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

PoC accepted 7/28/08 B. Cavanaugh

PRINTED: 07/15/2008
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
	295020	A. BUILDING _____ B. WING _____	06/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD REHABILITATION CENTER	2045 SILVERADA BLVD. RENO, NV 89512

(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 6/23/08 through 6/30/08. The census at the time of the survey was 89. The sample size was 23. 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.	F 000	**This Plan of Correction is being submitted pursuant to the applicable Federal and State Regulations. Nothing contained herein shall be construed as an admission that the Facility violated any Federal or State Regulations or failed to follow any applicable Standards of Care.**	
F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to post a notice of the availability of the most recent survey results and failed to post the results of the most recent survey in a place readily accessible to residents. Findings include:	F 167	**Please find our response to each deficiency following that deficiency. All attachments to responses are contained herein.**	

RECEIVED
JUL 28 2008
BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	admin	7/25/08

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.

F 167 483.10(g)(1) EXAMINATION OF SURVEY RESULTS

This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post a notice of the availability of the most recent survey results and failed to post the results of the most recent survey in a place readily accessible to Residents.

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

All Residents were affected by the deficient practice. Corrective action will include posting notices throughout the facility on the availability of the most recent survey results.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents at Rosewood Rehabilitation Center have the potential to be affected by the deficient practice. Corrective action will include posting notices throughout the facility on the availability of the most recent survey results.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Notices posted throughout the facility on the availability of the most recent survey results will be in blocked, heavy typeface enabling all Residents, Visitors, and Family Members to view it. The Notices will be monitored by the Administrator. (Copy Attached)

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

The Administrator will monitor the posting of the Notices on a daily basis to ensure that the Notices remain posted and in full view to Residents, Visitors, and Family Members.

Dates when corrective action will be completed?

Date when corrective will be completed is July 31, 2008.

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F 167	Continued From page 1 On the morning of 6/23/08, accompanied by the Central Supply/Scheduling clerk an initial tour of the facility was conducted. Observation of the facility during the tour failed to reveal evidence of a notice of the availability or the actual most recent survey results. Staff interview revealed that the survey results were in a binder which was kept in an unmarked closed cabinet behind the receptionist's desk in the front lobby of the facility. When asked to see the survey results, the receptionist, opened the cabinet and provided a blue binder. The label on front of the binder indicated it contained the survey results. The survey results along with the approved plan of correction were in the binder. The receptionist returned the binder to the cabinet and closed the cabinet door; the binder was not visible. The receptionist confirmed that the binder with the survey results was routinely kept in the closed cabinet and not left out.	F 167		
F 168 SS=B	483.10(g)(2) EXAMINATION OF SURVEY RESULTS A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to post information on how residents could contact the Bureau of Licensure and Certification. Findings include:	F 168		

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F 168 483.10(g)(2) EXAMINATION OF SURVEY RESULTS

This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post information on how Residents could contact the Bureau of Licensure and Certification.

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

No Residents were found to have been affected by the deficient practice. When posting the Notices on the availability of the most recent survey results, Notices will also be posted containing information on how Residents can contact the Bureau of Licensure and Certification. The Bureau's telephone number and address, including email address will be listed on the Notices.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents at Rosewood Rehabilitation Center have the potential to be affected by the deficient practice. As a part of posting the Notices on the availability of the most recent survey results, Notices will also be posted containing information on how Residents can contact the Bureau of Licensure and Certification. The Bureau's telephone number and address, including email address will be listed on the Notices.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Notices posted throughout the facility on the availability of the most recent survey results will be typed in blocked, heavy typeface enabling all Residents, Visitors, and Family Members to view it. Posting of the Notices will be monitored by the Administrator. (Copy Attached)

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

The Administrator will monitor the posting of the Notices on a daily basis to ensure that the Notices remain posted and in full view to Residents, Visitors, and Family Members.

Dates when corrective action will be completed?

Date when corrective action was completed is July 24, 2008.

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F 168	Continued From page 2 On the morning of 6/23/08, an initial tour of the facility was completed. Observation of the the facility failed to reveal posted contact information for the Bureau of Licensure and Certification. On the afternoon of 6/25/08, a second tour of the facility was provided by the Administrator. When asked if there was additional contact information posted, the Administrator confirmed there was not.	F 168		
F 221 SS=E	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and policy review the facility failed to ensure the use of waist restraints was assessed, less restrictive measures were attempted, consented to by the responsible party and medically necessary for 7 of 23 residents (#13, #16, #19, #20, #5, #22, and #21). Findings include: Review of the facility's policy "Use of Restraints" revealed that restraints were only to be used for the safety and well-being of the resident(s) and only after other alternatives had been tried unsuccessfully. In addition the policy stated that if the resident could not mentally and physically self-release, then the device was considered a restraint.	F 221		

F 221 483.13(a) PHYSICAL RESTRAINTS

This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, the facility failed to ensure the use of waist restraints was assessed, less restrictive measures were attempted, consented to by the responsible party, and medically necessary for 7 of 23 residents (#13, #16, #19, #20, #5, #22, and #21).

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

Seven Residents were found to have been affected by the deficient practice.

Resident #13

Resident #13: Survey results indicate Resident #13 on a non-releasing, back-closing belt. Resident #13 is currently using a front-releasing restraint. A Re-evaluation will be performed by Nursing Staff for Resident #13 to determine whether a less restrictive restraint application can be used. A Care Conference was on July 24, 2008 for Resident #13 to discuss Restraints. Documentation of Resident's Care Conference, including results, will be placed in Resident's Medical Record. Staff will determine whether a new Physician Order is needed for a restraint and obtain the Physician Order, if necessary, per facility policy. Consent was obtained per facility policy.

Resident #16

Resident #16 is currently using a non-releasing (seatbelt) restraint. Nursing will complete the evaluation for Resident #16 to determine whether a less restrictive restraint is appropriate or to consider eliminating the restraint. Staff will determine whether a new Physician Order is needed for a restraint and obtain the Physician Order, if necessary, per facility policy.

Resident #19

Resident #19 is currently using a back-releasing seatbelt. A Re-evaluation will be performed by Nursing Staff for Resident #19 to determine whether a less restrictive restraint application can be used. A Care Conference was held on July 24, 2008 for Resident #19 to discuss restraints. Documentation of Resident's Care Conference, including date, will be placed in Resident's Medical Record. Staff will determine whether a new Physician Order is needed for a restraint and obtain the Physician Order, if necessary, per facility policy. Obtain consent per facility policy.

Resident #20

Resident #20 is currently using a front-releasing seatbelt. A Re-evaluation will be performed by Nursing Staff for Resident #20 to determine whether a less restrictive restraint application can be used. A Care Conference was held on July 24, 2008 for Resident #20 to discuss restraints. Documentation of Resident's Care Conference, including date, will be placed in Resident's Medical Record. Staff will determine whether a new Physician Order is needed for a restraint and obtain the Physician Order, if necessary, per facility policy. Obtain consent per policy.

