STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____ RECEIVED APR 04 2011	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

CMS CERTIFICATION NUMBER

Revised baseline POC 2/22/11. L. Whitsitt, RDR

(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 Glossary ADL activities of daily living & and ARD Assessment Reference Date BID Twice per day BMI body mass index @ at CAA Care Area Assessment cm centimeter CNA certified nurse assistant DON director of nursing DM dietary manager et and I.V. intravenous L left MAR medication administration record mcg/g micrograms per gram MD medical doctor med(s) medications(s) MDS Minimum Data Set mg(s) milligram(s) PO by mouth POA power of attorney PRN as needed q every R right RAP Resident Assessment Protocol Res. or res Resident RN registerd nurse TID Three times per day TX treatment TAC triamcinolone TAR treatment administration record W/C wheelchair	F 000		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS	F 154		1/13/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Margaret Schwend	Administrator	4-4-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 154	Continued From page 1 The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family interviews, the facility failed to fully inform the risk versus the benefits on the use of side rails for one (#7) resident and/or his family, of 11 sampled residents. Findings include: Resident #7 was admitted to the facility on 5/17/10. Diagnoses included aneurysm, arterial disease, pain in limb, neoplasm, hypertension, fracture neck of femur, Kaposi's Sarcoma, anxiety state, dementia with behavior disturbance, and insomnia. On 12/8/10 at 8:30 a.m., a quarter side rail on the exit side of the bed was observed in the raised position in resident #7's room. The chart lacked documentation that risk versus benefits had been discussed with either the resident or family member. On 12/8/10 at 12:20 p.m., staff member B, DON, stated that risks and benefits for the side rail had been discussed with resident #7's wife. During a family interview on 12/8/10 at 1:15 p.m., resident #7's wife stated she did not remember if the risks and benefits of the side rail had been	F 154	Plan of Correction F154 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #7 is not using side rails. How other resident's identified as having the potential to be affected by the deficient practice: An audit has been conducted on all residents using side rails to ensure the resident or representative has been fully informed of the risk versus the benefits on the use of side rails. What measures and changes put into place to ensure deficient practice does not recur: Facility staff have been in serviced on side rails and the need to ensure the resident or representative has been informed of the risk versus benefit on the use of side rails. The in service was conducted on 1-4-11.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 154	Continued From page 2 discussed.	F 154	How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be completed weekly for 1 month, then quarterly to ensure those residents that use a side rail, transfer bar or positioning device are informed of the risk versus benefit of the use of those devices. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review, the facility failed to determine that two (#s 5 and 6) of 11 sampled residents and one (#14) supplemental resident, were safe to self-administer medications. Findings include: 1. Resident #6 was admitted to the facility on 7/14/10. Diagnoses included dementia with behavior disturbance, liver disorder, insomnia, diabetes, psoriasis, wound disruption, and pain in limbs. The Physician Order sheet with a Renewal Period of 10/1/10 through 10/31/10, documented the following medications to be kept at the bedside:	F 176	Plan of Correction F176 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #6 has been reassessed and will not be self-administering medication. Resident #5 has passed away. Resident #14 will not be self-administering medication. How other resident's identified as having the potential to be affected by the deficient practice: An audit has been conducted on all residents to determine that those that do	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 176	Continued From page 3 -Clobex Topical Lotion 0.05% BID; -Triamcinolone 0/1% apply to psoriasis lesions on feet BID; -Vectical 3 mcg/g topical ointment BID; and -TAC Cream continuous. On 12/8/10 at 10:30 a.m., resident #6 stated that he did apply the above listed creams, as necessary. These were kept in his room. A Self Administration of Medication Assessment form dated 7/14/10, read, "1. Does the Resident desire to self medicate?" The box on the form was checked N (no). This form was signed by the resident. The sections for the Physician Signature and Staff Signature were blank. The section for Diagnosis was blank. The Self Administration of Medication Assessment did not indicate that the resident could self administer medications. The care plan lacked documentation that the resident could self administer medications. 2. Resident #5 was admitted to the facility on 12/17/08. Diagnoses included dementia with psychosis, macular degeneration, and depressive disorder. The Physician Order Sheet with a Renewal Period of 11/1/10 through 11/30/10, documented the following medications to be kept at the bedside: -Systane 1-2 drops Eye PRN. May keep at bedside in locked box; -Sore-No-More Topical PRN. May keep at bedside in locked box; -Tums 2 tabs by Mouth one time daily. Give 2 tabs to be left at bedside every day;	F 176	self-administer medication can do so safely, and the facility self-administration policy is being followed. What measures and changes put into place to ensure deficient practice does not recur: Facility staff have been in serviced on safe self-administration practices and the self-administration policy and procedures. 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be completed weekly for 1 month, then quarterly to ensure safe self-administration of medication is being practiced and the self-administration policy and procedure is being followed. