DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/04/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295043	A. BUILDING B. WING	05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	3101 PLUMAS RENO, NV 89509

(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 This Statement of Deficiencies was generated as a result of an annual Medicare Recertification survey conducted at your facility on 5/19/08 - 5/22/08. The census at the time of the survey was 166. The sample size was 26. Two complaints were investigated during the survey. Complaint #NV00018252 alleged that the facility failed to provide the necessary equipment or failed to train employees in the use of the equipment to treat a resident's condition. The complaint was unsubstantiated. Complaint #NV00018272 alleged that the facility failed to provide quality services. The complaint was unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes Manor Care Health Services allegation of compliance. The alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 241 SS=D	483.15(a) DIGNITY 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.	F 241		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Payzale D Payzale	Administrator	6/16/08

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 241	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to prevent staff members from speaking in an undignified and respectful manner about a resident in his presence for 1 of 26 residents. (#26) Findings include: Resident #26: The resident was admitted to the facility on 12/3/07 with diagnoses including cerebral artery occlusion with infarction, diabetes mellitus, cardiac dysrhythmia, hypertension, and cardiac pacemaker placement. On 5/20/08 at 10:25 AM, a registered nurse (RN) and a licensed practical nurse (LPN) were observed having a conversation about Resident #26 at the nurses station. Resident #26 was at the nurses' station and heard the conversation. The LPN asked the RN if she could understand him (Resident #26). The RN replied "No, and he won't point to what he wants." The resident then pointed to the phone and the LPN asked, "Is that what you want, the phone?" The resident again pointed to the phone and was told by the LPN "It is not here, somebody has it." The LPN then reported to the RN "I already asked him if he wanted the phone." The RN replied "He calls people and they can't understand him and there he goes down that hall. What is he doing going down that hall for? He doesn't live down there." The RN was interviewed following the observation at 10:35 AM, and reported that Resident #26 was "completely alert and oriented; just hard to understand."	F 241	F 241 • A communication care plan was developed for Resident # 26. The nurse was educated on appropriate and respectful interactions with residents. • Residents identified with communication deficits have the potential to be affected. Residents at risk for decreased verbal communication will be identified and a communication care plan will be developed. • Staff will be re-educated on dignity and respectful communication with residents and not speaking about a resident in his/her presence. • Corrective actions will be monitored during monthly Customer service surveys and monthly Resident Council Meetings. The Administrator is responsible to monitor compliance.	6/1/08 7/6/08 7/6/08 7/6/08

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F 241	Continued From page 2 The director of nurses (DON) was interviewed on 5/21/08 at 8:00 AM, and reported that having a conversation about a resident in his presence was inappropriate.	F 241		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and interview, it was determined that the facility failed to ensure that a fluid restriction as ordered by the physician was followed and failed to ensure that the use of a Foley catheter was communicated to all care staff for 1 of 26 residents. (#13) Findings include: Resident #13: The resident was admitted to the facility on 4/30/08 with the following diagnoses: streptococcal infection, muscle weakness, hypoosmolality, hyperlipidemia, symbolic dysfunction, and anemia. On 5/20/08, Resident #13's medical record was reviewed. Review of the physician's orders revealed an order written on 5/6/08 to restrict fluid intake to two liters (2000 cubic centimeters) daily. On 5/7/08, the order was clarified and read 1,080 cubic centimeters (cc's) from dietary and 1,000 cc's from nursing. On 5/10/08, an order was	F 309	F 309 • A fluid restriction and urinary retention care plan were initiated and communicated to staff for Resident # 13. • Residents on a fluid restriction and residents with an indwelling catheter have the potential to be affected. These residents will have a care plan implemented and approaches communicated to staff. • Licensed staff have been inserviced on the facility's hydration program and communication of indwelling catheters. • The DON will track the status of residents with a fluid restriction and indwelling catheters. The DON will report to the QAA committee on a quarterly basis.	6/1/08 7/6/08 7/6/08 7/6/08

