STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295015		06/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE REGIONAL MED CTR SNF	825 ERIE MAIN/ PO BOX 391 TONOPAH, NV 89049

(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 the annual Medicare recertification survey conducted at your facility on June 1, 2009 through June 3, 2009, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was four residents. The sample size was four residents. 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 deficiencies were identified:	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		

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

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 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review, the facility failed to ensure that the resident or their legal representative made an informed choice about the risks and benefits of chemical restraints for 2 of 4 residents (#2, #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 5/9/08, with diagnoses including diabetes, coronary artery disease, hypertension, gastroesophageal reflux disease, chronic renal insufficiency, and depression. On 5/3/09 the facility's psychiatrist ordered the antidepressant Citalopram (Celexa) 20 mg once daily "for mood." On 5/22/09, the medication was discontinued by the facility's physician because of concerns about dizziness. Review of the resident's record failed to reveal evidence of a consent for Celexa and that the family had been	F 157		

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F 157	Continued From page 2 notified about the risks and benefits of the medications's use. In an interview on 6/3/09 at 9:00 AM, the Director of Nursing (DON) (Employee #2), confirmed that a consent for Celexa had not been obtained for the resident, and that the facility had no written policy regarding the use of consents for psychotropics. The DON presented a consent form that had been used by the facility in the past. There were twelve medications listed on the form, but Celexa was not included. The DON indicated that Celexa should be added to the list, and that she was currently working with Pharmacy to update the form to include more psychotropics. Resident #2 Resident #2 was admitted to the facility on 1/28/09, with diagnoses of chronic obstructive pulmonary disease, hypertension, glaucoma, dementia, cardiovascular disease, and history of depression and anxiety. Review of the physician's orders dated 5/28/09, revealed that the facility psychiatrist ordered the antidepressant Citalopram (Celexa) 20 milligrams every morning. On 6/2/09, review of Resident #2's medical record failed to reveal a consent for the Celexa. Review of the Nurse's Notes, starting shortly after admission to present, indicated the resident had become withdrawn, was frequently tearful, less interactive with her peers, eating less, having trouble sleeping at night and lacked interest in activities.	F 157		

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F 157	Continued From page 3 Review of the resident's Minimum Data Set (MDS), with the assessment reference date of 3/27/09, indicated the resident was sad, had a loss of interest in activities and had reduced social interaction. There was also no evidence of a care plan addressing the resident's depression. Review of the Care Conference Summary notes dated 4/29/09, lacked evidence that the resident's depression was being addressed. In an interview on 6/2/09, the DON, Employee #2, confirmed there was no consent form for the antidepressant or a care plan addressing Resident #2's needs associated with her depression. The DON indicated that there should have been a consent for the antidepressant and care plans should have been developed to address the depression from multiple stand points.	F 157		
F 167 SS=C	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 staff interview, the facility failed to post notification and make the	F 167		

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F 167	Continued From page 4 results of the most recent survey of the facility readily accessible for examination. Findings include: On the initial tour of the facility conducted the afternoon of 6/1/09, revealed that there was no notification posted to indicate where survey results could be found and the survey results were not available for examination. Following the initial tour of the facility, the Director of Nursing (DON) (Employee #2), was interviewed. The DON indicated she had been at the facility for approximately one and a half weeks and did not know where the results were kept. The DON confirmed there was no notice indicating where the survey information could be found and that the survey results were not available for examination. The DON further indicated that she was familiar with the requirement and that there should have been a notice posted and the survey results should be readily accessible to the residents and visitors.	F 167		
F 168 SS=C	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 staff interview, the facility failed to make information from agencies acting as client advocates available to the residents allowing them the opportunity to contact	F 168		