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 176	Continued From page 4 -Vicks Vapor Rub as directed, PRN, May keep at bedside in locked box; -may have mentholatum and skin creams at bedside PRN; and -May self administer medications listed in notes. A Self Administration of Medication Assessment form dated 12/17/08, read, "1. Does the Resident desire to self medicate?" The box on the form was checked N (no). This form was signed by the resident. The sections for the Physician Signature and Staff Signature were blank. The section for Diagnosis was blank. This was the only Self Administration of Medication Assessment form in the medical record. On 12/9/10 at 11:15 p.m., the surveyor and staff member H, charge nurse, observed the following medications in the resident's room: -On top of the dresser: Vasolin, Sore-No-More, and Mineral Ice; -In the unlocked drawer of the bedside table: Clear Eyes and Systane, mentholated rub, Eucerin Cream, Calazime Antibiotic Ointment, sore throat spray, and Chloraseptic. At this time resident #5 was asked about taking medications by herself. She stated she was not able to rub anything onto her arms or take anything by mouth independently. Staff member H stated she did not think resident #5 was able to self administer medications. The Self Administration of Medication Assessment did not indicate that the resident could self administer medications. The care plan lacked documentation that the resident self administered medications.	F 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 176	Continued From page 5 3. On 12/8/10 at 8:00 a.m., the medication nurse was noted delivering medications to resident #14 while the resident was eating breakfast. The nurse was observed assisting the resident while he was coughing after drinking liquid. Once the resident was done coughing, the nurse was observed walking back to the medication cart. The nurse set up and delivered medications to other residents in the dining room. Resident #14 was observed with a white pill grasped between his thumb and index finger of his left hand. He placed the pill in his mouth, got a drink, and coughed. The nurse had placed the pills on the napkin beside his plate, and the Milk of Magnesia was in a plastic medication cup. There were at least 6 pills the resident was taking. The resident continued to take his medications on his own, which took about 8 minutes. The nurse was not noted to check on the resident prior to him being assisted from the dining room at 8:09 a.m. At 8:13 a.m., the nurse was observed at resident #14's place setting, moving his napkin, plate, and cups to make sure he had taken all of his medications. On 12/9/10 at 10:00 a.m., resident #14's medical record was reviewed. Resident #14 was admitted on 6/28/05 with diagnoses that included dementia with behavior disturbance, convulsions, brain injury, and seizures. Record review was completed, with a Self Administration of Medication Assessment Form noted. The form was not dated, but was signed by the spouse, who was also the POA. The assessment showed the resident did not desire to self medicate. The MARs for November and December 2010 were reviewed, as were the physician orders. There were no orders for the	F 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 176	Continued From page 6 resident to self administer medications, and no notation on the MARs about leaving medications with the resident at the dining room table.	F 176		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 7 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff/resident interviews, the facility failed to ensure investigations were conducted to rule out abuse for 6 (#s 1, 3, 5, 7, 9, and 10) of 11 sampled residents and 2 (#s 16 and 18) supplemental residents. The facility failed to ensure that all alleged violations were reported to the State agency and the results of the investigations were reported to the State agency within 5 working days. The facility census was 43 residents; 19% of the residents (8 total) were affected. Specifically, --Seven residents (#s 1, 3, 5, 7, 10, 16, and 18) had injuries of unknown origin; these were not investigated. --Five residents (#s 1, 5, 7, 10, 16, and 18) had bruises or skin tears on their arms and hands within a three week time frame; this pattern was not identified or investigated. --Resident #9 reported an allegation of abuse to a staff member; it was not reported to the administrator or State Agency. The allegation was not thoroughly investigated. --Staff were not aware of whom to report allegations of abuse. The findings included: ABUSE POLICY 1. The facility's abuse policy read in pertinent part: "All alleged violations will be reported to the Administrator or Director of Nursing... An investigation of the reported allegation will be	F 225	Plan of Correction F225 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #1's bruises of unknown origin have been investigated, care plan interventions are in place to prevent reoccurrence, the results of the investigation were reported to the State agency. Resident #3's bruises have been investigated, care plan interventions are in place to decrease or eliminate bruising, the results of the investigation were reported to the State agency. Resident #5 passed away on 12/19/2010. The bruises have been investigated, the results of the investigation were reported to the State agency. Resident #7 bruising has been investigated, the results of the investigation were reported to the State agency. The care plan has been updated to indicate the resident's risk of bruising and interventions to decrease or eliminate bruising. Resident #9's allegation of abuse has been thoroughly investigated, the results of the investigation have been reported to the State agency. Staff are aware of who to report allegations of abuse. Resident #10 passed away on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 8 completed and steps taken to prevent further potential harm to the identified resident or others. Any employee suspected will be suspended pending the completion of an investigation. Allegations will be reported immediately (within 24 hours from the time the incident is known) to appropriate State agencies. An investigation will begin and upon completion, a final report will be sent to the State agency within a 5 day period. The report will include whether abuse was validated and any appropriate actions taken." Under the heading of "Identification" the policy read: "The facility will identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation." Under the heading of "Indicators of Abuse (not all inclusive) the policy included "bruises and/or hematomas, bilateral bruising on arms (may indicate shaking, grabbing, rough handling, inner arm or thigh bruising)... clustered bruises on the trunk from possible repeated striking, presence of old and new bruises at the same time from repeated injuries...injuries of unknown origin." The definition of "Injuries of unknown source" read: "Any injury that meets both of the following conditions: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.)"	