Resident #5

Resident #5 is currently using a back-releasing seatbelt. A Re-evaluation will be performed by Nursing Staff for Resident #5 to determine whether a less restrictive restraint application can be used. A Care Conference was held on July 24, 2008 for Resident #5 to restraints. Documentation of Resident's Care Conference, including date, will be placed in Resident's Medical Record. Staff will determine whether a new Physician Order is needed for a restraint and obtain the Physician Order, if necessary, per facility policy. Obtain consent per policy.

Resident #22

The restraint for Resident #22 has been discontinued following re-evaluation. A Physician's Order appears in the medical record to reflect this change.

Resident #21

Resident #21 is currently using a non self-releasing (seatbelt) restraint. A Re-evaluation will be performed by Nursing Staff for Resident #21 to determine whether a less restrictive restraint application can be used. A Care Conference was held on July 24, 2008 for Resident #21 to discuss restraints. Documentation of Resident's Care Conference, including date, will be placed in Resident's Medical Record. Staff will determine whether a new Physician Order is needed for a restraint and obtain the Physician Order, if necessary, per facility policy.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

In-service Training Session(s) will be initiated, including identification of less restrictive measures and documented on the Restraint Data Collection form. Staff In-service will also include ensuring that informed consent is obtained, review of the facility's Restraint Policy on the Use of Restraints, and Restraint evaluation. The ADON will perform a 100% audit on consent forms on a monthly basis. The ADON will then report findings to the DON and the Restraint Committee. The DON, ADON, and the Staff Development Coordinator will conduct the In-service Training Sessions until Staff is thoroughly familiar with the facility's policy on the use of Restraints and the Restraint Data Collection form, the Nursing Chart Audit Tool, and on utilization of less restrictive measures. In addition, documentation will be entered into the ADL book, as needed.

Additional In-services will be given by the Assistant Director of Nursing Services and the Staff Development Coordinator on Care Plans and Care Planning all Residents who are on a Restraint. The Unit Clerk will audit the Treatment Administration Record (TAR) for appropriate documentation and record findings on the Restraint Observation Record.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Corrective action(s) include the use of a Restraint Data Collection form and In-service Training Session(s) on the use of the Restraint Data Collection form, and on utilization of less restrictive measures for all Residents. Interventions, including less restrictive measures, will be attempted and documented on Restraint Data Collection form. Staff In-service will also include ensuring that informed consent is obtained, a review of the facility Restraint Policy on the Use of Restraints, and Restraint evaluation. The Assistant to the Director of Nursing Services will perform a 100% audit on consent forms on a monthly basis. The Assistant to the DON will then report findings to the Director of Nursing Services and to the Restraint Committee. The DON, Assistant to the DON, and the Staff Development Coordinator will conduct the In-service Training Sessions as needed, until Staff is thoroughly familiar with the facility's policy on the Use of Restraints and the Restraint Data Collection form, and on utilization of less restrictive measures. In addition, documentation will be entered into the ADL book, as needed.

Additional In-services will be given by the Assistant Director of Nursing Services and the Staff Development Coordinator on Care Plans and Care Planning all Residents who are on a restraint. The Unit Clerk will audit the Treatment Administration Record (TAR) for appropriate documentation and record findings on the Restraint Observation Record.

The facility owners will actively investigate innovations in Restraint-free environments. Programs such as *Falling Leaves Program* will be considered. The facility commitment will be to eliminate unnecessary Restraints and replace them with interventions that will reduce the risks of falls after the elimination of the Restraints. Additionally, the owners will work closely with its QIO and their commitment to reduce the number of Restraints in facilities.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

1. **All Restraints must be approved by the Director of Nursing Services and Physician prior to application.**
2. **All Restraints will be reviewed on a monthly basis by the Restraint Committee. All Clients with discontinued Restraints will be reviewed monthly by the Restraint Committee to determine their fall risk and non-Restraint fall risk interventions.**
3. **Prior to the Restraint Committee Meeting, a 100% review on Restraints will be conducted. This review will include the determination that the proper restraint is in use, that it is properly applied, and a check to determine whether the facility has any unauthorized restraints in use.**
4. **A monthly chart audit will be conducted by Medical Records to verify that the orders for Restraints are consistent with the number of Residents utilizing Restraints.**
5. **The facility will cross-reference and check to verify that Clients utilizing Restraints are consistent with what is captured via the MDS.**

Dates when corrective action will be completed?

Date corrective action will be completed is August 12, 2008.

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F 221	Continued From page 3 Review of the facility policy, "Physical Restraint Application" revealed that the purpose of the physical restraint was to prevent injury to the resident, when the resident had medical symptoms that warranted use of the restraints. A written consent should be obtained, that a physical restraint assessment was to be completed prior to the use of the restraints with follow up reviews no less than monthly, and specific documentation in the resident's medical record. Documentation was to include the date and time the restraint was applied, the name and title of the person applying the restraint, the type of restraint applied and the specific reason the restraint was applied and the length of time it would be used, each time the device was released and each time the resident was monitored. On observation of the facility the afternoon of 6/26/08, Residents #5, #13, #16, #19, #20, #21 and #22 were observed in their wheelchairs with soft belt waist restraints on. The soft belt waist restraints were secured and crossed around the waists of the residents. The restraint ties were positioned through the arm rests, criss-crossed behind the back of the wheelchairs and tied below to the anti-tip bars at the base of the wheelchairs. The application of the soft belt waist restraints did not allow the residents to untie or self release the restraint. Resident #13: The resident was admitted to the facility on 7/19/07 with the diagnoses of Parkinson's disease, general malaise and fatigue, abnormal gait and dementia. Resident #13 was observed observed in his	F 221		

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F 221	Continued From page 4 wheelchair with soft belt waist restraint on the afternoon of 6/26/08, on 6/27/08 and 6/30/08. Review of the record revealed an order dated 3/26/08 read "self releasing seat belt, attempted to get up unassisted, unsteady gait, increased fall risk." Fall risk assessments for Resident #13 were completed on 7/19/07, 11/26/07 and 1/2/08. 1/21/08, indicated "put on self releasing belt, chair alarm is ineffective, been getting up unassisted." Record review for Resident #13 failed to reveal evidence of an order for a non-releasing/back closing seat belt, documentation as to why a change from self-releasing to non-releasing restraint was needed, or what less restrictive interventions were attempted. The record failed to have evidence of a consent for a non self releasing seat belt or a care plan addressing the restraint. A consent for a self releasing belt was signed on 1/21/08 and the care plan for falls included the intervention of a self releasing seat belt. Review of the care plan conference summary for 4/24/08 failed to reveal evidence that self releasing seat belt or the seat belt restraint was addressed. Resident #16: The resident was admitted to the facility on 4/17/08 with diagnoses of urinary tract infection, general malaise, fatigue and Alzheimer's disease. Review of the record revealed a physician's order dated 6/23/08 for a "non-releasing seatbelt, patient has no safety awareness, continues to ambulate independently from his wheelchair	F 221		

