STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145705	A. BUILDING _____ B. WING _____	01/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGIL CALVERT N & REHAB CTR	**5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Certification Survey Licensure Special Survey Complaint Investigation # 1140047/IL51332 - F312 F253 Complaint Investigation # 1045067/IL51189 - F312 Complaint Investigation # 1140094IL51387 - F469	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide undergarments and socks for one (R3) of 11 sampled resident. The facility failed to ensure that hot water temperatures were at a comfortable level for 2 (R5, and R11) of 15 sampled residents. Findings include: 1. The Minimum Data Set (MDS) of 11/18/10, assesses R3 as moderately impaired with cognition, incontinent of bowel and bladder, and requires extensive assistance with personal	F 246		

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

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F 246	Continued From page 1 hygiene. During tour of the facility on 1/11/11, at 10:00 AM, E11, Licensed Practical Nurse, LPN, reported R3 has no family involvement in her care at the facility. On 1/11/11 at 1:00 PM E10 and E12, Certified Nurses Aides, (CNA's) provided incontinent care for R3. R3's pants, socks, and incontinent pad were heavily soaked with urine. When E10 removed R3's soiled pants , no underwear or incontinent brief was observed. R3 stated, "I need some of those pads for when I pee." When asked why incontinent briefs were not used for R3, E10 stated, "We can't put them on unless they tell us to." When E10 was asked if R3 had any underwear, she stated, "If she got them they're raggedy." E10 put clean pants on R3 without undergarments or an incontinent brief. On 1/12/10 at 9:50 AM and at 1:40 PM, R3 was sitting in her geriatric chair wearing socks labeled with the name of her roommate in large black letters. R3 stated, "I guess I got no clean socks." R3 reported the staff obtained the socks she was wearing from her roommate's drawer. 2. On 1/12/11 at 9:55 AM R11 complained of cold water in the sink. At 9:55 AM the water temperature from the hot tap was 70 degrees Farenheit. 3. On 1/12/11 R5's hot water in the sink was 74 degrees Farenheit.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain rooms, and equipment for 5 (R1, R2, R5, R11, and R12) sampled and one (R20) off sampled resident. 1. On 1/10/11 at 9:40 AM, R1 was in bed on her left side with a gastrostomy tube connected to a mechanical feeding pump. R1's right siderail was coated with dried feeding solution. Dried feeding solution was on the wall near the headboard of R1's bed. Feeding solution was dried on the tube feeding pole. R1's privacy curtain was soiled with dried debris. R1's geriatric chair arms were soiled with dried debris. On 1/11/11 at 10:10 AM and 1:15 PM R1's wall behind her bed, right siderail, tube feeding pole, privacy curtain and geriatric chair remain soiled. A bedpan was on the floor of the bathroom at 1:15 PM and 2:50 PM with dried fecal material on the seat. 2. On 1/10/11 at 9:38 PM and 12:05 PM R2's floor was dirty with dried debris. A glucometer test strip, soiled dressing, and a soiled Exelon patch labeled with an unreadable date was noted on the floor near R2's bed. E6, Licensed Practical Nurse, LPN, picked up the soiled Exelon transdermal patch from the floor and disposed of it. E6 confirmed the date on the patch was unreadable, and checked to see if R2 had a current Exelon patch applied. On 1/11/11 at 10:00 PM dried feeding solution was in a puddle on the floor near R2's mechanical feeding pump. At 12:30 the dried feeding solution remained on the floor. 3. During tour of F-hall on 1/10/11 at 2:40 PM	F 253		

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F 253	Continued From page 3 R12 and R20's bathroom floor was soiled with dried gray debris. R12 and R20 were receiving enteral feedings via a gastrostomy tube and mechanical pumps. R12's tube feeding pole was soiled with dried feeding solution. R20's mechanical pump was soiled with dried enteral feeding solution. 4. On 1/12/11 at 9:55 AM R11 was sitting in a wheelchair in his room.. R11's wheelchair arm is split, with exposed foam. The walls are marred, scraped, with exposed plaster. The door to the bathroom is scratched deeply. The room was cluttered, bedspread stained. 5. On 1/12/11 R5's door to the hallway was scraped, wood veneer was split and peeling on both sides of the door. The cabinet around the sink had chipped veneer around the perimeter of the doors. The bathroom door was deeply scratched and scraped. 6. A geriatric chair was in the hallway of the F-hall on 1/10/11 at 2:45 PM. The geriatric chair was soiled with a dried red solution on the inside of the right chair arm. A hydration cart soiled with dried red solution on both shelves was also in the hall	F 253		
F 254 SS=C	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the Facility does not always provide residents with bed and	F 254		

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F 254	Continued From page 4 bath linens which are in good condition. Findings include: 1. During the initial tour and throughout all days of the survey, it was noted that incontinent pads, bedspreads, and sheets are worn, dingy, and threadbare. The incontinent pads are rough, worn, and lumpy. The bedspreads are bleached out from washing and contain a faint hint of a pattern. The sheets are grey and thin. This was noted throughout the facility - in resident's rooms, on linen carts and in the laundry room. This was confirmed during the daily meeting with E1, Administrator, on 1/13/11.	F 254		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to provide adequate and timely incontinent care for 2 (R3, and R6) of 5 sampled residents observed for incontinent care. Findings include: 1. A review of R6's physician order sheet dated 1/1/11 indicated a diagnoses in part of Diabetes, and Osteoarthritis. Review of the most recent Minimum Data Set (MDS) dated 12/29/10,	F 312		