F 225	12/15/2010. Her bruises have been investigated, and the results of the investigation have been reported to the State agency. Resident #16's bruises have been investigated and the results of the investigation were reported to the State agency. The resident's care plan includes interventions to decrease or eliminate bruising. The care plan indicates the resident's risk of bruising. Resident #18's bruises have been investigated, the results of the investigation were reported to the State agency. The plan of care has been updated to indicate the resident is at risk for bruising. The care plan includes interventions to decrease or eliminate bruising. How other resident's identified as having the potential to be affected by the deficient practice: An audit has been conducted to ensure all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source are reported immediately to the administrator or DON, that the allegations of abuse have been investigated, and the finding of the investigation have been reported to the State agency. What measures and changes put into place to ensure deficient practice does not recur: All staff have received training on Cedar Wood Villa's abuse prevention and reporting policy, and the findings in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 9 Under the heading of "Investigation" the policy read: "In all cases of alleged abuse, neglect, or misappropriation of resident property, or injuries of unknown origin the Administrator or his designee will begin an investigation. The following steps will take place: 1) Intervene in the situation to protect all residents from the situation; 2) Report the situation to the proper authorities; 3) The actual investigation will include: a) Date and time and location of the incident; b) Identity of victim; c) Identity of alleged abuser if available; d) description of actual event; e) Interviews of accused...; f) Interview other potential witnesses and obtain written statements from witnesses that are signed, dated, in their own handwriting, and with their title...; g) Review medical record of resident for information regarding diagnosis, level of dementia, if any, and other pertinent information...; h) Interview resident if possible and/or family member...; i) Review the environment...; j) Review any injuries...; k) review any actions taken to intervene...; l) After review... determine validity, complete the investigation report and send to the appropriate State Agency; m) ...Determine appropriate action for the alleged abuser." 2. Resident #9 was admitted to the facility on 4/7/08. Diagnosis included; coronary artery anomaly, trans cerebral ischemia, insomnia, peripheral vascular disease, iron deficiency anemia, Meniere's disease, constipation, esophageal reflux, hypertension, depression and pressure ulcer to the buttock. According to the 9/15/10 quarterly MDS, the resident's memory was intact and she was modified independent with decision making. The resident was coded as having no behaviors or	F 225	F225 survey deficiency. 12-21-10. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be done weekly to ensure all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source are reported immediately to the administrator or DON, that the allegations of abuse have been investigated, and the finding of the investigation have been reported to the State agency. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 10	F 225		

mood issues and she had no impairment in communication. The resident required extensive assistance of one staff member with ADLs including bed mobility, transfers, and dressing. The resident required limited assistance of one staff member for toileting; she was not able to balance while standing without physical assistance. The resident did not walk during the observation period. The resident had a partial loss of voluntary movement on one side of her neck, to both legs and to one of her feet.

An informal interview with resident #9 was completed on 12/9/10 at 10:30 a.m., during the resident room review. Resident #9 was able to identify several of the family members from the pictures scattered around her room. She stated that she was happy with her room and was more happy that she did not have a roommate. Resident #9 stated that it was too warm in her room and asked that the surveyor turn down the heat as she stated she was unable to get to the thermostat.

Staff member K, CNA, was interviewed on 12/7/10 at 3:45 p.m., and stated resident #9 reported an allegation of abuse to her. Staff member K stated there was a case in which resident #9 reported to her that staff member O, CNA, who worked for the nursing pool, threatened to slap resident #9 if she would not get up and walk following assistance with ADLs (toileting). Staff member K stated the resident was not able to walk. Staff member K stated she reported the incident to staff member B, the DON, after the resident told her about it.

During record review of interdisciplinary progress notes, an entry regarding an interaction with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 11 CNA was found. The note dated 8/29/10 at 1400 (2:00 p.m.) stated, " Aguementive (sic) with CNA today, stating that CNA told her to walk." Staff member B was interviewed on 12/7/10 at 4:30 p.m., and stated she talked to staff member O, the alleged aide, about the resident's allegation. Staff member B stated staff member O denied making the statement to the resident. Staff member B stated the resident had a history of jumping to conclusions and making false allegations (the MDS and care plan were reviewed and did not include any information to this effect). Staff member B stated she talked with the resident's daughter who visited the resident frequently. Staff member B stated the resident's daughter was not sure she wanted staff member B to pursue it further. Staff member B stated staff member K had not reported the incident to her and initially she did not know which CNA it was. Staff member B was asked to provide documentation of the investigation into this incident at this time. Staff member B was interviewed a second time on 12/8/10 at 8:45 a.m., and stated resident #9 was uncomfortable with new staff and the facility had been using several pool staff for a period of about a month. Staff member B stated she stopped by to visit with the resident about the new staff and that is how she found out about the incident. She denied that staff member K reported the incident to her. She stated the resident's daughter was in the room at the time and asked the resident to inform her of the incident. The resident stated a CNA threatened to hit her if she did not get up off the commode. Staff member B said she did an investigation which consisted of talking with the charge nurse (staff member J),	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 12 the CNA who reported the incident to the surveyor (staff member K), and staff member O, the alleged perpetrator. The facility did not provide documented evidence of an investigation in accordance with facility policy including: reporting the incident to the administrator and State Agency, documentation of date and time and location of the incident; identification of victim; identity of alleged abuser; description of actual event; interviews of accused; interview of other potential witnesses such as staff members K and J; review of resident's medical record; interview with the resident; and review of any actions taken to intervene. There was a lack of evidence of determining the validity of the allegation, completing the investigation report and sending it to the appropriate State Agency. Staff member A, the administrator, was interviewed on 12/9/10 at 10:00 a.m. and stated she had not been aware of the allegation resident #9 made against the CNA until the survey. She stated the facility had not prohibited the pool CNA from working in the facility; however, the CNA had not been in the facility as there was no current need for pool staff. Staff member A stated she was not aware of any written documentation (investigation) being completed regarding the alleged incident. 