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F 168	Continued From page 5 these agencies. Findings include: On the initial tour of the facility conducted the afternoon of 6/1/09, revealed that there was no notification or information posted for the residents with contact information of agencies acting as client advocates. Following the initial tour of the facility, the Director of Nursing (DON) (Employee #2), was interviewed. The DON indicated she had been at the facility for approximately one and a half weeks and did not know where the contact information for the State Ombudsman, State Division of Aging and the State Bureau of Licensure were kept. The DON confirmed there was no notice or information posted with the contact information of the agencies acting as client advocates. The DON further indicated that she was familiar with the requirement and that there should have been notices posted with the agencies contact information, and that the information should be readily accessible to residents and visitors.	F 168		
F 221 SS=D	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, staff interview, and record review, the facility failed to ensure restraints were used for the treatment required by the resident's medical condition for one of four residents (#1).	F 221		

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F 221	Continued From page 6 Findings include: On the initial tour of the facility the afternoon of 6/1/09, Resident #1 was observed lying on her back with her hands positioned on her chest, sleeping quietly in her bed. The left side of the bed was observed against the wall with both of the upper half side rails in the upright position. There was also a floor mat along side the bed with a sensor alarm. Certified Nursing Assistant (CNA), Employee #5, who accompanied this surveyor on the tour, was asked why the side rails were up. The CNA indicated that the upper side rails were always in the raised position when the resident was in the bed. When asked if the resident was able to use the side rails for turning or repositioning herself while in bed or to assist herself getting in or out of bed, the CNA stated, "She (the resident) doesn't move." The CNA indicated that the resident required total care with all of her activities of daily living (ADL's), including turning, repositioning and transferring. The CNA was not sure why the mat with the sensor alarm was being used since the resident did not transfer herself, no longer ambulated or tried to get up on her own. The CNA further indicated that it was her understanding, for safety reasons, that since the four residents in the facility were so far away from the nurse's station that the mats had been placed along side each resident's bed to alert staff if a resident was getting out of bed without assistance. Resident #1 was admitted to the facility on 1/30/09, with diagnoses of Alzheimer's dementia, osteoporosis, hypertension, cardiomegaly and	F 221		

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F 221	Continued From page 7 pacemaker. Review of the resident's Minimum Data Set (MDS), with the assessment reference date of 3/5/09, indicated that the resident was severely cognitively impaired, unable to make her needs know, was totally dependent on staff for all ADL's including turning, repositioning and transferring. The MDS also indicated bed rails such as half rail or one side were used. Continued review of Resident #1's medical record, including assessments, nurses notes, care plans, care conference notes and doctor's orders failed to identify the need for the side rails. The record failed to reveal evidence that a fall risk, restraint, elopement or side rail assessments had been completed. The review also failed to reveal evidence of a current consent for the side rails. On 6/2/09, Resident #1's previous admission medical records were reviewed. Review of the records revealed a Consent for Inclusion in Restraint Elimination Program, in which the resident's guardian had signed in agreement with discontinuing the use of half side rails on 3/26/08. The record also revealed a signed doctors order dated 3/27/08 to discontinue all side rails on the bed. The morning of 6/2/09, the Director of Nursing, Employee #2, was interviewed. The DON confirmed, for the current admission (1/30/09), that there were no assessments, orders or consents for restraints or side rails for Resident #1. On the afternoon of 6/2/09, the facility's policy on	F 221		

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F 221	Continued From page 8 restraints was requested. The information provided included restraint and consent forms. Review of the information provided failed to reveal a facility policy on restraints. The DON confirmed that the consent forms were what was available.	F 221		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that background checks had been completed on all employees for 3 of 9 personnel (#3, #4, #8). Findings include: A review of the facility's personnel records failed to reveal evidence that background checks had been conducted on three contracted employees. In an interview on 6/3/09 at 2:00 PM, the Director of Nursing (DON), Employee #2, confirmed that background checks had not been completed on the contracted employees. The DON indicated that the facility's policy was to conduct background checks on all employees, including consultants.	F 226		
F 248 SS=C	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being	F 248		