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F 309	Continued From page 3 written to re-insert the Foley catheter for urinary retention. On 5/20/08, two nurses working on Resident #13's floor were interviewed. Neither of the nurses knew that Resident #13 had a Foley catheter. The LPN explained that Resident #13's fluid restriction was divided between meals. She stated that the resident was allotted 360 cc's for the day and evening medication passes and 280 cc's for the night medication pass. She stated that the nurses kept track in their heads of how much fluid the resident had had during the day, but that her intake was not specifically recorded. On 5/20/08, a certified nursing assistant (CNA) working with Resident #13 was interviewed. She stated that the resident could be given fluids to drink depending on how much she drank with her meals. She stated that the nurses recorded the resident's intake and would let the CNA's know how much she was able to have. She stated that the resident was always asking for something to drink. On 5/20/08, the medication administration record for Resident #13 was reviewed and revealed a beverage plan worksheet that outlined the fluid amounts that the resident could have with each meal. Resident #13 was limited to 120 cc's of juice or fruit punch and 240 cc's of milk with each meal for a total of 1080 cc's of fluid with meals each day. Resident #13 ate in a dining room on another unit from where she resided. A CNA from the dining room explained that the amount of fluids Resident #13 drank during each meal was recorded in a notebook after each meal. Resident #13's meal	F 309		

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F 309	Continued From page 4 intake sheet from the dining room notebook was reviewed. The fluid intake recorded for 5/2/08 - 5/17/08 ranged from a low of 480 cc's to a high of 1920 cc's for the three meals each day. The resident would receive additional fluids with medications. On 5/20/08, the Director of Nurses (DON) was interviewed. She stated that she did not know how the fluid intake for Resident #13 could be accurately calculated with only the meal fluid intake being recorded. After reviewing the meal fluid intake record she agreed that there were days when the resident may not have received enough fluids, and there were days when the resident received too much fluid with her meals. On 5/22/08, the activity assistant was interviewed. She stated that Resident #13 participated in activities, that she was aware that the resident was on a fluid restriction, and that they would ask the nurses whether the resident could have any additional fluids with the activity socials. She stated that Resident #13 had tried to give her jewelry to people in exchange for water. Review of Resident #13's interdisciplinary progress notes revealed the following entries: 5/6/08, 7:00 PM: The resident "continues to demand large amounts of H2O (water)." 5/7/08, 6:45 AM: "Patient given little sips of liquid at a time to avoid overhydration." 5/8/08, 9:00 PM: "Patient is on fluid restriction and patient's daughter did not want her to be so she was filling up her glass in bathroom and giving it to her." 5/10/08, 2:45 PM: "Patient requesting more H2O to drink." 5/14/08, 7:00 AM: "Patient allowed little sips of	F 309		

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F 309	Continued From page 5 H2O upon request." 5/15/08, 6:00 PM: "Very anxious and asking for water." 5/16/08, 11:50 AM: "Remains on fluid restriction but patient begging/asking for more despite drinking all served on meal tray and those given by this writer." 5/19/08, 10:15 PM: "Asking for water. Patient spends most of the day begging for water from anyone who walks by." Review of the physician progress notes for Resident #13 revealed that on 5/6/08, the physician documented, "Patient drinking enormous amounts of fluid. Measure urine output." On 5/13/08, the physician documented, "Patient bartering her diamond ring for H2O." Review of the record failed to reveal evidence that the resident's urine output was measured. On 5/21/08, the facility's policy for intake and output (I & O) measurements was reviewed. The policy documented that routine I & O's are not clinically indicated but may be ordered for "treatment of residents on strict fluid restrictions." The policy documented, "There are some clinical conditions in which it may be more important to evaluate a resident's intake."	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the treatment of wounds was performed in a manner to prevent the spread of infection for 1 of 26 residents. (#6) Findings include: Resident #6: The resident was admitted to the facility on 11/6/07 with diagnoses that included four stage IV pressure ulcers, cerebral palsy, mental retardation, myoneural disorder, and infection resistant to penicillins. On 5/20/08 wound care of the pressure ulcers was observed. The registered nurse (RN) was observed packing the wounds with sterile Iodophor impregnated gauze. The RN was observed touching the rim of the sterile gauze container on the resident's bedding and the resident's wound. Throughout the dressing changes the RN was observed to have used a pair of scissors that had been in her pocket. The RN was not observed to have cleaned the scissors prior to beginning the dressing changes or between dressings. The RN was observed to have washed her hands prior to beginning wound care and between treatment to the third and fourth wounds. She was not observed to have washed her hands prior to beginning treatment of wound number two or prior to treatment of wound number three. The RN was observed to have changed her gloves numerous times, but was not observed to have	F 314	F 314 • The nurse completing the dressing change on Resident # 6 has been re-educated on infection control practices during dressing changes. • Residents with orders for dressing changes have the potential to be affected. • Licensed nurses will be re-educated on infection control practices during dressing changes. • The wound care team will observe four dressing changes per month and report findings to the DON. The Director of Nursing is responsible for monitoring compliance.	5/23/08 7/6/08 7/6/08 7/6/08