3. Staff members interviewed were unable to consistently identify whom to report abuse allegations. The policy directed staff to report allegations to the administrator or DON. a. Staff member M, CNA, was interviewed on 12/8/10 at 11:00 a.m. She stated she would report	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 13 an allegation of abuse to the charge nurse. Only if she got no results would she report to the administrator or DON. Staff member L, CNA, was interviewed on 12/9/10 at 11:05 a.m. She stated she would report an allegation of abuse to the charge nurse. Other people she would report to if the charge nurse was unavailable would be the DON or the administrator. Staff member C, was interviewed on 12/9/10 at 11:22 a.m. She stated she would report an allegation of abuse to the charge nurse. Other people she would report to if the charge nurse was unavailable would be the DON or the administrator. INJURIES OF UNKNOWN ORIGIN 4. Bath sheets which included weekly skin assessments were reviewed for a three week period from mid-November 2010 through 12/8/10. Five residents were noted with bruises on their arms/hands as follows: --Resident #18 - On 12/22/10, she was noted with bruises to both arms above the elbows. On 11/21/10, she was noted with bruises on the back of both hands. --Resident #16 - On 12/2/10, she was noted with an old bruise to the left arm on the front and back. --Resident #7 - On 12/6/10, he was noted with bruises on the back of both forearms and bruises requiring a steri-strip around the left elbow. On 11/29/10, he was noted with a skin tear to the left elbow and steri strips to the left hand. --Resident #10 - On 12/6/10, she was noted with mottled bruises to the front of both forearms. On 11/29/10, she was noted with bruises on the front	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 14 of both forearms and a skin tear to the back of the left forearm. On 11/22/10, she was noted with bruises on the front of both forearms. On 11/17/10, she was noted with old bruises on both forearms and on the back of both hands. --Resident #5 - On 12/2/10, she was noted with bruises on the back of both forearms. --Resident #1 - On 12/2/10, he was noted with bruises on both forearms. On 11/22/10, he was noted with bruises on both forearms. On 11/12/10, he was noted with numerous bruises to both forearms. 5. Staff interviews On 12/7/10 at 4:50 p.m. a meeting was held with administrative staff including staff members A, B, C, and D. Staff were informed of bruising to the arms/hands of residents #s 1, 5, 7, 10, 16, and 18. Surveyors were directed to talk to the charge nurse, staff member J, about the bruises to these residents and the investigations into the causes. Staff member J was the charge nurse 4 days a week. Nurses were responsible for completing residents' skin audits, when residents are given baths on a weekly basis. On 12/8/10 at 4:40 p.m., a second meeting was held with the administrative staff including staff members A, B, C, and D. Staff member J, charge nurse, had not produced any investigations into the arm and hand bruises. Staff were asked for the investigations of the bruises for resident #s 1, 5, 7, 10, 16 and 18. These were not produced by the conclusion of the survey on 12/9/10 at 1:00 p.m. or thereafter. Staff member J, the charge nurse on duty who worked 4 days a week, was interviewed on 12/8/10 at 11:00 a.m. regarding bruises noted on	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 15	F 225		

multiple residents' arms during the three week period from mid-November 2010 through 12/8/10. She stated she had not identified a pattern of bruising to residents' arms/hands. She stated resident #s 1, 5, 7, and 10 may have been bruised to the arms/hands due to being transferred with the mechanical lift. She stated these residents had arm protectors in place; however, when observations were conducted on 12/8/10, only resident #7 had arm protectors on and in place.

Staff member J was given a list of the bruises as recorded on the bath sheets for residents #s 1, 5, 7, 10, and 16. When asked if she had completed investigations for these bruises, she stated she would review the information during this shift. Staff member J was not on duty on 12/9/10, and she left no information with the DON or administrator to indicate that any incident reports or investigations were conducted for the bruises of these residents.

Staff member A, administrator, who oversaw the abuse prevention program, was interviewed on 12/9/10 at 9:30 a.m., and stated she had not been aware of the bruises to resident #s 1, 5, 7, 10, and 16 prior to the survey. She stated she would have liked to have been aware of the bruises. Staff member A was informed that some of the bath sheets did not include a skin assessment by the nurse. Staff member A stated completion of the bath sheets should mean the nurse looked at the resident's skin. When asked about injuries of unknown origin, she stated the skin team determined if the injuries were suspicious and unwitnessed. If so, then the injuries were reviewed. She stated there should be incident reports in each case and staff should confer with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 16 her when there were lacerations, bruises, swelling, and skin tears. The administrator stated there were no incident reports or investigations for any of the bruises to residents #s 1, 5, 7, 10, and 16. These incidents were not reported immediately to the State agency and the results of the investigations were not reported to the State agency within 5 working days. 6. Resident #18 was admitted to the facility on 5/19/08. Diagnoses included hypothyroidism, hyperlipidemia, anticoagulant disorder, anxiety state, depressive disorder, and constipation. The resident was prescribed Coumadin (anticoagulant) for the anticoagulant disorder,; this placed her at higher