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F 312	Continued From page 5 indicated R6 is an assist of two staff for all transfers, and hygiene activities. A review of R6's care plan dated 12/30/10 indicated R6 is to be checked for incontinence and offered the toilet at least every two hours. On 1/12/11 at 1:10 PM R6 was transferred from her wheel chair to the bedside commode by E16, E5, and E17, Certified Nurse Aides, CNA's. R6 had a heavy urine odor, and the buttocks side of her pants were wet when she stood. The wheel chair had a puddle of urine in the seat where R6 had been sitting. Once on the commode, E5 and E6 removed R6's wet disposable undergarment from between her legs, but not her wet pants. At 1:17 PM R6 indicated she was done on the commode, and E17 and E18, CNA's, began to pull up R6's pants. At this time they were interviewed regarding R6's pants being wet and they both said they didn't think so. E17 and E18 were reminded that R6's wheel chair seat was wet when she got up. At this time E18 and E18 looked at R6's pants and stated "Oh, the pants are wet, we'll have to change them." 2. The MDS dated 11/18/10 assesses R3 as requiring extensive assistance with personal hygiene and is incontinent of bowel and bladder. The Physician's Order Sheet for 1/2011 documents an order for the diuretic medication, Furosemide 20 milligrams twice daily. The Braden Scale, dated, 11/18/10, assesses R3 as a high risk for the development of pressure ulcers. On 1/11/11 at 10:25 AM and 12:55 PM R3 was observed in a geriatric chair smelling strongly of urine. At 1:00 PM, R3 was transferred to bed. R3's pants, socks, and the incontinent pad that was in her geriatric chair were soaked with urine. A dressing soaked with urine was on	F 312		

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F 312	Continued From page 6 R3's coccyx. E10, CNA, cleansed R3's vaginal area in an up and down motion, five times with same surface area of the wash cloth. E10 did not cleanse R2's lower abdomen or inner thighs. E10 rinsed the same cloth in the sink, reapplied soap, and washed the back of R3's legs and feet. E10 failed to properly cleanse R3's buttocks and rectal area. E10 did not place underpants or an incontinent brief before placing a clean pair of pants and socks on her. On 1/12/11 at 9:50 AM R3 was sitting in her geriatric chair, smelling strongly of urine. R3 reported she was placed on the toilet at 9:00 AM, and reported, "I got a diaper on now, the throw away kind, in case I pee on myself." R3 remained in the geriatric chair, smelling of urine at 11:05 AM, 11:37 AM, 12:00 PM, 12:20 PM, 12:35 PM, and 12:55 PM. At 1:17 PM, R3 was transferred to bed by E20 and E21, CNA's.. The disposable incontinent brief was soaked with urine. At 1:35 PM R3 was transferred back to the geriatric chair, without underwear or an incontinent brief applied. R3's Care Plan, dated 11/19/11, reads, "She (R3) is nonambulatory, geri-chair bound, incontinent of bladder, at times bowel, requires assistance with ADL's (activities of daily living). An intervention reads, "Monitor for incontinence every 2 hours, clean, dry, change clothes, apply (barrier) ointment PRN (as needed)."	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		

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F 314	Continued From page 7 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to timely turn, reposition, and ensure appropriate monitoring and treatment of pressure ulcers was done for 3 (R6, R3, and R5) of 4 sampled residents with pressure ulcers. Findings include: 1. A review of R6's physician order sheet, POS, dated 1/1/11, indicated a diagnoses in part of Diabetes, and Osteoarthritis. and on 12/29/10, Duoderm times 2 weeks then discontinue was issued. Review of the most recent Minimum Data Set (MDS) dated 12/29/10, indicated R6 is an assist of two staff for all transfers, and hygiene activities. A review of R6's most recent care plan dated 12/29/10, indicated R6 had recently healed a pressure ulcer on her right buttock, and was to have duoderm on for 2 weeks to protect the newly healed area. The care plan indicated R6 is to be checked for incontinence and offered the toilet at least every two hours. Turn and reposition every 2 hours in bed and every 1 hour when in wheel chair. On 1/11/11 at 1:20 PM E9, Licensed Practical Nurse, LPN, indicated R6 previously had a pressure ulcer that had healed, and no longer had any treatment to the area. On 1/12/11 at 12:15 PM E9 indicated R6 no longer had any treatment to her right buttocks	F 314		

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F 314	Continued From page 8	F 314		

and no longer had any open areas that she (E9) was aware of.

On 1/12/11 at 1:10 PM R6 was transferred from her wheel chair to the bedside commode by E16, E5, and E17, CNA's. R6 had a heavy urine odor, and the buttocks side of her pants were wet when she stood. The wheel chair had a puddle of urine in the seat where R6 had been sitting. E16 and E17 removed R6's soiled disposable undergarment and sat her onto the commode.

As R6 sat on the commode, it was observed that there was duoderm dressing on R6's right inner buttock. The dressing was blood stained, was wet, and soiled brown and yellow. The duoderm dressing had partially come loose from R6's buttocks, and was wrinkled up off the affected area of R6's buttocks. The exposed area under the duoderm appeared to have a newly opened small Stage 2 area that was bright red.