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F 221	Continued From page 5 without staff assistance, release every 2 hours for repositioning, toileting and increased circulation." Review of the record revealed a nursing note dated 6/22/08 at 1:00 PM, noting that Resident #16 repeatedly set off the wheelchair alarm and released the self-releasing seat belt to get up and walk. The record contained a "Physical Assessment Restraint" form dated 6/23/08. The form was incomplete and unsigned. An approach in the care plan for the prevention of falls and mood manifestations documented the use of the self releasing seat belt. Resident #19: The resident was admitted to the facility on 5/4/06 with diagnoses of failure to thrive, Alzheimer's disease and dementia. Review of the record revealed a physician order dated 12/16/07 for "back closing seat belt to utilize while in wheelchair due to poor safety awareness, unsteady gait and impulsive getting up unassisted and history of falls, release every 2 hours for positioning, toileting and circulation (Alzheimer and debility)." Review of Resident #19's medical record revealed a verbal consent for the restraint was obtained on 12/16/07. Documentation failed to reveal that the verbal consent was followed up with a written consent. Review of the record revealed a "Physical Restraint Assessment" form dated 12/16/07. The form noted that the resident was able to remove the lap buddy, the resident had poor safety awareness, was impulsive getting up in wheelchair, had an unsteady gait and a history of	F 221		

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F 221	Continued From page 6 falls and Alzheimer's disease. Least restrictive measures of cueing Resident #19 not to remove the lap buddy, visual checks and toileting were not effective. A "Physical Restraint Assessment" form dated 1/8/08 noted that the resident had a Tab alarm on the wheelchair and bed, low bed with mats on the floor, and a back closing seat belt. All interventions were noted as appropriate. a "Physical Restraint Assessment" form dated 4/9/08 noted the same interventions, but did not indicate any attempts of removing the seat belt restraint or the results of any attempts. The documentation failed to reveal follow-up monthly physical restraint reassessments per facility policy. Review of the care plan conference summary notes dated 2/7/08 and 5/8/08 did not reveal that the back closing seat belt was discussed. Review of the record revealed that Resident #19's public guardian had given verbal consent on 12/16/07, but failed to have evidence of a written consent for the restraint. Resident #20: The resident was admitted to the facility on 3/4/08 with diagnoses of general malaise, fatigue, abnormal gait, stroke and congestive heart failure. Review of the record revealed a nurse's note indicating Resident #20 had a fall out of the wheelchair on 5/20/08; his Tabs alarm sounded. An Interdisciplinary Behavioral/Medication Review" form dated 5/28/08 noted that the resident continued to be restless, wandered into other resident rooms, and had an occasional fall secondary to his restlessness; Ativan was used minimally to calm him down and was effective.	F 221		

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F 221	Continued From page 7 Review of the record revealed a physician order dated 6/11/08 for "back releasing seat belt, poor safety awareness, release every 2 hours for toileting, circulation, positioning, sign off use every shift" and to "discontinue lap buddy." A "Physical Restraint Assessment" form was completed for Resident #20 on 6/12/08 which noted that the back release seat belt was recommended for unsafe transfers and poor safety awareness. A verbal consent for the back release belt was obtained on 6/11/08. The documentation failed to reveal evidence that the verbal consent was followed up with a written consent. Review of the care plan for Resident #20 revealed a care plan for the lap buddy which had been lined through and altered to read "back release seat belt" and added to the approaches. Review of the care plan conference summary dated 2/7/08 and 5/8/08 did not reveal that the back closing seat belt was addressed. Resident #5: Review of the record revealed an order for a back closing seat belt written on 12/11/06. The "Physical Restraint assessment" forms for 12/06/07, 2/07/08 and 3/12/08 noted that, in spite of a non releasing seat belt being in place since 12/11/06, Resident #5 continued to have falls. The documentation indicated that the falls occurred from the bed, not the wheelchair. The record revealed that use of a lap buddy was attempted on 4/22/08 for a period of 15 minutes; the resident was able to remove the lap buddy three times. She was then placed back in the waist restraint. A verbal consent for the back closing seat belt was 12/11/06; no evidence of a written consent	F 221		

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F 221	Continued From page 8 was found. The record revealed an occupational therapy restraint screening that was completed on 6/20/06. The screening recommended a lap belt with a back buckle in the wheelchair. Review of the care plan conference summaries for 3/20/08 and 6/19/08 failed to reveal evidence that the non self releasing seat belt was addressed. There was no evidence that the facility implemented any means to systematically and gradually introduce a reduction in the physical restraint being used for Resident #5. The record contained no evidence that other interventions had been attempted with the exception of the one time 15 minute use of a lap buddy. Resident #22: The resident was admitted to the facility on 6/23/08 following surgery for lung cancer. He also had a diagnosis of dementia. On 6/25/08, an order was obtained for the use of a non self releasing seat belt based on numerous attempts to ambulate without staff assistance. An additional order was written for a Tabs alarm. The physician's note that was written on 6/25/08 acknowledged that the resident was weak and shaky and getting up without assistance and recommended a self releasing seat belt. The record failed to reveal evidence of an explanation as to why the seat belt changed from a self releasing to non self releasing seat belt. Review of the physical restraint data collection completed on 6/23/08, failed to reveal an indication for the need for restraints. A fall risk data collection completed on 6/25/08 did not indicate that Resident #22 was at a high risk for falls. Verbal consent was obtained for a non releasing seat belt on 6/25/08. A new "Physical Restraint Assessment" form was completed on	F 221		

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F 221	Continued From page 9 6/25/08. The documentation indicated that the resident had not sustained any falls, that he was alert, verbal, made himself understood, cooperative, but that he was restless, wandered and was at risk for elopement. There was no indication that a self releasing seat belt or lap buddy had been attempted. When the resident was observed on 6/27/08 in the dining room, he appeared quiet, calm and cooperative. His soft tie belt was tied to the anti tip bars of his wheelchair. Resident #21: The resident had been readmitted to the facility in February 2008 following hospitalization for a fractured hip. The record revealed that Resident #21 was found on the floor next to her wheelchair without apparent injury on 6/19/08. On 6/19/08 an order was written for a Tabs alarm in her wheelchair. The Tabs alarm was implemented the following day. On 6/20/08, after a one day use, the order for the Tabs alarm was discontinued. A new order was written for a back closing (non self-releasing) seat belt. On 6/20/08, a physical restraint assessment was completed that identified that the resident had a fall in the last 90 days with injury, a fall within the last thirty days without injury and that she spoke only Spanish, not being able to make herself understood or to understand others. There was no indication that there had been other recent changes or any environmental concerns. The family was made aware of the situation. On 6/21/08, the family requested a "back closing seat belt." The documentation indicated that, on 6/21/08, a lap buddy was placed on Resident #21. Review of record revealed an approach in the care plan for the prevention of falls documented the use of the	F 221		

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F 221	Continued From page 10 back closing seat belt was per family request, not based on facility assessment or medical condition. When observed on 6/23/08 during the lunch meal, Resident #21 was restrained with a soft tie waist restraint tied to the anti tip bars of the wheelchair. In a conversion with the Director of Nursing on 6/30/08, she confirmed that a "back closing seat belt" was a non self-releasing type of restraints.	F 221		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide medically related social services for 2 of 23 residents (#6 and #12). Findings include: Resident #6: The resident was admitted to the facility on 11/27/07 with the primary diagnoses of Parkinson's disease and dementia. The initial Minimum Data Set completed on 12/1/07, and the subsequent the quarterly Minimum Data Sets completed on 2/25/08 and 5/25/08 noted that Resident #6 required a mechanical soft diet due to broken or missing	F 250		

F 250 483.15(g)(1) SOCIAL SERVICES

This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide medically-related social services for 2 of 23 Residents (#6 and #12).