risk for bruising. According to the skin assessments on the weekly bath records, resident #18 was noted with bruises to both arms above the elbows on 12/2/10. On 11/21/10, she was noted with bruises on the back of both hands. Staff member H, charge nurse, and the surveyor observed the resident's skin on her arms and hands on 12/9/10 at 8:45 a.m. The resident had a bruise near her left elbow and above the left upper arm. The resident stated, "It happened when they (staff) pulled me up to get ready for bed." Staff member H stated it may have been due to a metal bar on the wheel chair that was not padded and stated the resident bruised easily and was on Coumadin. (This was contradictory to how the resident stated the bruising occurred.) Interdisciplinary notes were reviewed for the previous three months. The only note regarding skin injuries was made by staff member H following the observation made with the surveyor	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 17 on 12/9/10 at 8:45 a.m. The following was documented on 12/9/10 at 10:15 a.m. "Bruising noted to L [left] upper arm 2 1/2 " [inch] round, healing bruises. resident (sic) states they occurred when she was being helped up. this (sic) person has L sided weakness with little movement to L arm. newer (sic) 1" bruise to elbow/FA [forearm] area directly in line with corner of w/c arm. this (sic) area not padded will look into getting this area padded actual arm is padded. states (sic) no pain to these areas." There was no indication in the care plan that the resident was at risk for bruising. The medical record lacked documentation that the cause of this bruising had been investigated and the care plan lacked interventions to decrease or eliminate the bruising. The results of the investigation were not reported to the State agency within 5 working days. 7. Resident #16 was admitted to the facility on 7/22/09; diagnoses included hypertension, chronic obstructive asthma, pulmonary valve disorder, depressive disorder, congestive heart failure, osteoporosis, atrial fibrillation, anxiety, dementia, neuropathy, edema and dysphagia. According to the 9/24/10 quarterly MDS, the resident had no memory, mood or behavior problems. The resident required supervision and set up assistance with most ADLs. The resident was prescribed 325 mg of aspirin daily, placing her at increased risk for bruising. According to the 11/24/10 skin assessment on the weekly bath record, resident #16 was noted with an old bruise to the left arm on the front and back. There was no bruising noted on weekly skin	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 18 assessments after this date through 12/9/10. Staff member H, charge nurse, and the surveyor observed the resident's skin on her arms and hands on 12/9/10 at 8:48 a.m. There was a bruise on the resident's right hand, approximately 3 inches in length, and three others by the thumb and forefingers. Staff member H stated these bruises looked old, having occurred possibly 5 - 7 days ago. There was also a bruise on the resident's left hand on a bony prominence. The resident stated she did not know how any of the bruises occurred. Interdisciplinary notes were reviewed for the previous two months and the only note regarding skin injuries was made by staff member H following the observation made with the surveyor on 12/9/10 at 8:45 a.m. The following was documented on 12/9/10 at 9:45 a.m. "Bruising noted to bilat [bilateral] wrists both have discoloration - dark to bony wrist prominence. very (sic) fragile thin skin states no pain to either area. unable (sic) to tell when or how bruising occurred - 1 area to (unable to read symbol) wrist 3 areas of bruising to (unable to read symbol) wrist. looks (sic) several days old. not (sic) recount to either side will suggest poss [possible] coverings to bony areas to decrease bumping or possible cushioning." The resident's care plan dated 3/10/10 included the problem of skin at risk for pressure related areas. It was not specific for bruising or injuries. However, approaches included checking the resident's skin for redness, skin tears, swelling and pressure. The medical record lacked documentation that the cause of this bruising had been investigated and the care plan lacked	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 19 interventions to decrease or eliminate the bruising. There was no indication the results of the investigation were reported to the State agency within 5 working days. 8. Resident #3 was admitted to the facility on 11/19/07; diagnoses included dementia without behavior, agitation, ankle ulcer, and limb pain. The resident was not prescribed medications putting him at increased risk for bruising. The resident was observed during the survey to be thin in appearance (first observed on 12/6/10 at 1:45 p.m.) The resident was able to do most ADLs with supervision or minimal assistance; he walked independently throughout the facility. The resident was not interviewable. A 7/22/10 nurse's note at 10:00 a.m. read, "This RN called to shower house to see bruising on resident of unknown origin: bruising on L et R side of ribcage et lower sternum. Res unable to relate as to how acquired bruises." A note by the same RN later at 10:55 a.m. read "Fax to Dr [physician's name] @ 10:50 re: [regarding] above; [name of resident's guardian] also notified via t.c. [telephone call]" On 7/22/10 the following information was submitted to the State Agency regarding resident #3's bruising, "Bruise of unknown origin. Will investigate and submit final investigation summary report." On 7/30/10 the following information was submitted. Under Brief Description of Alleged Incident: "Bruising was found around [resident's name] middle section during routine exam. [Resident's name] can not explain what happened. General assessment completed. No other problems noted at this time."	