On 1/12/10 at 1:15 PM E16, E5, and E17, CNA's, still had not noticed the duoderm. At this time the surveyor intervened and all three CNA's came and looked at the soiled duoderm and stated they were not aware R6 had a dressing on her buttocks. All three CNA's stated they had not put R6 into the wheel chair that day. All three CNA's indicated R6 had been gotten up around 6:30 AM by the night shift, and she had been sitting in her wheel chair all morning.

In an interview with R6, she stated that she had gone to the bathroom before breakfast, (8:00 AM), but had not gotten out of her chair since that time. R6 indicated that she knew there was a dressing on her buttocks, but the nurse had not looked at it for several days.

At 1:20 PM E9, came to R6's room and verified that she indeed did have a duoderm dressing on. E9 stated she had not been told about the

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F 314	Continued From page 9 dressing in shift report and therefore had not checked it's condition. E9 indicated that none of the CNA's on duty had mentioned any dressing to her. A review of the nursing notes for R6 dated 12/29/10, 1:00 PM indicated; open area to buttocks healed. MD ordered to continue duoderm x 2 weeks for protection. From 12/30/10 through 1/12/10 the nursing notes failed to indicate any other information regarding the condition of R6's right buttock. A review of R6's treatment record for 1/2011, indicated; Duoderm dressing to Left (not right) buttock every 3 days and prn after cleansing area with wound cleanser. Continue x 2 weeks then discontinue. The record indicated the dressing was changed only on 1/4 and 1/9 (every 4 days). The record indicated that the last time R6's skin was checked by nursing staff was 1/5/11. The Daily Wound Status Monitor log for 1/2011, indicated Right Buttocks. The sheet failed to show any information for the areas: Status of Dressings - intact, leaking, changed, and Symptoms of infection - redness, swelling, exudate, and pain. On 1/13/10 at 3:30 PM, E2, Director of Nursing stated she had no further information as to why staff were unaware of the status of R6's buttocks. E2 indicated the areas on R6's right buttocks were new. E2 indicated R6 at times is non compliant with toileting. E2 stated staff should at least be trying to reposition and toilet R6 at least every 2 hours. 2. The MDS, dated 11/18/10, assesses R3 as requiring extensive assistance with personal hygiene, bed mobility, and is incontinent of bowel and bladder. The Physician's Order Sheet for 1/2011 documents an order for the diuretic	F 314		

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F 314	Continued From page 10	F 314		

medication, Furosemide 20 milligrams twice daily. The Braden Scale dated 11/18/10 assesses R3 as a high risk for the development of pressure ulcers.

On 1/11/11 at 10:25 AM and 12:55 PM R3 was observed in a geriatric chair smelling strongly of urine. At 1:00 PM R3 was transferred to bed. R3's pants, socks, and the incontinent pad that was in her geriatric chair were soaked with urine. No pressure relieving cushion was noted in the geriatric chair. A dressing soaked with urine was on R3's coccyx. The date on the soiled dressing was unreadable. R3's buttocks and upper thighs were heavily creased from sitting on the incontinent pad in the geriatric chair.

On 1/11/11 at 1:05 PM E10, CNA, cleansed R3's vaginal area in an up and down motion, five times with same surface area of the wash cloth. E10, CNA did not cleanse R2's lower abdomen or inner thighs. E10 rinsed the same cloth in the sink, reapplied soap, and washed the back of R3's legs and feet. E10 failed to properly cleanse R3's buttocks and rectal area. E10 did not place underpants or an incontinent brief before placing a clean pair of pants and socks on her. The soiled dressing to R3's coccyx was not changed.

On 1/12/11 at 9:50 AM R3 was sitting in her reclined geriatric chair, smelling strongly of urine. R3 reported she was placed on the toilet at 9:00 AM, and the dressing to her coccyx fell off in the toilet. R3 confirmed the dressing to her coccyx was not changed on 1/11/11. R3 reported, "My back end needs a Band-Aid on it. I got a diaper on now, the throw away kind, in case I pee on myself." R3 remained in the geriatric chair, without repositioning, and smelling of urine at 11:05 AM, 11:37 AM, 12:00 PM, 12:20 PM, 12:35