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F 248	Continued From page 9 of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that an activities program had been designed to meet the interests and the psychosocial well-being of 4 of 4 residents (#1, #2, #3, #4). Findings include: A review of each resident's record revealed there was an initial activities assessment form which had been filled out by a Certified Nursing Assistant (CNA), Employee #7. However, there was no evidence that a care plan for each resident, outlining activity goals with measurable objectives, had been developed in order to monitor and evaluate their responses to the activities. Review of all four resident's records indicated that the resident's were admitted to the facility between 1/28/09 and 1/30/09. The section for Attitude (Psychosocial Well-Being) on Resident #1's Initial Activity Assessment was not completed, the bottom of the form indicated it was reviewed by the activities consultant on 4/18/09. Review of Resident #3's Resident Assessment Protocol Summary (RAPS) dated 3/17/09, identified activities as an area needing further assessment to determine care planning needs. On the morning of 6/2/09, CNA, Employee #7, was interviewed. The CNA specified she had completed the the first page of the initial activity assessments on the facility's four residents and	F 248		

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F 248	Continued From page 10 that other portions of the assessment were completed by the nurse or other appropriate staff. The CNA indicated she had completed the assessments the first part of February 2009. In the interview the CNA, Employee #7, indicated she had no previous experience as an activity assistant or coordinator, was not trained or certified in activities, and was not responsible for activity care plan development. The CNA indicated she was responsible for and had documented in the individual resident's participation in activities on the Resident Monthly Participation Log and made notations in the Activities Progress Notes. The CNA also indicated she was responsible for posting and running the activities that had been outlined by the facility's activity consultant. The CNA stated, "I write the activities on a white board in the activities room on a daily bases for the residents." On observation during the initial tour on 6/1/09, and throughout the survey ending 6/3/09, there were no monthly or daily calendars or calendars with activity events in the individual resident's rooms or common areas of the facility, including hallways, dining and activity rooms. The white board used by the CNA was blank on 6/1/09 and did not list any activities until the afternoon of 6/3/09. The CNA, Employee #7, indicated she had not received the activity program information from the facility's activity consultant and had called to request the information from the consultant on the morning of 6/3/09. The CNA indicated she did not always understand what needed to be done for a particular activity and that she could call the activity consultant if needed.	F 248		

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F 248	Continued From page 11 In the late afternoon of 6/1/09, an interview with the Director of Nursing (DON) (Employee #2) revealed the facility had previously (prior to January 2009) used monthly activity calendars which were posted in each resident's room and had a large decorated monthly calendar of activity events in a common hallway. The DON indicated that the current listing of activities, which were done on daily sheets for the month, were kept in a binder at the nurse's station. The DON confirmed the nursing assistants were running the activities. Review of the activity binder, failed to provide evidence of activities scheduled for June 2009. On 6/2/09 at approximately 11:00 AM, an interview with the facility's contracted Activities Consultant, Employee #4, was conducted by phone. The consultant indicated she had been advised by the facility to only come out on a quarterly bases to see the residents. The consultant confirmed she had not completed the individual resident's initial activities assessments and indicated that on 4/18/09, when she had been out to the facility for a quarterly visit, she had reviewed the assessments completed by the nursing assistant. The consultant also confirmed that individualized activity care plans had not been developed for each resident and that she had not participated in care conference or the completion of the resident's Minimum Data Set. On 6/2/09, the activity consultants contract was reviewed. The contract indicated the consultant was to: - assist in the planning, development, and implementation of resident activities; - assist in the development of individualized resident activity plan through assessments; - attend and participate in resident care	F 248		

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F 248	Continued From page 12 assessment meetings, assist in the planning, coordination and develop activities program that provides spiritual, physical, intellectual, social and emotional challenges that are beneficial in overcoming specific problems; - perform in-service training for resident care personnel; and - participate in the development of care plans in relation to the resident's illness, response to treatment and adjustment to care in the facility. The contract indicated the consultant was to devote between eight to sixteen hours per month to the facility in providing activity services. The contract was dated November 15, 2000, and there was no evidence of revisions to the contract. In an interview with the DON, on the afternoon of 6/2/09, the DON stated, "(She) Wasn't aware that the activity consultant had been directed to only come quarterly."	F 248		
F 250 SS=C	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 observation, record review and staff interviews, the facility failed to identify and provide medically-related social services to meet the needs and psychosocial well-being of 4 of 4 residents (#1, #2, #3, #4).	F 250		