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 20 Under What Actions, if any, Have Been Taken by the Facility, "Physician was notified, custodian was notified. Assessment was completed. Will continue to monitor." No additional documentation, reported to the State Agency, was found regarding this incident. Staff member J, charge nurse, was interviewed on 12/7/10 at 2:10 p.m. and asked about the 7/22/10 bruising to the resident's chest/rib cage. She stated an incident report was completed and the resident's decision maker was notified. She did not say how the bruises were sustained and reported that she was not the nurse on duty at the time of the incident. On 12/7/10 at 4:50 p.m., a meeting was held with administrative staff including the staff member A, staff member B, staff member C, social service/activity director, and staff member E, MDS coordinator. Staff was asked about the bruising to resident #3's chest area and to provide information regarding the investigation. On 12/8/10 at 4:40 p.m., a meeting was held with administrative staff including staff member A, staff member B, staff member C, and staff member E. Staff were asked a second time to provide documentation of the investigation into the bruising of resident #3. Staff member A, who oversaw the abuse prevention program, was interviewed on 12/9/10 at 9:30 a.m. She stated that although the State Agency was initially notified of the incident, there was no documented investigation regarding resident #3's bruises. The resident's care plan included the problem of	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 21 skin at risk for pressure related areas. It was not specific for bruising or injuries; however, approaches included checking the resident's skin for redness, skin tears, swelling and pressure. The medical record lacked documentation that the cause of this bruising had been investigated and the care plan lacked interventions to decrease or eliminate the bruising. There was no indication the results of the investigation were reported to the State agency within 5 working days. 9. Resident #5 was admitted to the facility on 12/17/08. Diagnoses included dementia with psychosis, macular degeneration, and depressive disorder. A mechanical lift was used to transfer the resident. Staff member J, the charge nurse on duty, was interviewed on 12/8/10 at 11:00 a.m. regarding the bruises for resident #5. Staff member J stated the resident was transferred with a mechanical lift and this may have been the cause of the bruises to the arms/hands. Staff member J was interviewed a second time on 12/8/10 at 5:30 p.m. and stated the resident always had some bruising. The charge nurse on duty, staff member H, and the surveyor observed the resident's skin on her arms/hands on 12/9/10 at 9:10 a.m. There was one bruise on the left forearm, approximately 1" in diameter. On the right forearm there were three bruises, one approximately 1 1/2" in diameter and the other two were smaller approximately 1/2" in diameter. The resident was unable to say how she sustained the bruises.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 22 A 12/2/10 Bath Sheet documented that resident #5 had large bruises on the back of the right forearm and small bruises on the back of the left forearm. An Interdisciplinary Progress Notes dated 12/9/10 at 9:15 a.m., documented "bruising noted to L [left] FA [forearm] thumb sized dark older coloration mid FA was noted on 12/8/10 to have been given moist heat to R [right] FA do not know if this was for bruising or generalized pain. L FA has 3 areas of dark older coloration of bruising 1" [one inch] size bruise. upper FA c [with] 2 very small bruises below that does not c/o [complain] of pain specific to bruised areas, states generalized pain "all over" not able to rate pain. med (sic) nurse notified of pain." There was no indication in the care plan that the resident was at risk for bruising. The medical record lacked documentation that the cause of this bruising had been investigated and the care plan lacked interventions to decrease or eliminate the bruising. There was no documentation that this incident had been reported to the State agency within 5 working days. 10. Resident #7 was admitted to the facility on 5/17/10. Diagnoses included aneurysm, arterial disease, pain in limb, neoplasm, hypertension, fracture neck of femur, Kaposi's Sarcoma, anxiety state, dementia with behavior disturbance, and insomnia. Staff member J, the charge nurse on duty, was interviewed on 12/8/10 at 11:00 a.m., regarding bruises for resident #5. Staff member J stated the resident was transferred with a mechanical lift and this may have been the cause of the bruises to the arms/hands. Staff member J was interviewed a second time on 12/8/10 at 5:30 p.m.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 23 She stated the resident hit his arms/hands on the hand rails in the hallway. She stated she took off the skin strip on this date and there was a scabbed area. Staff member H, the charge nurse, and the surveyor observed the resident's skin on his arms/hands on 12/9/10 at 10:05 a.m. There was an old scab at the left elbow and one on the middle knuckle of the left hand. The resident's entire forearms were discolored purplish and staff member H stated, "There is discoloration but not bruising." An 11/29/10 Bath Sheet documented the resident had a bruise and skin tear on the dorsum of the left hand, a skin tear on the left elbow, and redness around the coccyx. A 12/6/10 Bath Sheet documented the resident had an intact steri strip on the upper left forearm. The back of the right and left forearms had multiple bruising. Interdisciplinary Progress Notes documented the following: -7/11/10 - resident sustained a small skin tear on the left upper arm; -9/10/10 - a bruise was noted in the coccyx area; -9/15/10 - triangle shaped bruise to upper right buttock; -9/15/10 - bruise left buttock; -11/25/10 - skin tear noted on left forearm; -12/8/10 - left forearm scrape - left open to air; and -12/9/10 - small scabbed area to left elbow and hand. No longer require dressings. There was no indication in the care plan that the resident was at risk for bruising. The medical record lacked documentation that the cause of	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 24 this bruising had been investigated and the care plan lacked interventions to decrease or eliminate the bruising. There was no evidence that the results of the investigation were sent to the State agency within 5 working days. 11. Resident #1 was admitted on 4/9/10 for short-term respite. Diagnoses included secondary Parkinsonism, dementia with Lewy bodies, paralysis agitans, congestive heart failure, sleep apnea, anemia, renal failure, hypertension, glaucoma, depressive disorder, colostomy, and ulcer of heel and mid-foot. According to the skin assessments on the weekly bath records, resident #1 was noted with bruises to both forearms on 11/12/10 (numerous bruises documented on 11/12/10), on 11/22/10, and on 12/2/10. During record review, the Interdisciplinary Progress Notes revealed documentation of skin issues on the following dates: - 8/4/10 - Resident has been wearing arm protectors; - 8/16/10 - The nurse was called to the room for a bruise to left eyebrow; The resident ws unable to remember what happened; - 8/22/10 - Skin tear noted to left wrist; - 9/9/10 - Small open area on inside of upper left buttock; - 9/15/10 - Significant change MDS for skin issues; - 9/20/10 - Left buttocks open area; - 10/3/10 - CNA noted bruise on left cheek while shaving the resident; - 10/9/10 - Nurse found skin tear on dorsal aspect of right hand, reason unknown; - 10/21/10 - Bump with small open area and dried	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 