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F 314	Continued From page 11 PM, and 12:55 PM. On 1/12/11 at 1:17 PM, R3 was transferred to bed by E20 and E21, CNA's.. The disposable incontinent brief was soaked with urine. R3's buttocks and inner thighs were heavily creased. No dressing was on R3's coccyx. A sheared area, with denuded skin was noted to the right upper buttock, near the coccyx. E6, LPN, did a total body skin check after incontinent care was provided. A Stage I, nonblanchable red area was on R3's left inner thigh, where the edge of the incontinent brief had been applied. R3's back was heavily creased. E6, LPN failed to measure the sheared area to the right buttock. E6 failed to measure the Stage II pressure ulcer to R3's left inner thigh. A healed pressure ulcer was noted to R3's coccyx. At 1:30 PM E6 used a gloved hand to pick at the denuded skin on the right buttock, removing some of the tissue. After cleansing R3's coccyx area, a hydrocolloidal dressing was applied and dated by E6. At 1:35 PM R3 was transferred back to the geriatric chair, without barrier cream, underwear or an incontinent brief applied. The Treatment Administration Record (TAR) for January 2011 documents R3's last skin assessment on 1/05/11. No open areas were noted to R3's skin, including buttocks. A Physician's Order, dated, 12/28/10 reads, "Cleanse open area to right buttock with wound cleanser. Apply DuoDerm and change every three days and PRN (as needed)." The TAR shows no documentation the dressing to R3's coccyx was changed on 1//11/11. On 1/12/11, R3's Care Plan was reviewed. The last documentation, dated 11/19/10, shows a pressure ulcer to the left buttock as healed. No further pressure ulcers are addressed. R3's Care Plan, dated 11/19/11, reads, "She (R3) is	F 314		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 nonambulatory, geri-chair bound, incontinent of bladder, at times bowel, requires assistance with ADL's (activities of daily living)." The following interventions read: "Monitor for incontinence every 2 hours, clean, dry, change clothes, apply (barrier) ointment PRN (as needed). Turn every two hours when in bed, every one hour when in geri-chair/wheelchair. Pressure relieving cushion cushion to geri-chair/wheelchair." The facility's policy and procedure for skin breakdown prevention techniques reads, ""Avoiding massage or vigorous rubbing over skin that is at risk for pressure ulcer development, (such as sacrum, coccyx, heels, etcetera)." 3. R5 was admitted to the facility on 12/29/10. R5's Initial Nursing Assessment dated 12/29/10 listed an unstageable pressure ulcer to his right heel. There are no measurements or description of the area on the Initial Nursing Assessment or in Nursing Notes. A Physician's order dated 12/30/10 stated, "Float heels off mattress while in bed.....Follow up with ....(wound management specialist)". As of 1/11/11, R5 had not seen the wound management specialist. On 1/11/11 at 1:15 PM R5 stated he has a "sore" on his right heel. He stated the "sore" developed when he broke his left hip, was placed into a wheelchair, and used the right foot to push himself in the wheelchair. R5 stated he didn't feel the facility was treating the heel. R5 stated that while he resided at home, a home health nurse had measured the area and was changing a dressing daily to his right heel. At 1:20 PM E13, CNA, assisted R5 to transfer from the wheelchair to his bed. R5's socks were removed from both feet. R5 had a large, dark brown, dry eschar noted covering the entire back	F 314		

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F 314	Continued From page 13 surface of his right heel. The unstageable area was surrounded with dry, scaly skin. There was no dressing or covering on his right heel. R5 was left in the bed with his right heel resting directly on the mattress, not floated. On 1/12/11, Z3, Wound Care specialist, evaluated R5's right heel. Z3 stated, "He has an intact eschar on his heel, measuring 4 cm by 5 cm (centimeters).....continue with the same treatment, clean with saline, apply Betadine, and leave open to air." R5 had a Physician's Order dated 1/5/11 that stated, "Continue DuoDerm to sacrum x 2 weeks." On 1/11/11 at 1:20 PM, R5 did not have a DuoDerm in place on his sacrum as directed on the 1/5/11 Physician's Order.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to obtain and send a urine specimen timely, and failed to inform physician of inappropriate/ineffective antibiotic for one (R12) of six residents with Urinary Tract Infections (UTI); and failed to cleanse a perineal	F 315		

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F 315	Continued From page 14 area appropriately to prevent UTI for one (R3) of five residents observed for incontinent care in the sample. Findings include: 1. R12 has a partial diagnoses (from January 2011 Physician's Order Sheet (POS) of: Urethral Stent, Gross Hematuria, UTI. R12's Care Plan dated 10/22/10 described a problem of :..."history of UTI's, returned from hospital on 9/29/10.....UTI..had urethral stenosis ....bilateral stents removed on 7/21/10...". The interventions listed included "obtain labs as ordered, calling results to M.D." R12 saw the urologist on 12/13/10 for a check up prior to replacement of urethral stent. The urologist ordered a urinalysis with culture and sensitivity. On 12/15/10 the specimen was obtained. The laboratory did not receive the specimen until 12/17/10. R5 was started on the antibiotic, Levaquin 500 mg, 1 tablet daily for 10 days....UTI (urinary tract infection) and URI (upper respiratory infection). The culture results received three days later reported 50,000 - 100,000 Pseudomonas aeruginosa. The sensitivity report stated the Pseudomonas organism was "resistant" to treatment with Levaquin. On 1/5/11 a follow-up urinalysis with culture and sensitivity was obtained prior to R12's appointment for placement of urethral stent. R12 was placed on the antibiotic Macrobid on 1/10/11 prior to the procedure. Culture results received by the facility on 1/9/11 reported > (greater than) 100,000 Pseudomonas aeruginosa. The sensitivity results reported the organism was "resistant" to treatment with Macrobid (Nitrofurantoin). There is no documentation that	F 315		

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F 315	Continued From page 15	F 315		

R12's primary physician or urologist was informed of the laboratory results showing ineffective antibiotic for treatment of R5's UTI until 1/13/11, after R12 had the urethral stent replaced on 1/12/11.

On 1/14/11 at 8:45 AM E3, Corporate Nurse Consultant, stated that nursing staff was responsible for reviewing laboratory results and reporting abnormal results to the physician. E3 had no explanation for the two day delay from the collection date until the specimen was received by the laboratory.

