STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325078	A. BUILDING _____ B. WING _____	07/28/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RETIREMENT RANCHES INC.	2221 DILLON STREET CLOVIS, NM 88102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain all areas of the facility in good repair. The findings are: A. On 7/26/05 during the tour of the facility starting at 9:00 to 11:30 AM the following items in need of repair were observed: 1. The Northwest soiled utility room door had multiple areas of chipped paint on the right side of the door. 2. The nursing station desk located at "Quail Haven Crossing " revealed an exterior layer of laminate chipped off with wood exposed on the right side corner. 3. The laundry room to the left side of the first washing machine contained an area of broken linoleum with the cement floor exposed. 4. Resident room #125 door jam facing is loose. 5. The wall to the right of resident room #116 contained an area of torn wallpaper. 6. Room 132 contained a gouge in the wall with the sheetrock exposed. 7. Room 137 contained a gouge on the wall with the sheetrock exposed. 8. The East shower room had an approximately 4" X 8" area of floor tile missing at the doorway threshold. B. On 7/27/05 beginning at 9:00 AM the following was observed in the Alzheimer ' s Unit:	F 253	Items A 1, 5, 6, 7, B3 and 4. Paint chips, sheet rock damage, and wallpaper were repaired August 31, 2005. For paint chips, gouges and wallpaper of other residents, maintenance will do a room assessment and make corrections one week after finding. Maintenance will continue room(s) evaluation and schedule corrections as necessary. Monitoring by maintenance will achieve continued compliance. Q.A. will do a random room Review quarterly starting November 2005 Item A2. Did not affect any one resident. The repair was completed August 25, 2005 Other residents were not directly affected. Maintenance will perform a monthly inspection of nursing stations and make any corrections. Q.A. will perform quarterly nurse station assessments starting November 2005.	8/31/05 8/25/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Schultz	Administrator	9/7/05

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F 253	Continued From page 1 1. Areas of missing linoleum strips on the window seats in rooms 102, 103, 104, and 109 with wood exposed. 2. In room 107 the entrance door jam facing is loose. The bathroom door jam contained a hole in the plastic guard approximately nickel size. 3. Room 106 had 3 areas of plaster repair that were white and not painted the mauve color of the surrounding wall. 4. Room 101 contained on the right side wall beside the bed a gouge and areas of chipped paint in the bathroom. C. Room 139 contained two strips of duct tape holding the facing onto the end of the bathroom door. D. On 7/27/05 at 9:30 AM the maintenance supervisor was interviewed. The maintenance Supervisor stated, " The linoleum in the laundry hasn't been ordered. It hasn't been on a priority list. When asked about the other areas in need of repair stated, " We have the supplies, just don't have the man power to get to all of it. "	F 253		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 282	F 282 COMPREHENSIVE CARE PLANS 1. Per observation July 28, 29 and ongoing resident # 10 glasses were noted to have cushion on both sides. Oxygen tubing noted to have cushion in place. Resident with dressing on both ears per Dr. order. However, resident continues to pull dressings from ears and scalp area.	9/2/05