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F 314	Continued From page 7 washed her hands between glove changes. The RN was interviewed on 5/20/08 at 11:15 AM and stated "Haven't you ever been nervous?" She reported that she also had difficulty with the equipment and that the gauze container was not packed properly requiring a great deal more effort than is normally required to remove the gauze for packing the wounds. She reported that she did not have access to any more gauze and that the amount of gauze in the last container was all she had to change the dressings later in the day. The Director of Nurses was interviewed on 5/21/08 at 9:00 AM, and revealed that the facility referenced the Center for Disease Control (CDC) guidelines in regard to wound care. Review of recommendation of CDC revealed: Suggested citation: Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007 IV. Standard Precautions Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of health care. IV.A. Hand Hygiene IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from	F 314		

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F 314	Continued From page 8 contaminated hands to surfaces. IV.A.2. When hands are visibly dirty, contaminated with proteinaceous material, or visibly soiled with blood or body fluids, wash hands with either a nonantimicrobial soap and water or an antimicrobial soap and water. IV.A.3. If hands are not visibly soiled, or after removing visible material with nonantimicrobial soap and water, decontaminate hands in the clinical situations described in IV.A.2.a-f. The preferred method of hand decontamination is with an alcohol-based hand rub. Alternatively, hands may be washed with an antimicrobial soap and water. Frequent use of alcohol-based hand rub immediately following handwashing with nonantimicrobial soap may increase the frequency of dermatitis. Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.A.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves. IV.A.4. Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores (e.g., C. difficile or Bacillus anthracis) is likely to have occurred. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other	F 314		

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F 314	Continued From page 9 antiseptic agents have poor activity against spores. IV.B.2. Gloves IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intactskin (e.g., of a patient incontinent of stool or urine) could occur. IV.B.2.b. Wear gloves with fit and durability appropriate to the task. IV.B.2.b.i. Wear disposable medical examination gloves for providing direct patient care. IV.B.2.b.ii. Wear disposable medical examination gloves or reusable utility gloves for cleaning the environment or medical equipment. IV.B.2.c. Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Do not wear the same pair of gloves for the care of more than one patient. Do not wash gloves for the purpose of reuse since this practice has been associated with transmission of pathogens. IV.B.2.d. Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face).	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE 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	F 315		

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F 315	Continued From page 10 function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and resident interview, it was determined that the facility failed to provide services to restore as much bladder function as possible for 2 of 26 residents. (#19 and #2) Findings include: Resident #19: The resident was admitted to the facility on 3/28/08, with diagnoses that included diabetes mellitus, hypertension, and chronic airway obstruction. Her minimum data set (MDS) dated 4/4/08, indicated she exhibited modified independence in decision making. Record review revealed that Resident #19 was described as continent of urine on her Nursing Admission Evaluation form dated 3/28/08. Her MDS dated 4/4/08, revealed that the resident had inadequate control of her bladder and had multiple daily episodes of urinary incontinence. No evidence was found to indicate the resident's incontinence was evaluated in order to determine if she would benefit from bladder retraining or from prompted or scheduled toileting. Review of the activities of daily living (ADL) worksheet revealed that Resident #19 needed limited to extensive assistance with toileting and was incontinent of urine every shift. Review of the resident's care plan did not reveal a plan to attempt to restore bladder function. The ADL worksheet did not reveal the implementation of a toileting program or schedule.	F 315	F 315 • An individualized care plan has been developed and communicated to staff for resident # 19 and resident # 2. • Residents with urinary incontinence have a potential to be affected. Care plans for these residents will be reviewed and revised as necessary and approaches communicated to staff • Nursing staff have been re-educated on urinary incontinence guidelines and bladder patterning and analysis worksheet and communication of the approaches to staff. • After completion of the MDS, residents with incontinence without a toileting program will be reviewed in daily IDT meeting and toileting program will be initiated. The Director of Nursing is responsible for monitoring compliance.	6/1/08 7/6/08 7/6/08 6/1/08