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F 250	Continued From page 13 Findings include: Common Resident and Facility History: Review of all four resident's records indicated that the resident's were admitted to the facility between 1/28/09 and 1/30/09. Prior to this admission, the residents had previously resided, for an extensive period in the extended care area of the facility before being evacuated from the facility due to flooding. The four residents had been relocated to separate settings while the facility under went repairs. The four residents had been discharged for approximately one month before returning to the facility. When the residents returned in January 2009, they were admitted to different rooms, in designated beds located on the acute care section of the facility. On 6/1/09, in an interview with the facility's Administrator, Employee #1, indicated that the repairs to the extended care area had not been completed. The Administrator indicated that the four current residents (#1, #2, #3, #4) would remain in their current location and would not be returning to their previous surroundings. The Administrator indicated the facility intended to retain the current residents, but did not plan on taking any new admissions as vacancies became available. The Administrator further indicated that the facility's board had decided when the extended care area was re-opened that it would no longer be utilized for long term skilled nursing. On the afternoon of 6/1/09 a tour of the closed extend care section, where the residents had perviously resided, revealed a number of	F 250		

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F 250	Continued From page 14 remaining personal effects left by all four residents. Resident #3 Resident #3, who had resident in a private room by herself, still contained pictures, decorations, other homelike and personal items. A review of each resident's record revealed that initial contact and psychosocial assessments were completed by the facility's social services consultant on 4/18/09. There was no evidence that a care plan for each resident, outlining goals, approaches with measurable objectives for re-orientation, adjustment to placement or other psychosocial needs had been developed in order to monitor and evaluate their responses. Review of Resident #3's Psychosocial Assessment dated 4/18/09, indicated the resident was confused about her physical settings and room change, that the resident was routine oriented and had difficulty with change, and that cues to orient the resident were needed. An additional note by the facility's social services consultant date 4/18/09, indicated that the resident did not recognize her surroundings, needed repeated assistance fining her new room, that she had been very active in bingo and was now participating minimally in activities, that her affect was much less bright and needed assistance in making adjustment to a new area of the facility. Review of the resident's care plans failed to reveal evidence these needs were addressed. Resident #1	F 250		

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F 250	Continued From page 15 Review of Resident #1's Psychosocial Assessment dated 4/18/09, indicated that the resident would continued to be offered sensory stimulation, frequent cues for orientation. The Care Plan Conference Summary dated 4/29/09 indicated the need to change guardianship to the current county of residence. Review of the resident's medical records and care plans failed to reveal evidence these needs were addressed. Resident #2 Review of Resident #2's Nurse's Notes, starting shortly after admission to present, indicated the resident had become withdrawn, was frequently tearful, less interactive with her peers, eating less, having trouble sleeping at night and lacked interest in activities. Review of the resident's Minimum Data Set (MDS), with the assessment reference date of 3/27/09, indicated the resident was sad, had a loss of interest in activities and had reduced social interaction. The resident's Psychosocial Assessment Dated 4/18/09, indicated the resident needed assistance with adjustment to placement in the new area of the hospital, that she needed encouragement to express her wants and needs to reduce her nervousness, and that she had lost interest in activities. While the resident had been diagnosed with depression and was on medication, review of the resident's medical records and care plans failed to reveal evidence these needs were addressed. Resident #4 Review of Resident #4's Psychosocial Assessment date 4/18/09, indicated the resident was pleasant although her affect was flat, that the	F 250		