The facility's Laboratory Reports/Results Policy stated (in part) that nursing staff will report "all abnormal values to the resident's respective physician within 24 hours or by the next business day..."

The facility's Infection Control Policy, Antibiotic Use Surveillance, stated (in part), "4. Antibiotic surveillance data should be used for assessing appropriate use of antibiotics and establishing appropriate indications for their use within the facility."

2. The Minimum Data Set (MDS) dated 11/18/10 assesses R3 as requiring extensive assistance with personal hygiene and is incontinent of bowel and bladder. The Physician's Order Sheet for 1/2011 documents an order for the diuretic medication, Furosemide 20 milligrams twice daily.

On 1/11/11 R3's laboratory reports were reviewed. A urinalysis report dated 9/15/10 shows results, in part, of cloudy urine (Normal-clear/slightly cloudy), white blood cells 5-15 (normal-0-4), and many bacteria (normal-0). The report shows a urine culture is indicated. A review of the clinical record showed no urine culture and sensitivity report. On 1/11/11 at 2:00

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F 315	Continued From page 16 PM, E7, Registered Nurse, RN, confirmed the urine culture and sensitivity report for R3 had not been received, and called the laboratory for the results. The report dated 9/15/10, and faxed to the facility on 1/11/11 at 2:13 PM reads, in part, "over 100,000 colonies of three or more colony types of mixed urethro-gential flora. Isolates were not pursued. Recollection is advised." E7 reported the recollection of R3's urine for sensitivity was not obtained in September of 2010, as suggested by the laboratory. E7 reported R3's urine should have been recollected. The Nurses Note of 9/13/10 at 11:10 AM reads, "(Z4), physician, phoned related to resident having foul urine with history of UTI (urinary tract infection) and skin breakdown. New order received for UA (urinalysis)." The Nurses Note reflect the urine sample was obtained on 9/15/10, and sent to the laboratory at 1:45 PM. The Nurses Note, dated 9/15/10 at 5:00 PM documents Z4 was notified of the UA results and the culture and sensitivity results are pending. The Nurses Notes show an antibiotic was started on 9/16/10, at 2:00 PM. R3's Care Plan dated 11/19/10 fails to address R3's history and treatment of urinary tract infections in August and September of 2010.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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.	F 323		

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F 323	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure safe transfers, and interventions to decrease the potential for falls for 4 (R7, R6, R3, and R13) of 5 residents on the sample with a history of falls. Findings include: 1. A review of R6's physician order sheet, POS, dated 1/1/11 indicated a diagnoses in part of Diabetes, Left Hemi-paresis and Osteoarthritis. Review of the most recent Minimum Data Set, MDS, dated 12/29/10, indicated R6 is an assist of two staff for all transfers, and hygiene activities. The most recent care plan dated 12/30/10 indicated in part; R6 has appropriate safety/risk awareness. R6's fall risk is related to incontinence, pain, use of diuretics, and history of CVA with Left Hemiparesis. R6 has orders for a left wrist/hand splint and a prevalon boot to her left foot when up. R6 is wheel chair bound. A review of the incident report dated 1/4/11 indicated; On 1/4/11 at 5:30 AM, E19, Certified Nurses Aide, CNA, assisted R6 to get up and dressed for the day. The report indicated at approximately 5:45 AM, E19, sat R6 at the foot of her bed, feet on the floor pants below her knees. E19 told R6 at this time that she would come back and put R6 in her wheel chair, as soon as she could get another staff to help with the transfer. The incident report indicated R6 sat at the foot of the bed from 5:45 AM until 6:30 AM, waiting to be transferred to her wheel chair. On 1/13/10 at 11:00 AM R6 stated during the 1/4/11 event that she was upset when left to sit	F 323		

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F 323	Continued From page 18 for such a long time on the side of the bed. R6 stated that she held onto the foot board to keep her balance. R6 stated that she felt very nervous about being left alone in her room, as the door was closed. R6 indicated she had on her left arm brace and left foot boot, and her pants were left down below her knees. R6 indicated she was nervous that she could slip off the bed and not be able to help herself. R6 indicated that E19 did come at around 6:30AM with another CNA, and who helped put R6 into her wheel chair. On 1/14/11, E2, Director of Nursing, DON, indicated she was aware of R6's limits to her mobility. E2, indicated R6 had not mentioned being nervous to her about being left to sit on the side of the bed. E2 indicated she was aware of R6 being left with her pants below her knees, but did not know that her braces were also on during this event. E2 indicated when the incident report was done, it was viewed more as a dignity issue and than a fall concern. 2. A review of R7's physician's order sheet dated 1/1/11 indicated a diagnoses in part of; Alzheimer's Dementia, and Multiple Myeloma. The most recent MDS dated 12/21/10 indicated R7 is moderately cognatively impaired, and an assist of one staff for transfers. The most recent fall assessment done 12/21/10 indicated R7 scored 15, a high risk for falls. Observation of R7 on 1/11/11 indicated she utilizes a seat belt when in her wheel chair to remind her not to get up unassisted. The seat belt assessment done on 9/24/10 indicated R7 is unaware of safety concerns and her limitations. On 1/11/11 at 1:00 PM E16, CNA, assisted R7 to the bathroom. E16 did not use a gait belt when assisting R7 to transfer. E16 stated that some days she does use a gait belt for R7 and	F 323		

