titled, "Nourishments" dated 1/1/90 revealed "Appropriate HS nourishments will be offered to all residents unless contraindicated by the diet order. | F 368 | F371: The facility strives to provide sanitary conditions.<br><br>Staff will be inserviced by the Registered Dietician pertaining to storing position of meats in refrigerator, appropriate manner to thaw frozen foods, appropriate storage containers for left-over foods and appropriate timing of discarding left-over foods.<br><br>Auditing will be completed by the Dietary Manager and/or designee daily for one week and randomly weekly for six months.<br><br>Audits will be taken to the QAAC meeting at least quarterly. | 12-1-07 |
| F 371 SS=F | 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE<br><br>The facility must store, prepare, distribute, and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of policies and procedures, the facility failed during four of four days of survey to minimize the potential for food-borne illness. The facility failed to properly store and thaw frozen meat and to assure left-overs were stored in appropriate containers and discarded in a timely manner. The findings were:<br><br>1. Observation in the walk-in refrigerator on 10/16/07 at 2:40 PM revealed a plastic bag of raw frozen hamburger patties were stored on a pan on the second shelf. Directly below the raw meat was a plastic container of cherry pie filling. Interview with the dietary manager on 10/18/07 at | F 371 | | |

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8:50 AM revealed the raw hamburger was placed in the refrigerator to thaw. She further commented it was facility policy to never store raw meat directly above other food items.

According to the Educational Foundation (National Restaurant Association) 2004, ServSafe course book. Chicago, Ill: National Restaurant Association, Educational Foundation, page 8-4 and 8 - 5, raw meat should never be stored above cooked or ready to eat food because raw meat juices may drip and cross contaminate other food.

2. Observation on 10/16/07 at 3:42 PM revealed a package of white meat was in the sink in a pan of standing water. Interview with dietary aide #1 at that time revealed the bag contained frozen sliced turkey and was placed in the water at 2 PM to thaw. The dietary aide further commented this was a "usual" method for thawing meat. During an interview with the dietary manager on 10/18/07 at 8:50 AM she said thawing meat in standing water was not an acceptable food handling practice.

According to Food Code 2005, U.S. Public Health Service 3-501.13, Thawing. ...Potentially hazardous foods shall be thawed: ...B) Completely submerged under running water...

3. Observation in the reach-in refrigerator on 10/15/07 at 3:04 PM revealed re-used five-pound cottage cheese containers were used to store left-over carrots, pork chops, and fruit cocktail. Further observation showed left-over cauliflower was stored in a re-used five-quart ice cream container. Interview with the dietary manager at that time revealed it was facility practice to re-use cottage cheese and ice cream containers to store left-over food.

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| F 371 | Continued From page 25<br>According to Food Code 2005, U.S. Public Health Service, 4-502.13: "Single-service and single-use articles may not be reused." The Food Code defines single-use articles as, "...food containers, jars, plastic tubs or buckets..."<br><br>4. Observation on 10/15/07 at 3:04 PM showed a re-used five-pound container of cottage cheese labeled, "fruit cocktail 10/10." Interview at that time with the dietary manager revealed the fruit cocktail should have been discarded after 2 days.<br>Review of the facility policy titled, "Sanitary Food Preparation and Service" dated 1/1/90 revealed "Refrigerated leftovers will be used within 48 hours..." | F 371 | F425: The facility strives to provide routines to ensure medications are not out-dated.<br><br>All medication and treatment supplies will be examined to ensure they are not expired by nursery<br><br>A monthly review of all medications and treatments supplies will be completed by nursing staff.<br><br>Documentation of the reviews will be taken to the QAAC meeting at least quarterly. | 12-1-07 |
| F 425 SS=D | 483.60(a),(b) PHARMACY SERVICES<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. | F 425 | | |

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| F 425 | Continued From page 26<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure there were no expired medications available for administration to residents in two of two medication carts, one of one medication room, and one of one treatment cart. The findings were:<br><br>Observation on 10/18/07 at 9:30 AM revealed the following expired medications were available for administration to residents in the medication room: 4 bottles of bisacodyl (laxative) 5 milligrams (mg) and 2 bottles of Diphenhydramine (antihistamine, sleep aid) 25 mg. Observation of the east medication cart revealed there was one bottle of Diphenhydramine that expired on 3/6/07. Observation of the west medication cart revealed there was one bottle of aspirin 81 mg that expired on 9/16/07. Finally, observation of the treatment cart revealed there were the following expired items available for use: ten PDI compound Benzoin Tincture USP 10% swabsticks that expired in 12/06, one steri cath closed ventilation suction system (endotracheal) that expired in 1/05, three carboflex sterile 4 X 4 dressings that expired 1/07, and four bottles of Biolex wound cleanser that expired in 9/07. Interview with registered nurse (RN) #1 and #2 at the time of the observations confirmed these medications and treatment items should not have been available for resident use. | F 425 | F444: The facility strives to ensure hand washing by all staff.<br><br>The CNA observed will be inserviced for appropriate hand washing by the SDC.<br><br>Audits will be completed by the SDC pertaining to observation of appropriate hand washing by all staff randomly each week for one month and randomly thereafter.<br><br>Audits will be taken to the QAAC meeting at least quarterly. | 12-1-07 |
| F 444 SS=D | 483.65(b)(3) PREVENTING SPREAD OF INFECTION<br><br>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted | F 444 | | |