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F 250	Continued From page 16 resident exhibited all of the vegetative signs and symptoms of depression, that while the resident currently had a roommate, she had previously had a private room and had enjoyed her own little routine of activities in her own room and enjoyed that privacy tremendously and the change was a factor in mood change. Review of the resident's Resident Assessment Protocol Summary (RAPS) dated 3/17/09, identified changes in cognitive loss, decline in activities of daily living and changes in mood as areas needing further assessment to determine care planning needs. Review of the resident's care plans failed to reveal evidence these needs were addressed. On 6/2/09 at approximately 10:30 AM, an interview with the facility's Social Services Consultant, Employee #3, was conducted by phone. The consultant indicated she had contacted the facility some time late January 2009 or early February 2009 when she found out the residents had returned to the facility in January. The consultant indicated she had wanted to come out as soon as possible to see the residents, but had been advised by the facility to only come out on a quarterly bases to see the resident's. The consultant confirmed she had not completed the individual resident's initial psychosocial assessments until 4/18/09. The consultant indicated on 4/18/09, during her visit to the facility she had visited with each resident and was concerned with how the residents were adjusting to their return, with the limited dining and activity space and that she had noticed some decline in several of the residents. The consultant also confirmed that individualized care plans to address psychosocial needs, including	F 250		

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F 250	Continued From page 17 adjustment to placement in the new area of the facility (acute section) had not been developed for each resident, and that she had not participated in care conference or the completion of the resident's Minimum Data Set. On 6/2/09, the social services consultant's contract was reviewed. The contract indicated the consultant was to: - provide professional guidance and consultation; - participate in patient (resident) care conferences; and - to review case files, interview and make appropriate and necessary notes on individual patients (residents) and insure that they were up to date and integral with respect to assessments, treatment plans and progress notes. The contract indicated the consultant was to schedule visits to the facility on a mutually agreed schedule and that the consultant would provide no more than 16 hours of consulting time per month. The contract was dated August 13, 1999, and there was no evidence of revisions to the contract. In an interview with the DON, on the afternoon of 6/2/09, the DON stated,"(She) Wasn't aware that the social services consultant had been directed to only come quarterly."	F 250		
F 252 SS=C	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced	F 252		

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F 252	Continued From page 18 by: Based on observation and interview, the facility failed to create a homelike environment for its dining room/activity area. Findings include: A tour of the facility at 12:30 PM on 6/1/09, revealed that one of the facility's private/single occupancy bedrooms was being used as a dining and activity area for their four residents. Because of the size of this room, there was resident crowding, especially when all four were in the room at the same time. The room was also void of decorations. The Director of Nursing, Employee #2, acknowledged the inadequate size of the room. Note: On 6/2/09, the DON arranged for the residents to use the facility's main dining room for activities and meals. Cross Reference Tag 464 - Dining and Resident Activities	F 252		
F 278 SS=C	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		

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F 278	Continued From page 19 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that comprehensive assessments were completed with the appropriate participation of health professionals for 4 of 4 residents (#1, #2, #3, #4). Findings include: Review of all four resident's records indicated that the resident's were admitted to the facility between 1/28/09 and 1/30/09. A review of each resident's Minimum Data Set (MDS) record revealed on previous and current quarterly reviews, AB (demographic information), AC (customary routine) were blank; section AD (face sheet signatures) and section "A17 Attestation of Accuracy and Signatures of Persons Who Correct Portion of Assessment or Tracking Information" were either blank or unsigned and undated.	F 278		

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F 278	Continued From page 20 The review of the MDS for all residents, failed to reveal all required signatures and dates in Section AA #9 attesting to the accuracy of the assessment or who contributed in the completion of the assessment. On 6/2/09 at approximately 11:00 AM, an interview with the facility's contracted Activities Consultant, Employee #4, was conducted by phone. The consultant confirmed she had not completed the individual resident's initial activities assessments and indicated that she had not participated or contributed to the resident's comprehensive assessment (Minimum Data Set). On 6/2/09 at approximately 10:30 AM, an interview with the facility's Social Services Consultant, Employee #3, was conducted by phone. The consultant indicated she had not participated or contributed to the resident's comprehensive assessment (Minimum Data Set). The consultant further reported that when she was in the facility on 4/18/09, that she reviewed the residents MDS's and had signed but not dated the MDS's. The consultant indicated her signature was only in confirmation that she had looked at the document. On 6/2/09, an interview with the Director of Nursing (DON), Employee #2, indicated that the nurse that had completed the MDS's on all four residents was one of the facility's acute care nurses who did not have training in completing the comprehensive MDS assessment. The DON expressed that, due to staff's lack of training, the MDS's were not as accurate as they should have been.	F 278		
F 353 SS=F	483.30(a) NURSING SERVICES - SUFFICIENT STAFF	F 353		