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F 323	Continued From page 19 some days she does not use the belt, depending on how R7 is acting that day. On 1/13/11 E17 and E18, CNA's, transferred R7 to a commode in her room. At this time a gait belt was used on R7 during the transfer. Both E17 and E18 indicated they always use a gait belt for transfers as R7 is sometimes unstable on her feet. On 1/14/10 at 9:15 AM E2, DON. stated R7 is a stand by assist for transfers and doesn't need a gait belt. E2 indicated, "I transfer her all the time to the toilet, and she does fine". A review of the facility lifting and transferring policy indicated; for all residents requiring assistance in lifts and transfers, a gait/transfer belt or mechanical lift should be used. 3. R3's POS for January 2011 lists a diagnosis, in part, of Fracture of Right Hip. The Fall Assessment, dated 11/11/10, assesses R3 as a high risk for falls. The MDS dated 11/18/10 documents R3 requires extensive assistance with bed mobility and transfers. On 1/11/11 at 12:55 PM R3 reported she had a history of a fall after rolling herself in the geriatric chair to the toilet and fell during self transfer. No personal body alarm was in the geriatric chair from 10:05 AM through 4:05 PM on 1/11/11. On 1/12/11 at 9:50 AM, R3 was sitting in a geriatric chair. No personal or pad alarm was in the geriatric chair. At 1:09 PM R3 was wheeled to her room and transferred to bed with a gait belt and the assistance of two staff. The personal alarm was attached to the headboard of R3's bed, with no string or clip attached to it. E20, CNA, stated, "She's (R3) supposed to have a bed alarm, not in the geriatric chair." At 1:35 PM after receiving incontinent care R3 was transferred back to the geriatric chair. No alarm	F 323		

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F 323	Continued From page 20 was applied to R3. R3's Care Plan, dated 11/19/11, documents falls for R3 on 2/25/10, 2/27/10, 3/07/10, 3/31/10. The Care Plan documents R3 has short and long term memory loss, and is moderately impaired with decision making. The Care Plan documents R3 removed the bed alarm on 3/31/10, and was found on the floor. The Care Plan lists interventions, in part, "Personal alarm in place, check every shift that it is working order", and "Be sure to take her to the bathroom upon rising, prior to, after meals, activities, etcetera, at HS (bedtime)." 4. R13, with diagnoses, in part, of Dementia, Chronic Obstructive Pulmonary Disease and History of Seizures, has resided at the Facility since 9/26/90. Facility "Reporting Form" shows that R13 sustained falls in the Facility on 9/7/10, 10/23/10, 11/3/10, 11/4/10, 11/30/10 and 1/11/11. R13's Facility investigations into these falls show the following: 9/7/10 6:00 PM R13 was "found on floor in room sitting on his buttocks. He denies any pain or discomfort". There are no causative factors given for this fall. The investigation does not state if the alarm was sounding. The corrective action is "make sure personal alarm is attached and working at all times when up in wheelchair". 10/23/10 10:55 AM "(R13) in D Hall restroom found on floor sitting beside toilet. He denies any pain or discomfort. There is no bruising or open areas noted". The investigation does not state when R13 previously used the toilet, prior to his fall. The investigation does not state if he was wearing his personal alarm and if it was sounding. The corrective action for this fall is "make sure resident has personal alarm on. He has one but won't keep it on. Resident is also on	F 323		

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F 323	Continued From page 21 15 minute checks" 11/3/10 8:30 AM "Nurse called to resident's room. He has dried up blood on his pillow and back of head. He has complained of right hip pain. Resident stated he fell last night and got up by himself and didn't tell anyone". The corrective action for this fall is "advise resident to ask for help. Advise resident not to get up by himself. Resident always has personal alarm and he is non-compliant". 11/4/10 8:30 AM "Writer summoned to resident's room to find him sitting on the floor between wheelchair and bed. Resident stated that he was trying to get his hat which was placed above the bed". The investigation states that R13 detached his personal alarm from his right shoulder. There are no other causative factors given for this fall. The corrective action states "placed on 15 minute checks. Placed at nurses station when up in wheelchair". 11/30/10 7:25 PM "Alerted to sounding alarm in bathroom between F and E Hallways. When arrived, R13 was sitting on the floor "Indian style" facing the commode. The wheelchair was wet. The alarm was sounding faintly in the bathroom trash can". The investigation does not state when R13 was last toileted prior to the fall. There are no other potential causative factors for the fall. There is no corrective action given for the fall. 1/11/11 10:44 AM "(R13) was in the activity room. Resident stood up and fell on buttocks. Scraped hand. Personal alarm intact. There are no causative factors listed which may have contributed to his fall. The corrective actions is "Resident has personal alarm on. Staff will continue to remind resident not to get up unless he has assistance from a staff member". R13's physician's orders include Lasix 40	F 323		