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

Two Residents were found to have been affected by the deficient practice.

Resident #6

Resident was Care Planned on July 24, 2008. His next dental appointment is scheduled for August 5, 2008 at 3:30 pm. In the future, all appointments are to be scheduled directly on the Social Services Care Plan. The Social Services form is attached.

Resident #12

Corrective action includes re-evaluation and completion of new Level of Care status. Nursing Staff at Rosewood will perform the re-evaluation. If the re-evaluation indicates an increased level of functioning, it may be determined that skilled nursing services are no longer needed. Rosewood would then give the Guardian 30-day notice to move patient to a more appropriate facility to meet patient needs. The Discharge Plan is routinely discussed in the Care Conference.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents at Rosewood Rehabilitation Center have the potential to be affected by the deficient practice. In the future, all Residents affected by this practice will be identified through the following system changes:

Residents Needing Dental Appointments

The Administrator is notified at the time the visiting Dentist is scheduled to see Residents.

Upon exiting the facility, the visiting Dentist shall provide to the Administrator a listing of Residents seen. Consult (notes) will follow. Dentist Consult (notes) will then be placed in the Resident Medical Records.

Residents Desiring to Move to another Facility

All Residents who exhibit an interest in moving to another facility with a less restrictive medical environment will receive an evaluation from the Social Service Department. These expressions of interest will be acted upon based on comments from Residents to any facility staff person. Social Services will then contact the Resident or Resident's Guardian to follow-up on the possibility of moving the patient to a facility that the Resident requests. The Discharge Plan is routinely discussed in the Care Conference.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Social Services scheduling form, *Need for Visual, Dental, Hearing, or Psychiatric Appointment Care Plan*, will be used to document Resident Appointments. When completed, this form will be filed as a part of the Social Services Care Plan. The Director of Social Services will provide In-service Training to the Care Plan team on the use of the Social Services form.

Residents Needing Dental Appointments

In the future, all dental appointments are to be scheduled utilizing the *Need for Visual, Dental, Hearing, or Psychiatric Appointment Care Plan* form. When completed, this form will be filed as a part of the Social Services Care Plan. The Social Services form is attached.

Residents Desiring to Move to another Facility

If LOC re-evaluation indicates an increased level of functioning, it may be determined that skilled nursing services are no longer needed. Rosewood would then give the Resident or Guardian 30-day notice to move patient to a more appropriate facility to meet patient needs. The Discharge Plan is routinely discussed in the Care Conference.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

Residents Needing Dental Appointments

The Director of Social Services will work with the Director of Nursing Services to ensure the Social Services form is kept to document Resident dental appointments and that the Social Services form is properly inserted in the Care Plan. The Director of Social Services will provide In-service Training to the Care Plan team on the use of the Social Services form.

Residents Desiring to Move to another Facility

If LOC re-evaluation indicates an increased level of functioning, it may be determined that skilled nursing services are no longer needed. Rosewood would then give the Resident or Guardian 30-day notice to move patient to a more appropriate facility to meet patient needs. The Discharge Plan is routinely discussed in the Care Conference.

Dates when corrective action will be completed?

Date when corrective action will be completed is July 31, 2008.

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F 250	Continued From page 11 teeth and dental carries. The quarterly assessments indicated that he had lost seven pounds since his admission. Review of the record revealed that Resident #6 was seen by the facility's contract dentist at the facility on 4/19/08. The dentist wrote an order that read that "Patient requires referral to oral surgeon in preparation for requested dentures. Refer for: Radiographic evaluation, removal of all upper teeth, removal of following lower teeth #17 and #31." Review of the clinical record failed to reveal an entry by social services addressing the order or a notation in the care conference meeting notes of 5/25/08. There was no evidence that the care plan had been revised to address the need. An interview with the social services director on 6/23/08, revealed that she had not initiated any interventions regarding the dentist's order. She was not aware of what the status was regarding the order from the dentist. The social worker stated that Resident #6's primary insurance was Medicaid and it was difficult to find a dentist who would accept Medicaid. She confirmed there was no documentation in the clinical record addressing any interventions by the facility. Approximately one hour later, it was confirmed through the transportation aide that an appointment was scheduled for 7/15/08, three months from the time of the original order. The transport staff confirmed that they make the appointments. They do not receive a copy of the orders, but an inter-facility form with the appointment request on it. They do not keep the request once it was received. There was no	F 250		

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F 250	Continued From page 12 documentation available to determine if the transportation staff were informed of any specific instructions as to making the appointment timely or whenever available. They confirmed that they do not relay the appointment information back to the nursing or social service staff once the appointment was confirmed. An appointment book was used to document the appointments, but the resident's chart or treatment records were not included in the documentation of the appointment scheduled. There was no evidence of communication between nursing, transportation and social services to indicate that the three month delay was due to availability of the oral surgeon or staff attempting to meet Resident #6's needs more promptly. There was no evidence that social services intervened to promote coordination of interventions. Resident #12: The resident was admitted to the facility on 12/01/05. Diagnoses included atrial fibrillation, osteoporosis, hypertension, vertebral compression fractures, coronary artery disease, anemia, dementia, delusional disorder, personality disorder and narcissism. The resident had a guardian when admitted to the facility. During a group meeting with the residents, Resident #12 expressed a desire to have a small place of his own, stating that he did not know why he was being kept here. He was observed to been independent in ambulation, verbally appropriate and well dressed. He liked to sit in the lobby and read the daily newspaper. Resident #12 had a history of inappropriate behaviors, but had not been evaluated by a	F 250		

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F 250	Continued From page 13 psychiatrist since 2006. At that evaluation, the resident expressed the desire to be in a less restrictive environment. The evaluation found the resident was not depressed, angry or anxious, with no deranged or inappropriate mentations, and with reasonable insight. A Minimum Data Set completed on 11/23/07 indicated that, while he had some short term memory problems, Resident #12 was independent for decision making and had no indicators of delirium or disordered thinking. There were no indicators of depression, anxiety or sad mood. It was noted that the resident did resist care, but was easily altered. In a Minimum Data Set completed 2/21/08, Resident #12 had no indicators of delirium, disordered thinking, depression, anxiety, sad mood or behavioral symptoms. He remained independent in daily decision making. Review of the monthly flow records for documentation of sexually inappropriate remarks to staff, verbal abuse, or paranoid delusions showed that no such behaviors had occurred for the months of March, April, or May. Review of the pharmacist progress notes indicated that no behaviors had been observed as far back as 11/6/07. Social Services notes from 5/29/07 indicated that the resident was questioning why he continued to stay in the facility and asked a friend to attend the care conference to advocate for him. Further documentation indicated that the current guardian was not supportive of a discharge to a less restrictive environment based on an incident that occurred over three years ago. Documentation of additional actions undertaken to advocate for the	F 250		