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F 353	Continued From page 21 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the nursing schedule, the facility failed to provide sufficient staff on a 24-hour basis to meet resident's direct care needs for 4 of 4 residents (#1, #2,#3, #4). Findings include: On the initial tour of the facility the afternoon of 6/1/09, it was observed that the facility's four residents were located in rooms down the hall, approximately 85 feet, from the nurse's station.	F 353		

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F 353	Continued From page 22 On 6/2/09, an interview with Licensed Practical Nurse (LPN), Employee #5, revealed that the Residents #3 and #4 required assistance with toileting multiple times during the night. In separate interviews with LPN, Employee #10, and the Certified Nursing Assistant (CNA) (Employee #6), it was revealed that Resident #3 could use her call light, but routinely called out for assistance instead. On 6/2/09 in an interview with Resident #3, the resident confirmed that she did not use the call light to call for assistance, but that she yelled out whenever she needed help. Review of Resident #1's medical records revealed that she was severely cognitively impaired and totally dependent on staff (nursing and nursing assistants) for twenty four hour care including, medication administration, repositioning, turning, hygiene care and feeding. The resident was not capable of using the call light or calling out for assistance and needed to be checked on regularly by nursing staff throughout the day and night. Review of Resident #2's medical records revealed that she was moderately cognitively impaired and required extensive staff assistance (nursing and nursing assistants) for twenty four hour care including, medication administration, repositioning, turning, and hygiene care. Review of the nursing schedule revealed that during the day there was one LPN and one CNA assigned to the facility's four long term care residents. The schedule revealed that there were no CNA's scheduled at night, and that there was only one licensed nursing staff scheduled during the night to attend to the four long term care	F 353		

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F 353	Continued From page 23 residents. The Director of Nursing (DON) (Employee #2), confirmed the long term care nursing assignments. On 6/2/09, at 8:15 AM during the medication pass, LPN, Employee #5 assigned to the four residents, was observed being called away by the doctor to attend to a patient on the acute (hospital) section. The LPN later explained that she had been pulled away due to the acute care nurse being unavailable. The LPN indicated that was the reason she had to suddenly stop and interrupt passing medications to the four residents. On the morning of 6/2/09, CNA, Employee #7, assigned to the residents was observed coming out of an acute care patients's room. At the same time the LPN was observed at the nurse's station. This left the residents temporarily unsupervised. Upon interviewing the CNA, the CNA stated, "Sometimes I help with doing vital signs or help with the acute (hospital) patients when needed." On 6/2/09, in an interview the DON, she agreed that 24 hour coverage for the residents was compromised during emergent situations given the current staffing levels especially with the lack of CNA coverage at night.	F 353		
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356		

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F 356	Continued From page 24 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to post the required information on nurse staffing. Finding include: On 6/1/09, during the initial tour of the facility revealed that the staffing information for nursing was not in posted. On 6/2/09, during an interview with the facility's Director of Nursing (DON) (Employee #2), indicated that the required staffing information was kept in an unmarked binder at the nurse's	F 356		

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F 356	Continued From page 25 station and confirmed the information was not posted or in a prominent place that was readily accessible to residents and visitors.	F 356		
F 361 SS=F	483.35(a) DIETARY SERVICES - STAFFING The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and policy review, the facility failed to ensure that its dietitian provided frequently scheduled consultation to the food service manager. Findings include: An inspection of the facility's food service operations at 12:30 PM on 6/1/09, revealed that the facility had no planned menus and that the Dietary Manager, Employee #9, was planning meals one day in advance. She indicated that the current procedure for menu planning involved writing down her meals after she prepared them, and then faxing the month's meals to the	F 361		