25 blood noted on forehead while the nurse was giving medications; unknown origin; - 11/5/10 - Skin tear on left forearm noted during shower; - 11/17/10 - Left buttocks healed; - 12/8/10 - Physician order for left buttock wound care until healed. Staff member J, charge nurse, was interviewed on 12/8/10 at 5:30 p.m. She stated the resident's arm protectors were applied today at 10:15 a.m. and that staff had been unable to find them previously when it was reported that the surveyor did not observe them in place on 12/6/10 and 12/7/10. She stated the resident had a long-standing history of bruises. The charge nurse (staff member H) and the surveyor observed the resident's skin on his arms/hands on 12/9/10 at 9:00 a.m. The resident was noted to have skin protectors on his forearms. The skin protectors were removed for the skin observation. The resident's entire right forearm was discolored purple. The nurse stated, "I am not sure if it is a bruise or discoloration. It could be peripheral vascular disease." The resident's left forearm was similarly discolored with three darker areas. The nurse stated, "These are possibly new bruises, the darker areas." There was no indication in the care plan that the resident was at risk for bruising. The medical record lacked documentation that the cause of this bruising had been investigated and the care plan lacked interventions to decrease or eliminate the bruising. There was no indication of reporting these incidents immediately to the State agency and the results of the investigation to the State agency within 5 working days of the incidents.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 26 12. Resident #10 was admitted to the facility on 11/27/09 and readmitted on 10/22/10. Diagnoses included congestive heart failure, aortic stenosis, cerebrovascular accident, depressive disorder, psychosis, dysphagia, edema, renal failure, tachycardia, atrial fibrillation, and dementia with behavior disturbance. According to the skin assessments on the weekly bath records, resident #10 was noted with bruises and a skin tear. On 11/17/10, she was noted with old bruises on both forearms and on the back of both hands. On 11/22/10, she was noted with bruises on the front of both forearms. On 11/29/10, she was noted with bruises on the front of both forearms and a skin tear to the back of the left forearm. On 12/6/10, she was noted with mottled bruises to the front of both forearms. During an observation on 12/7/10 at 4:00 p.m., the surveyor noted bruising on the back of resident #10's left hand. Resident #10 was dependent on staff for ADLs and used a mechanical lift for transfers, according to CNA flow sheets and an 11/18/10 nursing notes. She used a wheelchair for locomotion around the facility. The resident could not wheel herself in the wheelchair. Resident #10 was receiving 81 mg of aspirin daily. During record review, the Interdisciplinary Progress Notes revealed documentation of bruising on the following dates: - 9/29/10 - The daughter noted a scab on right forearm and on the base of the right thumb. The daughter went to the charge nurse to determine what had happened. The forearm scab had been	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 27 listed on the bath sheet on 9/21, but the thumb scab was unknown; -10/11/10 - Left wrist skin tear, done while using the lift; -11/28/10 - Skin tear to right arm in area of prior bruising that happened when CNA took resident's shirt off. Staff member J, the charge nurse on duty who worked 4 days a week, was interviewed on 12/8/10 at 11:00 a.m. She stated residents #10 may have been bruised due to being transferred with the mechanical lift. Staff member J was interviewed again on 12/8/10 at 5:30 p.m., and stated the resident's 10/11/10 skin tear should have been investigated. She stated the resident had a history of being combative and bumping herself when trying to get out of the chair. Staff member H, charge nurse, and the surveyor observed the resident's skin on her arms/hands on 12/9/10 at 10:10 a.m. The resident's right forearm had 3 bruised areas, 1 approximately 4 - 5 inches in length. On the left hand there were 2 large bruises on the forearm and 4 areas with bruising on the resident's hand. The nurse stated, "There are maybe four areas of bruising; they could be new a couple days ago." There was no indication in the care plan that the resident was at risk for bruising. The medical record lacked documentation that the cause of this bruising had been investigated and the care plan lacked interventions to decrease or eliminate the bruising. There was no indication of reporting these bruising incidents, as identified by the weekly bath records and Interdisciplinary Progress Notes, immediately to the State agency and the results of the investigation to the State	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 225	Continued From page 28 agency within 5 working days of the incidents.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of resident council minutes, and resident interview, the facility failed to provide care in a manner and environment that maintained or enhanced residents' dignity for 4 (#s 4, 9, 10, and 17) of 11 sampled residents, as well as multiple unidentified residents. The facility failed to provide timely meal service, engage residents in conversation during meals, speak about residents in public settings in a respectful manner, adjust assistive devices to maintain dignity for a resident, and knock prior to entering residents' rooms. Findings include: 1. On 12/7/10 at 12:40 p.m., five residents were observed at a table in the dining room. Two CNAs were assisting the residents with their meals. The two CNAs were talking over the table about personal matters and did not include the residents in their conversation. On 12/7/10, the lunch meal was observed. Meal service began 15 minutes late and it took a long time to serve all residents their meals. Meal service began at approximately 12:30 p.m. Lunch meal service was scheduled to begin at 12:15 p.m. At 1:05 p.m. there were 5 residents who had not been served lunch in the main dining room.	