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F 282	Continued From page 2 interview the facility failed to follow the care plan for wound care and monitoring for cancerous lesions for one (Resident # 10) of 21 sampled residents. The findings are: A. On 7/26/05 Record review of resident # 10 ' s care plan dated 12/27/04 reads, "alterations in skin integrity related to recurrent open areas to nose, cheeks, pinnas bilaterally (ear lobes) Utilize ear cushions when oxygen in use. Areas of ears, nose/cheek will remain free from infection. Treatment to ears as directed, H202, bacitracin, Band-Aid, monitor for decline or change in condition. Cushion & cover both posterior earlobes with gauze." B. Observation on 7/26/05 at 11:00 AM Resident # 10 had glasses on with the sides of the glasses earpieces pressed against a wound on the right side of the scalp. There was no cushions or covers on the earlobes or the scalp wound. 1. The same observation occurred at intervals from 3:00 PM to 5:00 PM on 7/26/05 and on 7/27/05 at intervals from 9:00 AM to 10:30 AM with the glasses earpiece pressed against a wound on the right side of the scalp with no pressure-relieving device. C. On 7/27/05 at 10:30 AM Licensed Practical Nurse (LPN) #1 was asked about the lack of cushions and if the care plan was followed, LPN #1 stated, " No. " D. On 7/27/05 at 5:00 PM an interview with the Director of Nurses (DON) occurred. The DON was told the ear cushions had not been used and pressure was on the scalp wound, when asked if the care plan had been followed, the DON stated, " No. " E. Observation on 7/26/05 at 1100 AM Resident #	F 282	Per evaluation of wound care regimen by nursing staff and physician it has been determined that the resident causes trauma to healthy tissue by removing the dressings from his ears and that the wounds fare better without dressings. New orders are to apply ointment only and to apply dressings only as needed. Wound care to the ears and scalp is done on a daily basis and the wounds/lesions are observed/monitored at this time. The wounds/lesions are on the wound assessment sheet and are monitored for size, improvement/decline, change in condition, and signs/symptoms of infection. 2. Resident number # 10 is the only resident that has cancerous/lesions on ears and/or scalp. Therefore, no other residents would be affected by this same practice or lack of. 3. A mandatory nursing meeting was held on August 19, 2005 in which the importance of following the care plan and	

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F 282	Continued From page 3 10 skin was observed to have open wounds/lesions on both outer aspects of both ear lobes, the posterior aspects of both ear lobes and an open area on the lateral right scalp in the location of the resident ' s glasses ear stem. F. On 7/26/05 Record review of resident # 10 ' s medical record revealed one wound assessment document dated 2/21/03. G. Interview with the Director of Nurses (DON) on 7/27/05 at 5:00 PM when asked for wound assessments and documentation for resident #10, the DON stated, " There is none. " The DON was asked how wounds are monitored and stated, " We only assess & measure weekly the pressure ulcers and venous stasis ulcers. When asked if other types of wounds were assessed, the DON stated, " Not on the weekly assessment sheets, only in the nurse notes, I don't know how we'd measure those areas on his ears, there are multiple areas." H. Record review on 7/27/05 of the nurse's notes and nurse's monthly summaries for June and July 2005 contain no information on the wound located on the right side of the scalp just above the ear lobe. I. On 7/28/05 at 9:00 AM Licensed Practical Nurse #2 gave the surveyor a "Weekly Skin Condition Progress Report" that reads, 'Date identified 2004, updated 7/28/05.' "The assessment contains 3 areas assessed; both earlobes and the right scalp wound area."	F 282	monitoring wounds/lesions was emphasized. An admission pressure ulcer verification form has been updated to include other wounds/lesions. This form will remind staff to place wounds /lesions on the monitoring form and report such to the wound care nurse. 4. CQI and/or nursing personnel will perform random observations monthly for following of the care plan and monitoring for wounds/lesions for one month and again in 6 months for one week starting October 2005. 5. Date of completion for F-282 is September 2, 2005.	
F 324 SS=E	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.	F 324		

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F 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to lock the therapy room which contained a Hydrocollator containing hot water and left the room unattended on two occasions. The findings are: A. On 7/26/05 at 11:30 AM and at 3:30 PM the therapy room door leading to the physical therapy office and the door then leading to the therapy gym was unlocked. There was no staff in the therapy area. A Hydrocollator containing hot packs and hot water was accessible in the therapy gym on the right side of the gym. B. The Physical Therapy Supervisor was interviewed on 7/26/05 at 4:00 PM when asked if the gym should be locked if no one was in the gym, the PT Supervisor stated, "We lock the gym at the end of the day. The door on the other side of the gym is locked, one door is unlocked." When asked if a resident could get in the gym the PT Supervisor stated, "This door is hard for them to open. Someone could open it if they were strong enough." When asked if the Hydrocollator should be left unattended the PT supervisor stated, "The nurses use the hot packs. We had it locked but the nurses wanted to use it so we put it out here (in the gym)." C. The Hydrocollator water temperature was taken and was 160 degrees Fahrenheit. D. The PT Aide and the PT Supervisor were interviewed again on 7/27/05 at 10:00 AM. The PT Aide stated, "When were out of the gym walking someone, we have to keep the door to the gym locked. We don't have a (written) policy for locking the gym or taking daily temperatures. The Hydrocollator should be locked up. It also gets hot on the outside." The PT Supervisor	F324	No specific resident is affected by this finding. The Hydrocollator unit was moved into an area that is out of the way of residents and in locked area. No other residents are affected by this Finding. The Hydrocollator was moved from the therapy gym to a locked environment Each workday Monday thru Friday the therapy supervisor will check to see if security of the Hydrocollator is maintained. Q.A. will observe security quarterly starting in November 2005.	9/15/05 9/15/05