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F 361	Continued From page 26 Dietitian, Employee #8, at the end of each month. The Dietary Manager reported that the facility had used Sysco menus until the end of December when the facility temporarily closed for a month. The Director of Nurses (DON), Employee #2, acknowledged in an interview at 1:30 PM on 6/1/09, that the Dietitian had not been in the facility for five months since the (temporary) closure. The DON, who started her employment in mid-May, realized this fact and called the Dietitian to encourage her to conduct an on-site consultation visit. As a result of this call, the Dietitian came to the facility on 5/23/09. The facility's policy on nutritional services was reviewed and revealed, "The consultant clinical dietitian overseeing the dietary manager is responsible and accountable to the medical staff to provide food in the quantity and quality to meet the nutritional needs of the patient in accordance with the physician's diet order." At 1:00 PM on 6/3/09, an interview with the Dietitian was conducted by phone. The Dietician acknowledged that the current system of planning menus did not meet acceptable standards of practice, and that the menus should have been prepared in advance and pre-approved by her. The Dietitian also reported that since January, she had been uncertain as to how often the facility had wanted her to come in for consultation. The Dietitian's consultant services agreement was reviewed, and one of the responsibilities listed was: "Consultant services shall be defined as one monthly consultation, consisting of an 8-hour on-site consultation visit." The DON	F 361		

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F 361	Continued From page 27 acknowledged that this agreement was not being followed by the facility. Cross reference Tag 363 - Menus and Nutritional Adequacy	F 361		
F 363 SS=F	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure menus were prepared in advance and met the nutritional needs of residents in accordance with recommended dietary allowances. Findings include: A tour of the kitchen at 12:30 PM on 6/1/09, revealed that there were no pre-planned menus; rather, the Dietary Manager, Employee #9, planned and recorded the meals on the day of preparation. The Dietary Manager indicated that the kitchen had not used its pre-planned Sysco menus for five months. She further reported that meals were planned by her a day in advance, and that the Dietitian was not involved in reviewing menus before they were used, or assessing the nutritional adequacy of the meals. A review of the meals prepared for residents	F 363		

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F 363	Continued From page 28 during the month of May revealed a lack of detail. For example, the menu for 5/3/09 indicated "waffles, fruit." The Dietary Manager reported that when the Dietitian, Employee #8, came to the facility on 5/23/09, she had encouraged her to specify the amounts given. The Dietitian was interviewed by phone at 1:00 PM on 6/3/09. The Dietitian confirmed that menus were not being prepared in advance, and she acknowledged that the current system of menu planning was unacceptable and needed to be revised. Cross-reference Tag 361 Dietary Services - Staffing	F 363		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, the facility did not maintain sanitary conditions for the storage and preparation of food. Findings include: A tour of the facility's kitchen on 6/1/09, from	F 371		

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	295015		06/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE REGIONAL MED CTR SNF	825 ERIE MAIN/ PO BOX 391 TONOPAH, NV 89049

(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 371	Continued From page 29 12:30 PM to 2:00 PM, revealed the following: Improper thawing: Two frozen sealed hams were observed being thawed on the counter of the food preparation sink. The Dietary Manager, Employee #9, reported that the ham had been out since 7:00 AM. According to the facility's policy, "All frozen meat is to be defrosted under refrigeration, unless cooking is to be done from frozen state." Improper food dating: The following potentially hazardous foods (PHF's) were undated in the refrigerator: mashed potatoes, two pieces of leftover veal, a container of brown gravy, an opened bag of ham, an opened bag of roast beef, and cooked bacon. The Dietary Manager reported that the facility's policy was to date all PHF's and discard them after three days. The environmental health specialist conducted an inspection of the kitchen on 6/2/09, and the following findings were listed on the Food Service Establishment Inspection Report: 1. The drain line from the ice machine was made of flex tubing rather than a rigid line. 2. The spray hose in the dish washing room was leaking. It also needed to be raised and secured. 3. The water at both handwashing sinks took four minutes to warm up. 4. The plastic cup used to scoop dry cereals was in need of a handle. 5. The bags lining the dry food bins were not food-grade. 6. The cutting board on the steam table was worn. 7. The end cups on the ceiling light shields were missing.	F 371		