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| F 444 | Continued From page 27<br>professional practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure adequate handwashing was performed during one of two meal observations. The findings were:<br><br>Observation on 10/16/07 at 8 AM revealed certified nurse aide (CNA) #2 sneezed and coughed. She obtained a tissue from the medication cart to blow her nose. After discarding the tissue, the CNA served meal trays without first washing her hands. Observation revealed the CNA did the same thing at 8:21 AM and 8:28 AM. Interview with the infection control coordinator on 10/17/07 at 3:40 PM revealed the CNA should have washed her hands after coughing, sneezing or blowing her nose. Review of the facility's policy and procedure on handwashing, undated, revealed instructions to wash your hands "after sneezing, coughing, or blowing your nose." | F 444 | | |
| F 465 SS=D | 483.70(h) OTHER ENVIRONMENTAL CONDITIONS<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed on four of four days of survey to assure the kitchen and four of four resident | F 465 | F465: The facility strives to provide a safe, functional, sanitary and comfortable environment for Residents, staff and the public.<br><br>Kitchen: the doors to the cabinets will be repaired/replaced; the cabinet drawer will be repaired; the ceiling above the walk in refrigerator will be repaired to prevent dripping by Maintenance Supervisor.<br><br>The lower half of the corridor walls will be repaired/replaced by contractor to enable this area to be routinely cleaned. by housekeeping<br><br>The area will be cleaned when needed and a schedule for routine cleaning of the area will be developed and documented by Housekeeping Supervisor.<br><br>The documentation will be taken to the QAAC meeting at least quarterly. 12-1-07 | |

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hallways were maintained in a functional and sanitary manner. The findings were:

1. Observation in the kitchen on all days of the survey revealed the following maintenance problems:

a. Four doors were missing from the kitchen cabinets. Interview with the dietary manager on 10/16/07 at 3:45 PM revealed the door hinges broke "at least one year ago" and were never repaired.

b. A cabinet drawer containing serving utensils was placed either on the top of the cabinet, or on top of the chest freezer. Interview with the dietary manager on 10/15/07 at 3:17 PM revealed the roller guides for the drawer were not functional. The dietary manager said this had been a problem for "several months."

2. Observation on 10/15/07 at 3:05 PM and on 10/18/07 at 8:50 AM showed a dark substance had dripped from the ceiling down the front of the door to the walk-in refrigerator. Interview with the dietary manager at that time revealed the substance was from the "attic" and had been a problem for "a full year."

3. Observation on 10/17/07 at 11:30 AM revealed the lower half of all the corridor walls contained a colored protective covering. The coverings were discolored with numerous white splotches throughout the facility. On 10/18/07 at 9:53 AM the housekeeping supervisor stated she thought the white splotches were caused by some type of chemical and they couldn't be removed. During an interview on 10/18/07 at 12:30 PM the administrator stated the coverings were put on years ago, and something needed to be done with them.

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| F 502 SS=D | 483.75(j)(1) LABORATORY SERVICES<br>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and medical record review, the facility failed to ensure laboratory tests were performed as ordered for two (#1, #23) of 9 sample residents. The findings were:<br><br>1. Review of the 6/27/07 physician's orders for resident #23 revealed an order for a TSH (thyroid stimulating hormone) test. Review of the medical record revealed there was no evidence this test was performed.<br><br>2. Review of the medical record for resident #1 revealed a physician's order for a TSH test every three months. Review of the medical record revealed there was no evidence the test was performed in June 2006 as scheduled.<br><br>3. Interview with the director of nursing (DON) on 10/18/07 at 9:30 AM revealed she was unsure if these tests were completed. As of 10/25/07, the DON had been unable to locate evidence these tests were completed. | F 502 | F502: The facility strives to provide laboratory services.<br><br>Resident #1 and #23 will have the TSH testing completed. *by 12/1/07*<br><br>Laboratory testing requirements will be reviewed for all Residents by the DON and/or designee.<br><br>Laboratory testing requirements for all Residents will be reviewed at each quarterly Resident care plan meeting.<br><br>Results of reviews will be taken to the QAAC meeting at least quarterly. | 12-1-07 |