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FAYETTEVILLE HEALTH AND REHABILITATION CENTER	3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703

(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 Complaint # 12656 and 12584 was unsubstantiated	F 000		
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 and interview, the facility failed to ensure an assessment was completed prior to and post Hemodialysis for 1 of 1 casemix resident, (Resident # 17) who required Hemodialysis. This failed practice had the potential to affect 1 resident (Resident # 17) in the facility who received dialysis according to the Resident Census and Conditions of Residents form dated 8/1/07. The findings are: 1. Resident # 17 had diagnoses of Renal Failure and End Stage Renal Disease. The Minimum Data Set dated 6/27/07 documented the resident was independent in cognitive skills for daily decision making and received Dialysis. a. The " Nursing Procedures Manual" under the "Policy Title: Hemodialysis Care" received from the Nurse Consultant on 8/3/07 at 5:05 p.m. documented, "Standard: Physician's orders for care of the hemodialysis resident should include information regarding visits to a dialysis center, along with care of the access site. ... Process: ...	F 309		

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 309	Continued From page 1 4. Palpate for a thrill and monitor the site for pain, swelling, redness or drainage: notify the physician if abnormalities are found." b. On 8/3/07 at 4:19 p.m., LPN (Licensed Practical Nurse) # 3 was asked what assessments do you do prior to and after dialysis. LPN #3 stated, "They weigh him before and after he goes." c. On 8/3/07 at 4:22 p.m., LPN # 4 was asked what assessments do you do prior to and after dialysis. LPN # 4 stated, "Wake him up at 5:30 (a.m.) and do blood sugars and ask him how he is ... " d. On 8/3/07 at 4:24 p.m., RN (Registered Nurse) # 1 was asked what assessments do you do prior to and after dialysis. RN # 1 stated, "We get weights from Dialysis Center. I talk to him to see how he is feeling and look at shunt site." e. On 8/3/07 at 5:45 p.m. the DON (Director of Nursing) was asked what types of assessments should be done prior to and after dialysis. DON stated, "I think they should check to make sure there are no bruises or skin tears or anything like that before and after they go. I would say they should check the shunt. ... I think it is our policy to assess every resident when they leave. His vital signs should be assessed. Heart and lung sounds. I think a thorough assessment should be done when he comes back."	F 309		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		

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individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure wound care was provided in a manner to prevent cross contamination for 2 case mix residents (Residents #5 and 17) and failed to ensure Physician's orders were followed for 1 (Resident #17) of 5 (Resident #4, #5, #6, #17 and #18) case-mix resident's that required wound care. These failed practices had the potential to affect 14 residents in the facility that required wound care as documented on a list provided by the Nurse Consultant on 8/3/07. The findings are:

1. Resident #5 had diagnoses of Paralysis Agitans and Non Insulin Dependent Diabetes Mellitus. The Minimum Data Set (MDS) dated 5/1/07 documented the resident had moderately impaired cognitive skills for daily decision making and had 2 stage II pressure sores.

a. On 8/1/07 at 11:45 a.m., License Practical Nurse # 6 cleansed the stage 2 coccyx wound on the left buttock, which was approximately 3 centimeters (cm) in diameter. Using a 4 x 4 that had been sprayed with a wound cleanser, LPN #6 cleansed the wound with a back and forth motion, she then went directly to the stage II ulcer on the right buttock and cleansed it with the same 4 x 4.

2. Resident # 17 had diagnoses of End Stage

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F 314	Continued From page 3 Renal Disease and Insulin Dependent Diabetes. The Minimum Data Set dated 6/2707 documented resident had independent cognitive skills for daily decision making, had 1 stage 4 and 1 stage 2 pressure sore and had a wound infection. a. The "Physician's Order dated 7/23/07 documented: "Left heel. Clean w (with)/ NS (normal saline) apply NS soaked 2 X (by) 2 gauze, secure w/ 4" (inches) mefix, change BID (twice a day) and PRN (as needed) til (until) healed." b. On 8/3/07 at 3:33 p.m., LPN (Licensed Practical Nurse) provided wound care to the residents LLE. LPN # 4 cleansed the stage 4 wound area on the resident's left heel with a cloth dampened with tap water and soap using a back and forth motion and the same area of the cloth.	F 314		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure proper accessories were used with a Broda chair, failed to ensure the manufacturer recommendations were followed for the application of a soft belt restraint for 1 of 1 case-mix residents (Resident # 3) who required the use of a Broda chair and the use of a soft belt restraint. This failed practice had the potential to affect 4 residents in the facility who required the use of a Broda chair and	F 323		