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F 323	Continued From page 22 milligrams twice a day. The Nursing 2010 Drug Handbook, states that dizziness, vertigo and orthostatic hypotension are adverse reactions of Lasix. There are no baseline orthostatic hypotension readings in R13's Facility clinical record. R13's most recent MDS dated 10/22/10 shows that he has short and long term memory problems; moderately impaired cognitive skills for daily decision making; and requires the limited physical assistance of one person for bed mobility, transferring, walking and toilet use. During an interview with E11, Quality Assurance Nurse, it was stated that any new fall interventions would be written on R13's care plan. The only new intervention written on R13's plan on care is "7/21/10, ensure his personal alarm is intact and in working order every shift. E11 stated that the Facility also implemented 15 minute checks after R13's fall on 10/23/10 however, it is not on his Facility plan of care. E11 confirmed that no other interventions were attempted, such as scheduled toileting, physical therapy evaluation, activities, strengthening exercises, etc.	F 323		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		

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F 425	Continued From page 23 administering of all drugs and biologicals) to meet the needs of each resident. 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. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to ensure refrigerated medications were not expired for 4 of 24 refrigerated medications reviewed. The facility failed to ensure that medications were either destroyed or returned to the pharmacy for 8 of 26 reviewed refrigerated medications. This had the potential to affect all 73 residents in the facility. Findings include: 1. On 1/14/11 at 9:00 AM a review of the facility medication refrigerator indicated there were three medications that had expired, but were still stored in the refrigerator. The medications were; Cephalexin 250 mg / expired Nov, 2010, Bicillin Injectable / expired 12/2010, and Cubicin 375mg, Intravenous marked discard after 12/2010. Three bags of an IV antibiotic were stored next to the freezer in the refrigerator, and were in various stages of freezing. The bags were marked "Discard by 12/2010." 2. A review of the locked emergency crash cart indicated 5 pre-filled Sodium Chloride syringes stored on the cart had an expiration date of Sept	F 425		

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F 425	Continued From page 24 2010. A bottle of eye wash solution, Sodium Chloride/Sodium Borate Based had expired in 2008 was also on the crash cart. 3. Numerous IV administration sets, and in-line catheter sets stored in the medication room, and on the emergency crash cart had various expired dates on them ranging from 2008 through 2010. 4. A large plastic bag contained at least 8 different resident's injectable Ativan's. Several of the bags were duplicated, one bag had a broken vial of Ativan mixed in with the non-broken vials. Facility flu vaccines were mixed in with the resident Ativan vials. 5. Additionally, there were various discontinued medications still stored in the refrigerator that belonged to 6 residents who no longer lived in the facility. 6. During the medication review on 1/14/11 E2, Director of nursing indicated that the assigned pharmacist as well as nursing staff is to do monthly routine checks of the medication storage areas and crash cart. E2 indicated she did not know why the pharmacist, or nursing staff had not found, and discarded these items prior the observations made on 1/14/11.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

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F 431	Continued From page 25 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure all insulin vials are properly dated when opened for 7 (R23, R27, R28, R29, R30, R31, and R32) extended sample residents using insulin. The facility failed to ensure that stock medications are properly labeled and include expiration dates. This had the potential to effect all 73 residents in the facility.	F 431		

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F 431	Continued From page 26 Findings include: 1. On 1/14/11 a review of the facility stock medication box was done with E11, Care Plan Nurse. During the review the following medications were found to be incorrectly stored in a red tool box: Envelope hand written Cephalohexin 500mg, inside 6 tablets in individual bubble packs, unmarked with no expiration dates. Envelope hand written Macrobid 100mg, inside a loose capsule, no expiration date. Envelope hand written Augmentin, inside pills in individual bubble packaging with name of medication hand written on each pack, no expiration dates. Envelope hand written Pen-V-K, 250mg, two capsules inside, unmarked, no expiration dates. Envelope marked Tri-Meth Sulfa, inside tablets in individual bubble packs with no names or expiration on packaging. Envelope marked Levaquin 500mg, inside a tablet of Levaquin in a bubble pack with name of medication hand written on package, no expiration date. Numerous envelopes with antibiotic names; Mephyton 5mg, Amoxicillin 250mg, Amoxicillin 500mg, Trimeth Sulfa DS, Azithromycin 250mg, and Amoxicillin 500mg. All above envelopes were empty and had not been refilled. Review of the sign off sheets for the stock medications indicated no organized method of recording was used. Staff had written the names of the medications taken from the box on blank sheets of typing paper. Several months of lists were in the box. During the medication review on 1/14/11, E2, Director of Nursing indicated that the assigned pharmacist as well as nursing staff are to do	F 431		

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F 431	Continued From page 27 monthly routine checks of the medication stock box. E2 indicated staff had not informed her prior to today (1/14/11) of the medications that were improperly labeled. E2 did not know why the box with missing, and mislabeled medications had not been removed by the pharmacist. 2. On 1/14/11 at 9:45 AM the A-Hall, B-Hall, and C-Hall Medication Carts had open, undated insulin bottles. A-Hall had opened, undated insulins for R23 and R28. C-Hall had opened, undated insulins for R29, R30, R31 and R32. B-Hall had an opened, undated insulin for R27.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		

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F 441	Continued From page 28 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to adequately develop an ongoing infection control program that adequately collects data to analyze, and track current and active resident infections. This has the potential to affect all 73 residents in the facility. The facility failed to follow current standards of infection control practice for one, (R3) of six residents observed with incontinence, and failed to appropriately handle soiled linens in one of one soiled utility areas. Findings include: 1. On 1/12/11, the facility infection control log from 7/2010 through 12/2010 was reviewed. For all months reviewed the log was incomplete for the majority of residents identified with infections. The log was incomplete in the following areas:	F 441		