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F 250	Continued From page 14 resident's placement elsewhere were not found until the week of the survey. There was no care plan addressing the possibility of discharge. In an interview with the facility social worker on 6/25/08, she stated that she had only been there since August 2007 and was not aware that the resident wished a different type of placement. In the interview with social services, it was stated that the guardian did not generally attend care conferences, but sent her assistant. During a conference on 5/29/08, the guardian's assistant mentioned negative behaviors that would preclude a discharge to a less restrictive environment based on three year old information.	F 250		
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, it was determined that the facility failed to clarify and/or implement physicians orders and to notify the physician when orders had not been carried out for 1 of 23 residents (#9). Findings include: Resident #9: The resident was admitted to the facility on 2/20/08 with diagnoses of atrial fibrillation, anemia, chronic renal failure,	F 309		

F 309 483.25 QUALITY OF CARE

This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to clarify and/or implement Physician's orders and to notify the Physician when orders had not been carried out for 1 of 23 Residents (#9).

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

Resident #9

One Resident was found to have been affected by the Deficient practice. Physician was notified that this *difficult-to-obtain*-drug was late to arrive. Medication was properly administered upon arrival with Physician approval. Corrective action will include In-service Training for Nurse on Documentation in Medication Administration Record (MAR) and notification to Physician that drug was not given. Pharmacist will notify DON when an unusual dose or drug is unavailable per agreement between the facility and the pharmacy.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents have the potential to be affected by the same deficient practice.

Documentation in the MAR and Nurse's Notes and notification to Physician that drug was not given will be performed by Nurse identified. The Director of Nursing Services has implemented a new policy regarding Pharmacist notification to DON when an unusual dose or drug is unavailable (attached).

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

In-service Training for Nurse on Documentation in Medication Administration Record (MAR) and notification to Physician that drug was not given. Pharmacist will notify DON when an unusual dose or drug is unavailable per Agreement between the facility and the Pharmacy. The implementation of this policy takes effect immediately.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

All Nursing Staff will attend In-servicing Training on the importance of Documentation in the Medication Administration Record (MAR). Monitoring will be performed under the supervision of the Director of Nursing Services by checking and re-checking MARs to ensure that documentation is provided.

Dates when corrective action will be completed?

Date when corrective action will be completed is August 8, 2008.

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F 309	Continued From page 15 hypertension coronary artery disease and anxiety. Review of the record revealed that on 4/4/08, the physician ordered that Resident #9's Digoxin dose be held for one day, then to restart the Digoxin at a lower dose of 50 mcgs per day. On 4/9/08, a nurse contacted the physician to clarify an order for a Digoxin level laboratory test, stating that the first dose had just been given of the reduced dose of medication. Review of the Medication Administration Record (MAR) showed that the medication for the dates of 4/5/08, 4/6/08, 4/7/08, and 4/8/08 were circled indicating that the medication was not given. The back of the MAR did not contain any documentation as to why the medication was not given as ordered. In an interview with the director of nurses, she indicated that the pharmacy had difficulty in obtaining that particular dose of the medication. The record did not contain any documentation that the physician was notified that the medication was not given or of the difficulty in obtaining the medication.	F 309		
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 function as possible. This REQUIREMENT is not met as evidenced	F 315		

F 315 483.25(d) URINARY INCONTINENCE

This REQUIREMENT is not met as evidenced by: Based on observation, policy review, staff interview, and record review, it was determined that the facility failed to ensure that Foley catheters were changed every 30 days per facility policy for 2 of 23 Residents (#3 and #6), failed to ensure that Foley catheter collection bags were not placed directly on the floor for 1 of 23 Residents (#6), and failed to ensure that Physician orders were followed after the removal of a Foley catheter for 1 of 23 Residents (#1).

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

Three Residents were found to have been affected by the deficient practice.

Resident #3

Catheter was changed for Resident #3 on July 1, 2008. Catheter bag was elevated and did not have contact with floor. In-service on revised policy for catheter changes is on-going.

Resident #6

The Nurse was In-serviced, under the direction of the DON on writing delayed orders. Bowel and Bladder and Post Void Residual (PVR) will be added to Nursing Audit tool. The catheter for Resident #6 was changed on June 27, 2008.

Resident #1

Nurse will be In-serviced on completing orders as written. Resident will be re-evaluated for inclusion in a bowel and bladder program. The Nurse will also be In-serviced on the need to obtain Post Void Residuals (PVRs), per Physician Order, when a catheter is removed.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents at Rosewood have the potential to be affected by the same deficient practice.

Corrective action(s) include revision of the current policy and procedure to add qualifying information and instructions regarding the proper procedure for the handling and use of a Foley catheter. Staff will be In-serviced on the revised policy beginning August 12, 2008, and as needed. The Physician Order will be included on the Treatment Record. The Admission Order Sheet will reflect our revised policy. Staff will be In-serviced on the revised policy on Catheter Care, specifically on *changing the catheter every 30 days and as needed per assessment parameters* and *using individual nursing judgment assessments regarding catheter status and character of urine, for changes in general appearance.* The Staff Development Coordinator will add *Catheter Care* to Nursing Orientation. Catheter use will be re-evaluated on a per Resident basis, and a catheter will not be used in place of Bowel and Bladder. Bowel and Bladder and Post Void Residual (PVR) will be added to Nursing Audit tool.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Corrective action(s) include revision of the current policy and procedure to add qualifying information and instructions regarding the proper procedure for the handling and use of a Foley catheter. Staff will be In-serviced on the revised policy by August 12, 2008, and as needed. The

Physician Order will be included on the Treatment Record. The Admission Order Sheet will reflect the revised policy. Staff will be In-serviced on the revised policy on Catheter Care, specifically on *changing the catheter every 30 days and as needed per assessment parameters* and *using individual nursing judgment assessments regarding catheter status and character of urine, for changes in general appearance.* The Staff Development Coordinator will add *Catheter Care* to Nursing Orientation. Catheter use will be re-evaluated on a per Resident basis, and a catheter will not be used in place of Bowel and Bladder. Bowel and Bladder and Post Void Residual (PVR) will be added to audit.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

The Director of Nursing Services will be responsible for monitoring corrective actions to ensure the deficient practice is being corrected and will not recur. Staff will be In-serviced on the revised policy by August 12, 2008, and as needed. The Physician Order will be included on the Treatment Record. The Admission Order Sheet will reflect our revised policy. Staff will be In-serviced on the revised policy on Catheter Care, specifically on *changing the catheter every 30 days and as needed per assessment parameters* and *using individual nursing judgment assessments regarding catheter status and character of urine, for changes in general appearance.* The Staff Development Coordinator will add *Catheter Care* to Nursing Orientation. Catheter use will be re-evaluated on a per Resident basis, and a catheter will not be used in place of Bowel and Bladder. Bowel and Bladder and Post Void Residual (PVR) will be added to Nursing Audit tool.