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F 323	Continued From page 4	F 323		

required soft belt restraint. The facility also failed to ensure that the furniture, a resident ' s television and doors were free of rough, sharp and jagged areas. This failed practice had the potential to affect 92 residents in the facility who were not confined to their room as documented on a list provided by the Director of Nurses on 8/3/07 at 5:35 p.m. The findings are:

1. Resident #3 had diagnoses of Huningtons Chorea and Psychosis. The Minimum Data Set (MDS) dated 4/10/07 documented the resident as moderately impaired in cognitive skills for daily decision making, required extensive assistance for bed mobility and transfer of two person physical assist did not use any devices or restraints within the last 7 days.

a. Nurses Notes dated 7/24/07 9:30 p.m. Late Entry documented: "Resident noted to have increased agitation ... Resident was repositioned 3x (three times) back in broda chair, resident kept sliding out under soft belt."

Nurses Notes dated 7/26/07 at 9:15 a.m. documented: "Transfer assist x 2 (times two) up to broda chair with soft belt. Resident still sliding under restraint and noted to have increased aggression."

Nurses Notes dated 7/28/07 at 2:00 p.m. documented: "... attempted to slide out of soft belt, had to be repositioned by staff ..."

b. The "Broda Seating Operating Instructions" documented: " Improper Restraint Use " Risk of Serious Injury " : We recommend that alternatives to physical restraints be used with residents while seated in the chair except under

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F 323	Continued From page 5 the specific instructions of the resident ' s primary caregiver and with permission of the resident ' s family or guardian. Physical restraints have been identified as a common cause of serious injury to residents while they are seated. ... If a physical restraint is determined to be appropriate to prevent sliding or falling out of the chair, we recommend that the BRODA thigh belt be used. If a physical restraint is determined to be appropriate to prevent self - injury from resident movement, we recommend the BRODA HSP padding package. ... Improper Use: The improper use of the chair can be dangerous to the resident ... 12. Using non Broda accessories to the chair. Accessories... Broda does not recommend use of other manufacturer's accessories on Broda chairs. The "Posey Wheel Chair Support" documented: Posey Soft Belt/Wheel chair Belt- Application- 1. Place around patient's waist and thread through slots between back rest and support bars of back rest. c. On 7/30/07 at 1:47 p.m., the resident was propelling self down the hall in a Broda chair with a Posey soft belt restraint on. The Posey soft belt restraint is not a Broda accessory. At 6:13 p.m., the resident was propelling her self down the hall in a Broda chair with the Posey soft belt restraint on. The Posey restraint was not applied appropriately: The left strap of the soft belt was wrapped around the outside of the arm rest of the wheel chair and tied to the bar across the bottom of the chair. d. On 7/31/07 at 12:00 p.m., 2:25 p.m. and 4:50 p.m., the resident was in a Broda chair with a Posey soft belt restraint on. On 8/1/07 at 2:10	F 323		

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F 323	Continued From page 6 p.m., the resident was propelling self down the hall in the Broda chair with the Posey soft belt restraint on. 2. Resident # 2 had diagnoses of Cerebral Vascular Disease, Transient Cerebral Ischemia, and Dementia with Behavior Disturbances. The Quarterly Minimum Data Set dated 5/31/07 documented that the resident had moderately impaired skills for daily decision-making and required extensive assistance of one person for mobility and transfers. a. On 8/1/07 at 8:30 a.m., a television (TV) in the resident's room had an approximately 2-3 centimeter section of plastic missing with a sharp point on the surface of the right rear corner of the set. The area was located on the outer aspect of the TV where the resident had access to the site. 3. On 8/2/07 the following observations were made: a. At 1:30 p.m., the piano leg in the lobby had a chipped area of wood approximately 12 inches by 2 inches leaving sharp edges and nails protruding approximately 1/16 inch. b. At 2:00 p.m., in the Day Room across from the Nurse's station, a chair had missing vinyl approximately 3 to 4 inches in diameter on both arms leaving rough edges. c. At 2:03 p.m., the entrance door of room 50 on E hall, had a piece of laminate missing that was approximately 2 inches and an area of laminate, approximately 3 inches, that was loose causing sharp edges.	F 323		
F 332	483.25(m)(1) MEDICATION ERRORS	F 332		