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F 324	Continued From page 5 stated, "We should lock the gym when we're not here."	F 324		
F 426 SS=E	483.60(a) PHARMACY SERVICES - PROCEDURES 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. This REQUIREMENT is not met as evidenced by: Based on observation of the facilities medication rooms (2) and treatment carts/cabinets (2), and staff interview, the facility failed to ensure expired supplies and medications were removed on or before expiration date. The findings are: A. On 7/27/05 , beginning at 4:30 pm, observation of the Station (2) medication room with the Director of Nursing (DON) revealed (5) hemocult cards with an expiration date of 6/05. Observation of the Station (1) medication room with the DON revealed (7) hemocult cards with an expiration date of 6/05. An interview with the DON was conducted on 7/27/05 about policy for checking expired drugs/supplies. The DON stated, "the ward clerk checks these items and supplies the medication room." B. On 7/27/05 observation of the treatment cart/cabinet for Station (2) with Quality Assurance Nurse revealed 2 half full bottles of Prep Solution with expiration date of 2/04. Three (3) 75ml	F 426	PHARMACY SERVICES PROCEDURES 1. All expired items have been discarded, most of which were not being used. 2. No residents will be affected by the above as all these items have been discarded. 3. A form has been developed to assist in checking each storage area that contains items with expiration dates. This check system for expired items will be performed on a monthly basis by nursing personnel. A mandatory meeting was held on August 19, 2005 to remind staff of importance to discard items when they expire. 4. CQI and/or nursing personnel will perform random assessments of items with expiration dates in storage areas in November 2005 and again in May/June 2006 time frame. 5. Date of compliance for F-426 is September 2, 2005.	9/2/05

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F 426	Continued From page 6 bottles of Sterile 0.9% Sodium Chloride with expiration date of 3/01 and seven (7) hemocult cards with the expiration date of 2/03. C. On 7/27/05 observation of the treatment cart/cabinet for Station (1) with the DON revealed twenty (20) yellow top vacu-tainer tubes with expiration date of 6/05 and two (2) with expiration date of 2/05. Three (3) 75 ml bottles of Sterile 0.9% Sodium Chloride with expiration date of 3/01. One Jar of 1% Silver Sulfadiazine Cream with no date to show when opened and no expiration date. One (1) aerosol can labeled Granul-Derm for a resident with expiration date 4/27/05. Interview with the DON stated "this resident was no longer in the facility."	F 426		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	F-514 CLINICAL RECORDS 1. Resident #12 now has a history and physical (H&P) in her medical record dated June 2, 2005. 2. An audit of all active medical records will be performed to identify any residents that may not have an H&P in their medical records. This will be done by September 7, 2005. 3. A log will be maintained to assist in keeping H&P's current in each active medical record. 4. CQI and/or nursing personnel will perform random audits monthly for H&P's in the active medical records for one month and again in 6 months for one week starting October 2005. 5. Date of compliance for F-514 is September 7, 2005.	9/7/05

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F 514	Continued From page 7 by: Based on record review and interviews the facility failed to have complete medical records for 1 (#12) of 21 sampled residents. The findings are: A. On 7/28/05 a record review of Resident #12 ' s clinical record contained no history and physical (H&P). The admission date was 6/2/05. B. LPN #1 was interviewed on 7/28/05 at 9:45 AM and after searching the record stated, " I don ' t see it. Let me call the hospital and get one here. " 1. Medical record supervisor was interviewed 7/28/05 at 10:10 AM. When asked if there should be a H&P in the medial record stated, " They should have one (H&P) that comes from the hospital. B. The Medical record supervisor gave a list of the facility ' s required documents that reads, " The following items should remain in the active record. " ....# 5. History and Physicals - 2 years for continued stay. "	F 514		