Dates when corrective action will be completed?

Dates when corrective action(s) will be completed are August 12, 2008 and August 15, 2008.

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F 315	Continued From page 16 by: Based on observation, policy review, staff interview, and record review, it was determined that the facility failed to ensure that Foley catheters were changed every 30 days per facility policy for 2 of 23 residents (#3 and #6), failed to ensure that Foley catheter collection bags were not placed directly on the floor for 1 of 23 residents (#6), and failed to ensure that physician orders were followed after the removal of a Foley catheter for 1 of 23 residents (#1). Findings include: Review of the facility policy titled "Catheter Care, Urinary" revised September 2005 revealed that a urinary catheter (Foley) was to be changed every 30 days and as needed. An interview with the infection control nurse, the director of nurses, and a charge nurse on 6/23/08 at 10:00 AM, confirmed that all Foley catheters were to be changed every 30 days and as necessary. Interviews with four licensed practical nurses (LPN's) from both Station A and Station B on 6/23/08, revealed that the nurses were not consistent in the frequency that a Foley catheter was to be changed. The interviews revealed that two of the LPN's thought that the catheters were to be changed every 30 days and as necessary; the other two LPN's thought the catheters should only be changed as necessary, for example, mal functioning or evidence of sediment or infection. All the LPNs confirmed that the treatment administration record was where the catheter changes were documented. The nurses also confirmed that the current treatment	F 315		

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F 315	Continued From page 17 administration record for any of their residents with catheters did not indicate the day when the catheter was to be changed that specific month. Three residents in the facility had Foley catheters. All the orders had been transcribed to read that the catheters were to be changed as needed, not monthly and as needed. There was no documentation transcribed to the current month to indicate when the catheter had been changed last. The records revealed that one of the three residents had had her catheter changed at least once a month. Two others did not (#3 and #6). Resident #3: The resident was admitted to the facility on 5/22/08. A Foley catheter was implemented on 5/23/08. The treatment administration record did not indicate that the catheter was to be changed 6/23/08. The catheter was not changed during the survey period. It was also observed on 6/25/08, that during a position change from the wheel chair to the bed the wound care nurse and a nursing assistant placed the collection bag directly on the floor. When interviewed, both confirmed that the collection bag should have been in a cover bag and should not have been placed on the floor due to increased risks of infection. Resident #6: The resident's catheter was changed on 4/2/08, due to a urinary tract infection. This was confirmed by nurses notes. There was no entry on the treatment administration record to reflect that the catheter had been changed. Review of the physician's orders and lab results revealed that Resident #6 had a subsequent urinary tract infection on 6/5/08. Antibiotics were ordered. His catheter was not changed at this time. Observation of	F 315		

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F 315	Continued From page 18 Resident #6's collection bag and tubing revealed cloudy yellow urine with sediment. Interviews with the nursing staff on 6/23/08, could not determine why Resident #6's catheter had not been changed in response to the urinary tract infection identified earlier this month or because of the sediment present. An order was received on 6/23/08, to change the catheter every month and as necessary. The treatment administration record indicated that the catheter was to be changed on 6/27/08. There was no specific reason noted for the catheter change to wait four days. An LPN was interviewed on 6/25/08 and could not explain why the change was delayed for four days. Resident #1: The resident was readmitted to the facility on 5/13/08 following an acute facility admission. Her diagnoses included anemia, failure to thrive, Alzheimer's disease, debility, congestive heart failure, and anxiety. An order was written on 5/20/08 to discontinue the Foley catheter, to a start bladder program, and to obtain a post void residual test every shift for 72 hours. If the post void residual was greater than 350 cc's, the staff could straight cath Resident #1 every eight hours as needed. The staff was to notify the physician if the resident was unable to void or if the post void residual exceeded 350 cc's after 24 hours. There was no documentation in the record that Resident #1's Foley catheter was discontinued or if any post voiding residuals were obtained or recorded. The facility policy indicated that the documentation should include the date and time of the removal, the name and title of the person performing the procedure and any assessment	F 315		

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F 315	Continued From page 19 data obtained during the procedure. Review of the record failed to reveal evidence that a bladder program was initiated or that an assessment for bladder training was completed after the Foley was removed. The facility policy indicated that voiding patterns were to be documented as well as the identification of risk factors and contributing medications. There was no summarization of the resident's continence status or indication that any type of toileting program was established on a 3 to 5 day trial as described in the facility policy. The record contained an active care plan for a Foley catheter with a target date of 8/8/08 as well as a care plan for potential for a urinary tract infection and skin break down due to bladder incontinence. The resident was in incontinence briefs at the time of the survey.	F 315		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS 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. 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	F 329		

F 329 483.25(l) UNNECESSARY DRUGS

This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to act on a recommendation by the consulting pharmacist to discontinue a medication for 1 of 23 Residents (#12).

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

One Resident was found to have been affected by the deficient practice. The use of Pharmacy sheets will be closely monitored under the supervision of the Director of Nursing Services. A Master Pharmacy Sheet will be kept and a book/log/manual will be created to check back on Pharmacist recommendations.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents have the potential to be affected by the deficient practice.

Resident #12

The medication Ogen was discontinued on July 8, 2008. The medication history for Resident #12 on Ogen is 0.75 dose everyday upon Admission. This was decreased to 0.37 everyday on February 28, 2008, and then discontinued on July 8, 2008 Per Physician Order. Per Physician Order, Depakote was decreased on August 15, 2007 to 500 milligrams from 750 milligrams, and 500 is the lowest possible dose.

The use of Pharmacy sheets will be closely monitored under the supervision of the Director of Nursing Services. A Master Pharmacy Sheet will be kept and a book/log/manual will be created to check back on Pharmacist recommendations.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The use of Pharmacy sheets will be closely monitored under the supervision of the Director of Nursing Services. A Master Pharmacy Sheet will be kept and a book/log/manual will be created to check back on Pharmacist recommendations. The Director of Nursing Services will be responsible for monitoring systemic changes to ensure the deficient practice does not recur.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

The use of Pharmacy sheets will be monitored under the supervision of the Director of Nursing Services. A Master Pharmacy Sheet will be kept and a book/log/manual will be created to check back on Pharmacist recommendations. The Director of Nursing Services will be responsible for monitoring corrective actions to ensure the deficient practice does not recur.

Dates when corrective action will be completed?

Date when corrective action will be completed is July 31, 2008.