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F 441	Continued From page 29 identifying if a culture was done, failure to document organisms involved, failure to identify if the resident was put on isolation. In multiple instances log failed to identify any ongoing or repeated tests, or additional antibiotics ordered if the infection was not resolved. On 1/13/10 in an interview with E11, Care Plan Nurse, she indicated that she does try to reconcile the log on a monthly basis. E11 stated she utilizes information sent from the pharmacy / antibiotics ordered for residents, and laboratory / tests performed on residents, to track trends from the previous month. The Infection Control Policy Manual indicates; page 5; #1 At a minimum the infection control designee will conduct weekly infection surveillance within the facility using data collected from communication with staff, resident records, medication records, physical assessments, environmental observations and follow-up information from hospital records. #2 The infection control designee will record identified infections on the monthly infection control line listing for the purposes of tracking and to facilitate the analysis of surveillance data. #3 The infection control line listing will contain but is not limited to the following information; resident identifier, type of infection, date of onset, location within the facility, and appropriate laboratory information. On 1/13/11 in an interview with E11, and E2, Director of Nursing, E11, indicated that she did not realize that all areas of the infection log were necessary to be filled out. E11 and E2 provided no further information as to why the infection control log / tracking was not done as the facility policy directed. 2. On 1/11/11 at 12:55 PM R3 was transferred to	F 441		

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F 441	Continued From page 30 bed to provide care. R3 was incontinent of a large amount of foul smelling urine. E10, Certified Nurses Aide (CNA), cleansed R3's perineal area, legs and feet wearing one pair of gloves. After drying R3's legs and feet, E10 used soiled gloves to place clean socks on R3's feet, pull up her pants, apply a gait belt to R3 and transfer her to the geriatric chair. E10 used the same soiled gloves to open the door, before removing her gloves and washing her hands. R3's Laboratory Reports dated 8/19/10 and 9/15/10 confirm R3 has a history of urinary tract infections. The facility's policy and procedure, entitled, 'Perineal (Incontinence)Care' reads, in part, "Pat areas dry with a towel, remove the protective pad from the bed and dispose of it appropriately, if soiled, and remove gloves and dispose of them in the proper receptacle. Drape resident and pull side rail up if needed for safety, and wash hands." 3. During the General Observations of the Facility on 1/11/11 it was noted there was an incontinent pad covered with feces thrown on the floor next to the hopper in the soiled utility room.	F 441		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that areas used for storage of medications, food storage, and clean / dirty utility	F 465		

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F 465	Continued From page 31 rooms were kept clean and free of dust, debris, and dead insects. Findings include: 1. On 1/14/11 a review of the facility medication room was done with E11, Care Plan Nurse. Observation of the medication room floor indicated it was covered with dust, and had a grey dirty appearance. Several bandaids, tongue blades, numerous bits of paper, and other debris lay all around the floor. Numerous boxes were stored in the in the room on the floor along the walls. The freezer inside of the medication refrigerator was covered with several inches of ice. Three resident use ice packs were frozen into the freezer and could not be removed. The inside walls of the refrigerator were stained with food drippings. 2. During the General Observations of the Facility, on 1/11/11, the following was noted: There were several dead cockroaches on the shelving in the pantry. The shelves in the pantry contain the nutritional supplements and tube feeding supplies. There was a build-up of soil, dirt, debris, paper towels, and plastic spoons on the floor behind the ice machine in the pantry. There was an incontinent pad covered with feces thrown on the floor next to the hopper in the soiled utility room. There is a build-up of soil and debris on all of the floors throughout the Facility in the corners and at the floor/wall junctures. On 1/13/11 E1, Administrator, confirmed the above observations.	F 465		
F 469	483.70(h)(4) MAINTAINS EFFECTIVE PEST	F 469		

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F 469 SS=E	Continued From page 32 CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to have an effective pest control program that effectively eliminates roaches in the facility. Findings include: 1. During a tour of the facility on 1/10/11 at 9:07 AM R17 stated, "Haven't seen any roaches recently." R17 reported observing live roaches in her room in the recent past. Three small lives roaches were observed on R17's bathroom floor when the light was turned on. On 1/10/11 at 9:10 AM in room 107, a small live roach was observed under the sink when the wash basin was moved. At 1:50 PM, R4 stated when asked about pests in her room, "They (roaches) come out at night." On 1/10/11 at 8:55 AM E8, Housekeeper, stated "I've seen a few here and there, now and then. It's hard to get them all because they'll hide in wood." On 1/10/11 at 9:00 AM R6 reported she had seen live roaches in her room in the past. The facility's Pest Control Service Agreement and Customer Invoices for 10/2010, 11/2010 and 12/2010 documents they will provide services for roaches and spiders bi-weekly for two months. The Customer Invoices, dated 10/11, 10/26,	F 469		

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F 469	Continued From page 33 11/08, 11/19, 12/01, and 12/29/10 document bi-weekly pest control services were provided, but fails to show if any live pest activity was cited, or what facility areas were treated. 2. On 1/12/11 during the group interview, six of six residents noted the facility had a problem with roaches. Three residents noted the roaches were in their bathrooms. One resident indicated they had seen roaches in their bathroom that morning. On 1/14/11 during a confidential family interview, the family noted there were roaches in their family member's bathroom.	F 469		