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F 332 SS=E	Continued From page 7 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview of the 4:00 p.m. and 5:00 p.m. medication passes on 7/30/07 and 8:00 a.m. medication pass on 8/31/07 the facility failed to ensure that the medication error rate was less than 5%. Physicians orders were not followed on 4 residents (Residents #13, #14, #15 and #16) of 11 residents observed during the medication passes. Medication errors were made by 3 Licensed Practical Nurses (LPN), (LPN #1, #2, and #3) of 5 licensed nurses observed administering medications in the facility. This practice had the potential to affect 97 residents according to the Administrator on 07/30/07. The medication error rate was 7.69% based on observation of 51 medications and 1 omission for a total of 52 medications with 4 medication errors observed. The findings are: 1. Resident #13 had a physician order dated 10/19/06 for Ibuprofen 200 milligrams (mg) 2 tablets by mouth (po) twice a day (bid) with meals. a. On 7/30/07 at 4:33 p.m. during the 5:00 p.m. medication pass LPN #1 administered Ibuprofen 200 mg, 2 tablets with 1 teaspoonful of pudding. b. The resident ate in her room. On 7/30/07 at 5:20 p.m. It was announced on the intercom, "Hall trays are ready."	F 332		

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F 332	Continued From page 8 c. According to the Centers for Medicare and Medicaid Services Medications that must be taken with Food or Antacids: The most commonly used drugs that should be taken with food or antacids are the Nonsteroidal Anti-Inflammatory Drugs (NSAIDS). There is evidence that elderly, debilitated persons are at greater risk of gastritis and GI bleeds, including silent GI bleeds. Ibuprofen is included in the examples of commonly used NSAIDS list. 2. Resident #14 had a physician order dated 7/18/07 for KCL 10 Milliequivalent (mEq) 1 tab (tablet) po three times a day (tid). a. On 7/30/07 at 4:46 p.m., LPN #2 administered the KCL 10 mEq with 3 ounces of water. b. On 7/31/07 at 11:05 a.m. the surveyor asked what time is the evening meal served? The Nurse Consultant stated, "About 5:00 p.m." c. According to the Centers for Medicare and Medicaid Services (CMS) Medications for Adequate Fluids with Medications: Potassium supplements (solid or liquid dosage forms) such as Micro K should be administered with or after meals with a full glass (e.g., approximately 4 - 8 ounces of water or fruit juice). This will minimize the possibility of gastrointestinal irritation and saline cathartic effect. 3. Resident #15 had a physician order dated 6/10/07 for Razadyne 8 mg 1 tab po twice a day (bid) @ (at) 8:00 a.m. - 5:00 p.m. give w/or after food. a. On 7/30/07 at 4:55 p.m., during the 5:00 p.m.	F 332		

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F 332	Continued From page 9 medication pass LPN #1 administered the Razadyne 8 mg with water. b. The resident was sitting in the dining room and no food trays had been served for the supper meal. 4. Resident #16 had a physician order dated 11/16/06 for Synthroid (Lithyroxine sodium) 0.125 mg 1 tab po every day @ 8:00 a.m. a. On 7/31/07 at 7:40 a.m. during the 8:00 a.m. medication pass LPN #3 administered all schedule medications except the Synthroid 0.125 mg. b. According the Medication Administration Record (MAR) dated 7/1/07 thru 7/31/07 the medication was schedule for 8:00 a.m. and the 8:00 a.m. was hand written over to make it a 6:00 a.m.	F 332		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and	F 334		

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F 334	Continued From page 10 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second	F 334		

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pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure the flu vaccination was offered and administered to 2 casemix residents (Residents # 4 and 5) and the pneumococcal vaccination was offered and administered to 5 of 5 case mix residents (Residents # 1 through 5). These failed practices had the potential to affect 40 residents who did not receive the flu vaccination during the past flu season and 93 residents who were not offered the pneumococcal vaccine according to the Resident Census and Conditions of Residents form dated 8/1/07 and the listing of Residents present in the facility during the last flu season that was received from the Administrator on 8/1/07. The findings are:

1. The facility's policy entitled "Inoculations" documented "Purpose: One of the leading causes of death in persons age 65 or over is pneumonia and influenza. The Centers for Disease Control and Prevention recommend that individuals over the age of 65 years have: an annual flu shot, a pneumococcal vaccine one time, second vaccine may be given 5 years following first immunization. ... Process: Upon admission nurse should interview the resident and physician to determine the status of prior inoculations. Findings should be documented in the medical record and MDS