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F 425 SS=F	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 observation, staff interview and record review the facility failed to provide pharmaceutical services to ensure appropriate measures were in place for the recapitulations of current medication orders, that medication administration records reflected current orders for 4 of 4 residents (#1, #2, #3, #4), and for the disposal of medications. Findings include: Review of all four resident's records indicated that the resident's were admitted to the facility between 1/28/09 and 1/30/09. (Prior to this admission, the residents had previously resided,	F 425		

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F 425	Continued From page 31 for an extensive period in the extended care area of the facility before being evacuated from the facility due to flooding. The four residents had been discharged for approximately one month before returning to the facility.) A review of each resident's medical records, including Physician's Orders failed to reveal evidence of a current listing or recapitulation of medication orders with justification for medications being administered since their admission in January. Review of each resident's medication administration record, since their admission in January revealed medications being listed from the resident's previous admission which had been discontinued during the previous stay. On the morning of 6/2/09, an interview with the Director of Nursing (DON) (Employee #2), was conducted. The DON confirmed there was no recapitulation of the four resident's medication orders, and that the current medications being administered lacked justification (diagnoses) for each medication. On the morning of 6/2/09, during med pass observation the Licensed Practical Nurse (LPN), Employee #5, was observed throwing out an unused medication in a trash can located by the nurse's station. The trash can with the disposed of medication was within view and reach of residents, staff and visitors. The LPN indicated that is were she routinely disposed of unused medications. The DON, Employee #2, who was at the nurse's station at the time of the observation was asked if there was a policy and procedure for the disposal	F 425		

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F 425	Continued From page 32 of unused medications. The DON indicated there was not a facility policy and procedure for the disposal of unused medications.	F 425		
F 441 SS=F	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, interview and facility policy review, the facility failed to ensure that tuberculosis (TB) testing was completed for 3 of 9 employees (#3, #4, #8). Findings include: A review of personnel records failed to reveal evidence of TB testing for contracted staff. In an interview on 6/2/09, Employee #2 indicated that the facility should have conducted TB tests on all employees and kept documentation of the tests in their records. The facility's contracted staff policy was reviewed and revealed, "The required contract staff information listed below will be maintained by Human Resources for each contracted individual: evidence of licensure, certification, or registration	F 441		

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F 441	Continued From page 33 when applicable; references; contract; and TB testing."	F 441		
F 464 SS=C	483.70(g) DINING AND RESIDENT ACTIVITIES The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a dining/activities room with sufficient space to accommodate all activities. Findings include: A tour of the facility at at 12:30 PM on 6/1/09, revealed that one of the facility's private/single occupancy bedrooms was being used as a dining room/activity area for their four residents. Because of the size of this room, the residents had difficulty congregating together, especially since they used wheelchairs and walkers. The Director of Nursing, Employee #2, acknowledged the inadequacy of the room. Note: The DON on 6/2/09, had arranged for the residents to use the facility's main dining room for activities and meals. Cross Reference Tag 252 - Environment	F 464		
F 497 SS=C	483.75(e)(8) REGULAR IN-SERVICE EDUCATION	F 497		

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F 497	Continued From page 34 The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete an annual performance review and provide cognitive impairment training for 2 of 2 certified nursing assistants (CNAs) (Employees #6, #7). Findings include: A review of personnel records failed to reveal evidence of performance evaluations or cognitive impairment training for the facility's two CNAs. The Director of Nursing, Employee #2, confirmed that the CNAs had not received cognitive impairment training or performance reviews over the past year.	F 497		