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F 315	Continued From page 11 Resident #19 was interviewed on 5/20/08. She confirmed she had episodes of urinary incontinence and needed to wear pull ups. She stated that she thought she would benefit from reminders to toilet before she had an accident. A registered Nurse (RN) was interviewed and confirmed that Resident #19 was not on a toileting program or schedule. The Director of Nurses (DON) was asked for the policy and procedure for bladder training. She provided a copy of the Bladder Patterning and Analysis Worksheet. The worksheet's purpose was to identify a resident's usual bladder pattern and to provide suggested intervention steps for care plan development. Resident #2: The resident was admitted to the facility on 4/1/04, with diagnoses that included dementia, cerebrovascular accident and hemiplegia. Her minimum data set (MDS) dated 3/3/08, indicated she had moderately impaired cognitive skills. The MDS also revealed she had multiple incidents of urinary incontinence on a daily basis. Record review of the care plan revealed that Resident #2 was on an individualized toileting plan. The plan directed that the resident was to be toileted "upon awakening, after breakfast, and q (every) 2 hours thereafter during the day and always at HS (bedtime)." Review of the activities of daily living worksheet revealed that the resident was usually incontinent of urine but was, at times, able to maintain continence throughout a shift. The toileting program section of the ADL worksheet did not indicate the program was	F 315		

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	295043		05/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	3101 PLUMAS RENO, NV 89509

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F 315	Continued From page 12 consistently followed by staff. On 5/21/08, a certified nurses assistant (CNA) was interviewed. He reported that he toileted Resident #2 in the morning and before meals. He also toileted her when she indicated she needed toileting and when she looked like she needed to. He did not follow the toileting plan as indicated in the care plan.	F 315		
F 371 SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that food was served under sanitary conditions. Findings include: Observation of the noon meal trayline was conducted on 5/20/08. At 12:05 PM a cook's helper on the trayline was serving altered textured diets. The helper removed her gloves and put on oven mitts to remove a box of rolls from the oven. She returned to the tray line without replacing her gloves or washing her hands. The helper did recognize the error, but had already handled some food items before replacing her gloves. On 5/21/08, the lunch trays were observed being served to the residents on Wellington unit.	F 371	F 371 • The cook has been inserviced on correct glove use and correct handwashing techniques. The housekeeper and CAN have been inserviced on distributing food under sanitary conditions. • All residents have the potential to be affected. • Dietary staff will be inserviced on glove use and correct handwashing techniques. Staff will be re-educated on food distribution during meal service. The Dietary Manager is responsible to ensure that the dietary staff utilize correct techniques. The Dietary Manager will observe handwashing techniques during food preparation and distribution. • The Registered Dietitian will conduct random weekly observations for proper glove use and handwashing techniques with corrective action as needed. The Nurse Managers will observe food distribution during meal service and report findings to the Director of Nursing, Trends will be reported to the Administrator for QAA review.	5/27/08 7/1/08 5/27/08 7/6/08