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F 329	Continued From page 20 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to act on a recommendation by the consulting pharmacist to discontinue a medication for 1 of 23 residents (#12). Findings include: Resident #12: The resident was admitted to the facility on 12/1/05. Diagnoses included atrial fibrillation, osteoporosis, hypertension, vertebral compression fractures, coronary artery disease, anemia, dementia, delusional disorder, personality disorder and narcissism. The resident had a guardian when admitted to the facility. The resident had a history of inappropriate behaviors, but had not been evaluated by a psychiatrist since 2006. The evaluation found the resident was not depressed, angry or anxious, with no deranged or inappropriate mentations, and with reasonable insight. A Minimum Data Set completed 11/23/07 indicated that, while he had some short term memory problems, he was independent for decision making, and had no indicators of delirium or disordered thinking. There were no indicators of depression, anxiety or sad mood. It	F 329		

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F 329	Continued From page 21 was indicated that the resident did resist care, but was easily altered. In a Minimum Data Set completed 2/21/08, Resident #12 had no indicators of delirium, disordered thinking, depression, anxiety, sad mood or behavioral symptoms. Review of the physicians orders indicated that Resident #12 had been on his current dose of Ogen for sexually inappropriate remarks to staff since 2/28/08, and Depakote each evening for a mood disorder with agitated features since August 2007. Review of the monthly flow records for documentation of sexually inappropriate remarks to staff, verbal abuse, or paranoid delusions showed that no such behaviors had occurred for the months of March, April, or May. Review of the pharmacist progress notes revealed that no behaviors had been observed as far back as 11/07. In the December 2007 notes, it was indicated that Resident #12 had not had a dose reduction of Depakote since August 2005, nor a reduction of the Ogen since 12/1/05. The pharmacist further indicated that long term use of the estrogens increased the risk for breast cancer even in men and recommended a dose reduction at that time. In the 2/28/08 pharmacy notes, it was documented that the dose reduction was put into place on 1/16/08 and further recommended that if the residents behaviors remained stable after one month that there be a trial discontinuation of the drug, Ogen. The notes from 5/29/08 indicated that the pharmacist had spoken with the social worker about the resident's behaviors and continued to feel that the Ogen be discontinued and made that recommendation. On 6/23/08, the pharmacist attended an	F 329		

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F 329	Continued From page 22 Interdisciplinary Team Behavior/Medication Review for Resident #12. Again, it was recommended that the Ogen should be discontinued. At the time of the survey, the resident was still receiving the medication, Ogen, with no documentation of inappropriate behaviors.	F 329		
F 371 SS=E	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 kitchen observations and staff interview, it was determined that the facility failed to ensure that food was stored and prepared under sanitary conditions. Findings include: An interview with the dietary manager on 6/23/08, revealed that the current plan for discarding refrigerated foods is to label the food with the date when it is opened or prepared, and then discard the product within four to five days. The Dietary Manager revealed that a new policy was drafted with more specific discard dates for individual food products, but had not gone into effect. An interview with a cook during the initial tour on 6/23/08 revealed that foods were to be discarded within 48-72 hours after the date on the item. During the second observation on 6/25/08, a second cook stated that foods were to be	F 371		

F 371 483.35(i)(2) SANITARY CONDITIONS – FOOD PREP & SERVICE

This REQUIREMENT is not met as evidenced by: Based on kitchen observations and staff interview, it was determined that the facility failed to ensure that food was stored and prepared under sanitary conditions.

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

All Residents were found to be affected by the deficient practice. Immediate changes have been made to ensure that food is be prepared, distributed, and stored under sanitary conditions. Systems are being implemented to ensure that employees correctly, properly, and thoroughly wash their hands and change their gloves between tasks in order to decrease the risk of cross-contamination. Step-on trash cans will be purchased for food preparation areas to further decrease the risk for cross-contamination. Food processing equipment will not be stored on the floor; it will be stored on a clean, sanitized shelf in the Dietary Department. The Dietary Staff will monitor stored food for expiration dates, on a daily basis.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents at Rosewood Rehabilitation Center have the potential to be affected by the deficient practice. Immediate changes have been made to ensure that food is be prepared, distributed, and stored under sanitary conditions. Systems are being implemented to ensure that employees correctly, properly, and thoroughly wash their hands and change their gloves between tasks in order to decrease the risk of cross-contamination. Step-on trash cans will be purchased for food preparation areas to further decrease the risk for cross-contamination. Food processing equipment will not be stored on the floor; it will be stored on a clean, sanitized shelf in the Dietary Department. The Dietary Staff will monitor stored food for expiration dates, on a daily basis.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

1. **A new policy will be implemented regarding the preparation, distribution, and storage of food under sanitary conditions.**
2. **Dietary Staff will be In-serviced on the new policy of acceptable food storage periods and labeling of foods. Acceptable food storage times will be posted on refrigerators and freezers for reference for the use of all Dietary Department Employees.**
3. **Dietary In-services will be held on hand-washing and glove changing. Step-on trash cans will be purchased for food preparation areas to decrease the risk for cross-contamination.**
4. **Dietary Staff will be assigned lockers for storage of personal items, i.e, keys purses, coats, backpacks.**
5. **Food processing equipment will not be stored on the floor; it will be stored on a clean, sanitized shelf in the Dietary Department.**

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

1. **The Dietary Staff will monitor stored food for expiration dates, on a daily basis.**
2. **Three (3) Serve-Safe Certified Staff will monitor daily Dietary Department Employees for hand-washing and glove changing and correct practices if and when violated.**
3. **Storerooms will be checked on a daily basis for proper storage of personal items.**
4. **Dietary Staff will be In-serviced on the proper storage of equipment that is not in use.**

Dates when corrective action will be completed?

Corrective action, including all In-Service Training Sessions, will be completed by August 12, 2008.

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F 371	Continued From page 23 discarded four days after the date on the product. Observations of the refrigeration/freezer units and dry storage area of the kitchen were conducted on 6/23/08 and 6/25/08. On 6/23/08, a container marked "Slaw" and dated 6/14/08, and a plastic container marked "celery" and dated 6/17/08, were found in the refrigerator. The dietary manager confirmed that both of the products should have been discarded. A subsequent tour and inspection on 6/25/08, revealed a container marked "pudding for tonight" was dated 6/18/08. A tray of seven servings of diet puddings, five servings of jell-o, and three servings of chocolate pudding were undated in the refrigerator. The date that these were prepared could not be confirmed. An observation of meal preparation on 6/23/08, revealed a dietary assistant preparing food for the evening meal. A disposable fork she was using was dropped on the floor. This assistant picked up the fork and discarded it into the trash can, which required her to lift the trash can lid with her hand. The assistant then returned to the food prep area without washing her hands. She was not wearing gloves. During the initial tour on 6/23/08, a purse and car keys were observed on a shelf in the dry food storage area, next to food products. On 6/25/08, a spray bottle of deodorant was observed on the same shelf in the dry food storage. The dietary manager confirmed that the staff had limited access to securing personal items and that the dry food storage area was closest to the back door.	F 371		

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F 371	Continued From page 24 A food processor/chopper was observed on the floor of a second dry food storage area. The machine was covered by a plastic type covering. This area was adjoined the wall where the dishwasher was located. Debris was observed around the edge of the plastic. One of the cooks stated this was a non-functioning machine. The dietary manager stated it was a new machine. Neither staff member could explain why it was being stored on the floor.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES 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 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 staff interview and observation, it was determined that the facility failed to ensure that medication containers were labeled with the date	F 425		

F 425 483.60(a), (b) PHARMACY SERVICES

This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, it was determined that the facility failed to ensure that medication containers were labeled with the date opened and filed to ensure that Residents were not administered outdated medications.