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F 334	Continued From page 12 [Minimum Data Set]. Residents who have not previously had inoculations, or who are due for inoculations, should be offered those services, unless medically contraindicated. Physicians' orders for inoculations should be received, along with resident/legal representative permission. Documentation of medical contraindications should be provided by the attending physician, when the physician feels an inoculation is contraindicated. Each resident or legal guardian should receive information on the benefits and potential side effects of the immunizations. Documentation should be included [in] the medical record. ...". 2. Resident # 1 was admitted to the facility on 10/16/06 with diagnoses of Dementia and Malnutrition. a. The Nursing Admission form dated 10/16/06 did not document the resident's vaccination status for the pneumococcal (PPV) or influenza (Flu) vaccine. b. The Minimum Data Set dated 6/2/07 documented that the resident did not receive the Influenza and Pneumococcal vaccines. The MDS documented that the vaccinations were not offered. c. On 8/1/07 at 10:30 a.m. the Director of Nursing (DON) was asked who was responsible for the immunization program. The DON stated, "[Registered Nurse (RN) # 1]." The DON was asked if there was any documentation for the Influenza and/or Pneumococcal vaccines for [Resident # 1]. The DON stated, "Ask [RN # 1]". d. On 8/1/07 at 8:50 p.m. RN # 1 was asked who	F 334		

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was responsible for the immunization program. RN # 1 stated, "I was in charge in January and February, then I became the Weekend Supervisor and I was not doing immunizations. I just started back as the Resident Care Nurse one month ago and have been working the floor on evenings since then. The floor nurse should be doing the immunizations - no idea who is responsible for over seeing the program."

e. The TB Surveillance - Nursing Home form for this resident was received from the Assistant Director of Nursing (ADON) on 8/2/07. The ADON stated, "This is all I could find." There was an area on the form for the documentation of immunizations such as Flu, and other (Tetanus, Pneumococcal, Hepatitis, etc). They were not addressed.

f. A list provided by the Director of Nursing on 8/2/07 at 4:03 p.m., documented 62 residents were billed for Influenza injections on 1/4/07.

g. On 8/2/07 at 4:03 p.m., the DON stated, "I only have proof of 4 pneumococcal vaccines given to any residents in the facility."

h. On 8/3/07 at 1:05 p.m. the DON was asked what was the present process for the management and monitoring for the current program for immunizations. The DON stated, "Before this (RN # 1) and [Licensed Practical Nurse # 4] had been trying to catch it up. RN # 1 hasn't been able to - she has been working on the floor."

i. On 8/3/07 at 3:20 p.m., the ADON was asked if there was a consent form for the flu vaccine that was given to [Resident # 1]. The ADON stated

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F 334	Continued From page 14 "No". 2. Resident #3 had diagnoses of Huningtons Chorea and Psychosis. The Minimum Data Set (MDS) dated 4/10/07 documented the resident had moderately impaired cognitive skills for daily decision making and the PPV (Pneumococcal Vaccine) was not up to date and had not been offered. a. On 8/3/07 after review of the clinical record, the Pneumococcal Vaccine area of the "Pneumococcal/Flu Vaccine Educational Information Review" form was blank. There was no documentation in the clinical record the resident had been offered a PPV. 2. Resident #2 had diagnoses of Paralysis Agitans and Insulin Dependent Diabetes Mellitus. The Minimum Data Set (MDS) dated 7/13/07 documented the resident had moderately impaired cognitive skills for daily decision making and the PPV (Pneumococcal Vaccine) was up to date. a. The Pneumococcal Vaccine area of the "Pneumococcal/Flu Vaccine Educational Information Review" dated 11/27/06 documented: Has the resident received Pneumococcal Vaccine? The answer was "doesn't know".. As of 8/3/07, there was no documentation in the clinical record, verifying the resident had received the pneumococcal vaccine within the past 5 years and there was no documentation in the clinical record that the resident had been offered or administered the pneumococcal vaccine. 3. Resident #5 had diagnoses of Paralysis Agitans and Non Insulin Dependent Diabetes	F 334		