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F 371	Continued From page 13 During the tray pass a housekeeper approached the tray cart and placed a dirty tray into the cart beside six clean trays that were about to be served. A certified nurses assistant opened the door to the cart to assist the housekeeper.	F 371		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F 431 • The opened and undated vials of medications and expired OTC's were discarded. • A visual inspection by the Director of Nursing was completed and opened and undated vials and expired medications were discarded. • Licensed nurses will be inserviced on proper labeling and dating when a multi-dose vial is opened. • The Director of Nursing and Pharmacy consultant will make periodic inspections of the medication carts and medication rooms for undated and expired medications. The Director of Nursing is responsible for monitoring compliance.	5/23/08 6/1/08 7/6/08 7/6/08

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F 431	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation and policy and procedure review, it was determined that the facility failed to ensure medications were labeled with the date opened and that expired medications were removed in accordance with the facility policy. Findings include: Review of the facility's policy and procedure related to the storage of drugs and biologicals read as follows: Policy: Drugs and biologicals will be stored in a safe secure, and orderly manner, at proper temperatures, and accessible only to licensed nursing and pharmacy personnel. Procedures: "12. Any outdated, contaminated, or deteriorated drugs, or those in containers which are cracked, soiled, or without secure closures must be removed from stock and destroyed according to procedures for drug destruction. If any drug has not been used in at least two months, an attempt should be made to obtain an order for its discontinuance. All other drugs should be immediately ordered from the pharmacy." Observations of the medication storage rooms throughout the facility was conducted on 5/20/08 and revealed the following: The 400 (Windsor) and 500 (Cambridge) Halls. Observed in the refrigerator were one undated	F 431		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 15 open vial of Tuberculin (general use) used for tuberculosis testing, one undated open vial of Ativan (prescribed for a specific resident), and a vial of Glucose in the "Glucose Emergency Kit" which had an expiration date of 3/06. Observation of over the counter (OTC) medications revealed the following expired medications: two bottles of Vitamin B-12 with an expiration date of 10/07, one bottle of Ferrous Gluconate with an expiration date of 4/08, and one tube of hemorrhoid ointment with an expiration date of 4/08. The 100 (Wellington) Hall. Observation of the refrigerator on the Wellington unit revealed one 10 milliliter vial of Humulin-N Neutral Protamine Hagedorn (NPH) insulin and one 10 milliliter vial of Lantus insulin that were opened, but not dated. Observation of the OTC medications revealed the following expired medications: two bottles of Zinc Gluconate 50 milligrams containing 100 tablets that had expired on 03/08, one bottle of Lactaid (lactase enzyme) 9,000 FCC (food chemical codex) lactase units containing 120 tablets that had expired on 2/08, and one tube of hemorrhoidal ointment with an expiration date of 4/08. The observation of the medication room revealed a small blue basket containing 56 unit dose, three milliliter vials of sterile normal saline for inhalation that had expired; 32 vials had an expiration date of 5/07, 21 vials had an expiration date of 4/07, and three vials had an expiration date of 3/07.	F 431		

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F 431	Continued From page 16 Brighton Unit Observation of the OTC medications in the medication room on 5/20/08, revealed the following expired medications: one bottle of Primrose 500 mg containing 250 tablets with an expiration date of 2/08 and one tube of hemorrhoidal ointment with an expiration date of 4/08.	F 431		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to screen 1 of 26 residents for tuberculosis. (#1) Findings include: Resident #1: The resident was admitted to the facility on 4/11/08, with diagnoses that included adult failure to thrive, hypertension, asthma colonic malignancy and chronic diarrhea. Review of the record failed to reveal evidence that the resident was screened for tuberculosis upon admission to the facility.	F 441	F 441 • Resident # 1 was screened for tuberculosis with negative results. • New admissions to the facility have the potential to be affected. • TB screening has been added to the chart audit that is completed by the Nurse Managers upon admission. • Chart audits are reviewed during daily IDT meeting. Problems identified will be corrected. The Director of Nursing is responsible for ensuring compliance with TB screening.	6/1/08 7/6/08 6/14/08 6/1/08

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F 441	Continued From page 17 On 5/20/08, a licensed practical nurse (LPN) was interviewed. She was unable to find documentation that indicated Resident #1 received testing for tuberculosis. She confirmed that the facility performs two step mantoux testing on all new resident admissions unless they have a history of a positive reaction to testing.	F 441		

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