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

All Residents were found to have been affected by the deficient practice. Corrective action includes an updated, revised Policy on "Open Dates" for Medications and a form Checklist that is used to ensure medication containers are labeled with the *date opened* and a notation checked on the form that the form is filed and where it is filed.

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents at Rosewood Rehabilitation Center have the potential to be affected by deficient practice. Corrective action includes an updated, revised Policy on "Open Dates" for Medications and a form Checklist that is used to ensure medication containers are labeled with the *date opened* and a notation checked on the form that the form is filed and its location.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Corrective action includes an updated, revised Policy on "Open Dates" for Medications and a form Checklist that is used to ensure medication containers are labeled with the *date opened* and a notation checked on the form that the form is filed and its location. Specifically, for Insulin, open date will be included and medication discarded every 30 days. For PPD, open date will be included and medication will be destroyed every 30 days. The Checklist form will be kept every week and reported to DON. The form will include medications in the cabinets of the Med Room, the Refrigerator, and on the Med Carts.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

The Director of Nursing Services and/or her Assistant or Designee will monitor corrective actions to ensure that the Medication Checklist form is being used and that open dates are listed. The form will be monitored to ensure that medications are destroyed at the time of expiration and that forms are properly filed.

Dates when corrective action will be completed?

Date when corrective action will be completed is August 5, 2008.

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F 425	Continued From page 25 opened and failed to ensure that residents were not administered outdated medications. Findings include: An interview on 6/23/08 and 6/24/08, with licensed nursing staff on Station A revealed that it was the responsibility of each staff member to date multidose vials or pill bottles when the containers were first opened. The night shift staff as well as the contract pharmacist were responsible to check stock medications for out-dated medications on a monthly basis. Observation of the medication room on Station A revealed that the refrigerator contained an open vial of Procrit with no date on the vial and five ampules of Promethazine 25 mg with expiration dates of February 2008. A stock medication cabinet with emergency supplies contained two packages of 50% Dextrose with expiration dates of 5/1/08. Observation of the medication cart for the back hall of Station A revealed an open and undated vial of Lantus Insulin and an open and undated vial of Novolog Insulin. The Station A front hall medication cart contained a stock medication bottle of Vitamin E which was opened on 3/2/07. Staff confirmed that open bottles were to be discarded one year after opening.	F 425		
F 441 SS=B	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	F 441		

F 441 (483.65(a) INFECTION CONTROL

This REQUIREMENT is not met as evidenced by: Based on interview and facility infection control documentation, it was determined that the facility failed to ensure that the infection control program thoroughly investigated infection data to minimize or prevent infections, and failed to maintain a record of corrective actions related to infections.

What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?

No Residents were found to have been affected by the deficient practice. A new program of policies and procedures has been implemented for establishing, maintaining, and monitoring Infection Control at Rosewood. The new program is designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection. (Copies attached)

How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All Residents have the potential to be affected by the deficient practice. A new program of policies and procedures has been implemented for establishing, maintaining, and monitoring Infection Control at Rosewood. The new program is designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection. (Copies attached)

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

A new program of policies and procedures has been implemented for establishing, maintaining, and monitoring Infection Control at Rosewood. The new program is designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection. The new policy and procedure is attached herewith. The Infection Control Coordinator and/or Designee will In-service Nurses and facility Staff on the importance of Infection Control throughout the facility. The Infection Control Coordinator and/or Designee will In-service Nurses on the use of *Individual Resident Infection Worksheet*(s). The Infection Control Coordinator and/or Designee will gather Individual Resident Infection Worksheet(s) as submitted by the Nurses. The Infection Control Coordinator and/or Designee will then tally infections for statistical purposes to submit to the QA Committee Chairperson and place on the *Rosewood Monthly Summary of Infection Control.* The QA Committee Chairperson and the QA Committee meet on a monthly basis.

During their meetings, Infection Control is discussed, trends are identified, investigations are initiated when warranted, and where appropriate, corrective measures implemented. Corrective Measures might include: Identification a particular Staff Member(s) associated with an incidence of infection, identification of the area(s) of incidence of infection, identifying whether a Resident has been recently discharged from an acute hospital and could have contributed to the infection, randomly observing Staff for proper techniques in hand washing, hand-sanitizing between patient contact; hand washing, hand-sanitizing after wearing gloves; identification of the proper technique for Residents in isolation; peri care with Foley cath in place; peri care without Foley cath in place; bathing Residents; and determining whether staff infections are contributing to Resident infection rate. The Infection Control Coordinator and/or Designee will work with Housekeeping Staff ensuring proper use of PPE, disinfection of rooms on a daily basis and

between Residents, disinfection of all surfaces throughout the facility, and the maintenance of clean, disinfected work space for Staff and visitors. The Infection Control Coordinator and/or Designee will perform monthly rounds, record information, and complete the *Infection Control Environmental Surveillance Form* for submission to the QA Committee Chairperson. The Infection Control Coordinator and/or Designee will propose a corrective plan for all deficient practices related to Infection Control and submit the corrective plan to the QA Committee Chairperson. The Infection Control Coordinator and/or Designee will keep copies of all information submitted to the QA Committee Chairperson.

How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change?

Monitoring of the new policy and procedure for the Infection Control Program will be performed by the QA Committee Chairperson and the Director of Nursing Services by requesting and utilizing for accuracy and timeliness copies of the *Rosewood Monthly Summary Report of Infection Control* and the *Infection Control Environmental Surveillance Form*.

Dates when corrective action will be completed?

Anticipated Date of Correction for full implementation of the new policy and procedure, including In-service training of Staff is August 8, 2008.

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ROSEWOOD REHABILITATION CENTER	2045 SILVERADA BLVD. RENO, NV 89512

(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 441	Continued From page 26 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 interview and facility infection control documentation, it was determined that the facility failed to ensure that the infection control program thoroughly investigated infection data to minimize or prevent infections, and failed to maintain a record of corrective actions related to infections. Findings include: An interview on 6/25/08, with the infection control coordinator revealed that she received copies of physician orders for antibiotics and lab reports and compared them on a monthly basis to identify resident infections. She demonstrated that she tracked specific infections using a floor plan of the facility and a code symbol for the type of infection. The infection control coordinator stated that she only reported infections that were acquired in the facility to the quality assurance committee. Review of a graphic diagram of infections revealed that in January 2008, there were six reported urinary tract infections. In February, fifteen cases were reported. The infection control control coordinator stated that she did not investigate what the causes or contributing factors were for the increase in cases. She stated that the next month's urinary tract infections were back down, so there was not an ongoing problem.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	295020		06/30/2008

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