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F 334	Continued From page 15 Mellitus. The Minimum Data Set (MDS) dated 5/1/07 documented the resident had moderately impaired cognitive skills for daily decision making, was not offered a flu vaccine and the resident's PPV (Pneumococcal Vaccine) was up to date. a. On 8/3/07 after review of the clinical record, there was no documentation in the clinical record of the PPV had been administered in the facility and there was no documentation available that the resident had been administered the PPV elsewhere. b. The TB Surveillance - Nursing Home form received from the ADON on 8/2/07 at 1:55 p.m. documented the resident was last administered a flu vaccine on 9/26/05. The column that documented the vaccine given documented, (hand written) PPD (Abbreviation used for results for a Tuberculin Skin Test). 4. Resident # 4 was admitted to the facility on 3/5/07 with diagnoses of Acute Respiratory Failure. The Minimum Data Set dated 6/4/07 documented the resident did not receive the Influenza and Pneumococcal vaccines and the vaccinations were not offered. a. The TB Surveillance - Nursing Home form, no date, was received from the Assistant Director of Nursing (ADON) on 8/2/07 at 1:55 p.m.. The ADON stated, "This is all I could find." There was an area on the form for the documentation of immunizations such as Flu, and other (Tetanus, Pneumococcal, Hepatitis, etc). They were not addressed.	F 334		
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY	F 363		

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F 363	Continued From page 16 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 observation, record review and interview, the facility failed to ensure the planned written menu for pureed and mechanical soft diets were followed. This failed practice had the potential to affect 21 residents on pureed diets who received meal trays from the kitchen and 29 residents on mechanical soft diets as documented on the diet list dated 7/30/07. The findings are: 1. On 7/30/07 the planned, written menu for the supper meal documented the residents on pureed diets were to receive 2x2 in (inch) square of brownie. a. On 7/30/07 at 4:36 p.m., Employee #1 placed 15, 2x2 inch squares of brownies in the food processor, added more than 2 cups of milk and pureed. She then used a spoon to portion the mixture into 19 bowls. 2. On 7/31/07 the planned written menu for the noon meal documented the residents that were on pureed and mechanical soft diets were to receive a 2 x 2 inch square lemon bar. The menu also documented for each resident that had physician orders for a pureed diet to receive one slice of bread.	F 363		

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F 363	Continued From page 17 a. On 7/31/07 at 11:50 a.m., Dietary Employee #2 placed seven small rolls in the food processor, then added 7 slices of bread and ground them up to be served to 21 residents on a pureed diet for the noon meal. b. On 7/31/07 at 11:56 a.m., Dietary Employee #3 was placing 2 x 2 inch lemon squares into individual bowls. Fifhteen squares were left in the pan. The employee then brought 21 extra bowls and placed them on a tray. The employee then placed nine of the remaining squares in the individual bowls and then cut the remaining 6 squares in half and placed them onto the remaining 12 bowls left. At 12:17 p.m., some residents on regular or mechanical soft diets were served half lemon bars. c. There were no lemon bars prepared for the residents on pureed diets. All residents on pureed diets were given butter scotch pudding.	F 363		
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure food items were prepared in a palatable manner by methods that conserve the nutritive value. This failed practice had the potential to affect 21 residents who received pureed diets from the kitchen as documented on the facility's Diet List dated	F 364		

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7/30/07. The findings are:

1. On 7/30/07 at 3:33 p.m., pureed peas, Swedish meat balls, pureed Swedish meat balls, ground Swedish meat balls and super soup were in the oven cooking at 400 degrees Fahrenheit (F). At 4:45 p.m., the mashed potatoes were dried up at the top. The edges of the pan were burnt and top of the ground meat was dried. Dietary Employee #1 stated, " I put them in the oven at 1:36 p.m."

2. On 7/30/07 at 4:40 p.m., Dietary Employee #1 was pureeing noodles to be served to the residents on a pureed diet with hot water from the sink. The facility did not prepare the food with a calorie dense liquid.

a. On 7/31/07 at 5:05 p.m., Dietary Employee #5 stated, "I pureed Swedish meat ball and noodles with water, yesterday."

3. On 7/31/07 at 9:10 a.m., pureed chicken, ground chicken, baked beans and hot dogs to be served to the residents at 12:00 p.m. were in the oven cooking at the temperature of 400 degrees F. There were also three pans that contained oven fried chicken in the conventional oven cooking at 350 degrees F. Dietary Employee #3 stated, "I put them in the oven at 8:50 a.m."

a. At 9:20 p.m., Dietary Employee #3 placed two pans of broccoli on the stove. At 10:04 p.m., mashed potatoes were made and left on the stove. At 10:12 a.m., Dietary Employee #3 placed the pan of the mashed potatoes in the oven at a temperature of 400 degrees F. At 11:29 a.m., the top of the mashed potatoes to be served to the residents at noon meal was dried

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F 364	Continued From page 19 up. The ground diced chicken was dried up and oven fried chicken was dried and the edges were burnt. b. On 7/31/07 at 1:37 p.m., Dietary Employee #4 stated, " ... we serve the employees lunch. The food had to be ready at 10:45 a.m., then it stays there too long and dries up."	F 364		
F 371 SS=C	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 observations and interview, the facility failed to ensure food stored in the freezer and storage area was sealed or covered to prevent freezer burn or cross contamination, failed to ensure the ice machine and ice scoop holder were free of debris, failed to ensure food equipment, floor, and door frames were free of debris and in good conditions. These failed practices had the potential to affect 95 residents who received meal trays from the kitchen as identified by the Diet Roster dated 7/30/07. The findings are: 1. On 7/30/07 at 12:00 p.m., the following observation made were: a. A bag of Oatmeal Raisin cookies were on the shelf in the storage room and were not sealed. b. A bag of cornflakes on the shelf in the storage	F 371		

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F 371	Continued From page 20 room was not sealed. 2. On 7/30/07 at 3:33 p.m., the following observations were made: a. A box of pork chop in the freezer shelf was not sealed. b. A bag of breaded beef patties in the freezer top shelf was not sealed. c. A box of zucchini on the shelf in the freezer was not sealed. d. A box of squash on the shelf in the freezer was not sealed. There was a box of french fries stored directly on it. e. A clear bag that contained garlic bread at the bottom of the refrigerator was not sealed. f. The inside right angle of the ice machine by the panel had blackish matter on it. The ice scoop holder on top of the ice machine had water standing in it. There was blackish matter floating or sailing on top of the water. The ice scoop was sitting directly in it. The ice scoop holder had no lid on it. There was a basin filled with stained brownish towels sitting next to the ice scoop holder. Dietary Employee #4 stated, "The basin with the stained towels sitting beside the ice scoop holder belong to housekeeping." She also stated, "I don,t know how often they clean it." g. The metal frame on the wall by the janitor's closet was loose exposing the wood in the Dietary department. h. A can opener had blackish substance on the	F 371		

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F 371	Continued From page 21 blade. i. The floor by the food preparation area and two compartment sink was heavily soiled and had a rusty greasy look. j. The floor had a 34 inch chipped area in front of the hot water heater door exposing the concrete. k. The base board below the wall by the hand washing sink was loose and hanging. l. There was approximately an 8 inch gap below the wall between the storage room and dish washing room. The base board to this wall was also missing m. The juice dispenser spouts for orange juice, apple juice, cranberry juice, grape juice, prune and fruit punch had an accumulation of dried on sticky residue left over stained juices above and below the edges and corners of the spouts. n. The air vent above the juice machine was covered with dust. o. There was a 56 inch gap of missing baseboard below the wall, opposite the milk box and leading to the dish washing machine. p. There was a 6 inch gap of missing baseboard in front of the milk box that exposed the cement. q. There was a 2 and one half inch gap missing baseboard by the door in the storage room.	F 371		
F 425 SS=C	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency	F 425		

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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, the facility failed to ensure expired medication was removed from the A/F and D/E medication carts and the medication back-up cabinet; and that items which required a physician's prescription were labeled in accordance with state law and accepted principles of pharmacy labeling and storage for the facility. This failed practice had the potential to affect 97 residents in the facility, as identified by the administrator on 7/30/07. The findings are:

1. On 7/31/07 the following observations were made:

a. At 9:40 a.m. in the Back -Up Medication cabinet there were six bottles of Ferrous Sulfate

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F 425	Continued From page 23 Elixir 220 milligrams (mg)/ 5 milliliters (ml) 473 ml which had expired 5/07. b. At 10:00 a.m. in the A/F medication cart there was one bottle of Vitamin C 250 mg 100 tablets which had expired 5/07. c. At 10:15 a.m. in the D/E medication cart there were nine tablets of Ativan 1 mg tablets which had expired 7/24/07; four vials of unrefrigerated Procrit 3000 units/ml with a fill date of 7/10/07 and an axillary label from the pharmacy provider to refrigerate; three Diskus of Advair 250/50 unlabeled; one Diskus of Advair 500/50 unlabeled; one vial of Albuterol 3 ml.unlabeled; one bottle of Bacteriostatic 0.9% Sodium Chloride 30 ml. unlabeled; and two vials of Cyanocobalamin 1000 mcg/ml 1 ml. unlabeled.	F 425		