F 241	Plan of Correction F241 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #4, 9, 10 and 17 will be provided with care in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. These residents will be provided timely meal service, be engaged in conversation during meals, be spoken to in a respectful manner, receive appropriate use of there assistive devices, and staff will knock prior to entering there rooms. How other resident's identified as having the potential to be affected by the deficient practice: An audit has been conducted to ensure all residents are provided with care in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 241	Continued From page 29 All residents were served by 1:10 p.m., 55 minutes after the scheduled start time. There were a total of 42 residents; it took approximately one minute on average to serve a meal tray. On 12/7/10 at 12:50 p.m., resident #4 stood up to leave. Two CNA's told him lunch was coming. Resident #4 sat back down. At 12:58 p.m., resident #17 wheeled himself out of the dining room. He had not been served lunch. On 12/8/10 at 12:45 p.m. a resident (whose meal was on the cart) came to the south dining room as the cart with the meal trays arrived. The resident stated, "How come the food is so late?" Meal service for lunch was to begin at 12:15 p.m.; the room trays were the first meals served to residents. Approximately 8 - 10 residents' meals came on the cart. On 12/7/10 at 4:45 p.m., thirteen residents were observed in the dining room awaiting their dinner. Dinner was not served until 5:30 p.m. At least six of the residents required assistance to the dining room. 2. Review of the September 2010 Resident Council Minutes Concerns documented that the nursing staff in the dining room were not always responsive to the needs of the residents. During the group meeting on 12/7/10 at 2:30 p.m., two residents expressed concern with the wait period for meals and the discomfort from sitting for long periods of time while awaiting their meals. They both indicated that at lunch time, residents were brought to the dining room between 11:30 a.m. and 11:45 a.m. and the meal was not served until 12:15 p.m. They also stated that there were	F 241	What measures and changes put into place to ensure deficient practice does not recur: All staff have received training on the requirement that all residents are provided with care in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The training was conducted on 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be conducted weekly for 1 month, then monthly for 3 months, then quarterly to ensure all residents are provided with care in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 241	Continued From page 30 not enough staff in the dining room at meal time to assist those requiring assistance or who were dependent upon staff for eating. 3. Staff members referred to residents who required assistance with eating as "feeders" during the survey. 4. On 12/7/10 at 12:45 p.m., staff member I, cook, stated the "Feeders" trays were ready. 5. During the evening meal observation on 12/7/10 beginning at 5:30 p.m., two CNAs were observed in the dining room assisting residents with their meals. The CNAs were observed discussing personal issues between each other, rather than interacting with the residents. During the morning meal observation on 12/8/10 at 7:35 a.m., an unidentified kitchen staff member was observed as she stepped out of the kitchen doorway. She stopped just outside the door, then loudly asked the CNA who was in the dining room if she was "ready for the feeders yet." The CNA was noted to be the only CNA in the dining room at that time. She was heard to tell the kitchen staff member that she was on the floor doing room trays, but that she had seen the Companion headed to the dining room. The kitchen staff member returned to the kitchen. There were over 20 residents present in the dining room at that time. 6. On 12/9/10 at 7:25 a.m., resident #10 was observed sitting in a wheelchair beside the nurses' station. The resident was asleep, slumped forward with her glasses on. The glasses were noted to be crooked with the left nose piece sitting on the bridge of the nose, and	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 241	Continued From page 31 the right nose piece was hanging freely over her right cheek. There were five residents sitting around the nurses' station and the charge nurse was sitting at the nurses' station. 7. On 12/9/10 during wound observations with the charge nurse between 10:30 a.m. and 12:00 p.m., the nurse entered seven resident rooms without knocking prior to entering. 8. On 12/9/10 at 11:45 a.m., while the surveyor was sitting in the activity room at the end of the North Hall, a staff member was heard hollering down the hall, "They need to see [resident #9's] back side." There were 2 residents in the hallway and several of the resident rooms in the North Hall were occupied.	F 241		
F 272 SS=B	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 272	Continued From page 32 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to conduct a comprehensive and accurate assessment on the use of positioning and transfer devices for two (#s 1 and 7) of 11 sampled residents and one (#12) supplemental resident. Findings include: 1. Resident #7 was admitted to the facility on 5/17/10. Diagnoses included aneurysm, arterial disease, pain in limb, neoplasm, hypertension, fracture neck of femur, Kaposi's Sarcoma, anxiety state, dementia with behavior disturbance, and insomnia. On 12/8/10 at 8:30 a.m., a quarter side rail on the exit side of the bed was observed in the raised position in resident #7's room. An Evaluation for Use of Side Rails was completed 10/4/10. The section on -"Why is the use of a side rail(s) being considered?" documented "bed adjustment. New bed has controls in 1/4 side rail". This form lacked assessment entries in the	F 272	Plan of Correction 272 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident's #1, 7, and 12 have had the temporary side rails removed. How other resident's identified as having the potential to be affected by the deficient practice: An audit of all resident beds was conducted to determine which had positioning and transfer devices. Those residents using positioning, transfer devices or rails have had a comprehensive assessment for the use of these devices. What measures and changes put into place to ensure deficient practice does not recur: Staff received training on the need to complete comprehensive and accurate assessments on the use of positioning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 272	Continued From page 33 following areas: -"Identify all that contribute to the resident's need to use side rail(s)": sub sections included 'Physical, Cognitive, and Security' which identified specific indications under each sub section; -"Additional Considerations" section was not completed to indicate if the rail was a restraint, Medications that require increased safety measures, fluctuations in consciousness, decline in cognitive status, delirium, if the side rail would impede the resident's freedom of movement and if the side rail would obstruct the resident's view; -"Recommended Use" section was blank. -The "Recommended Type" indicated 1/4 partial rails for the left and right upper bed. The section documenting that the side rail precautions had been discussed with the resident or family was blank. The "Comments" section read, "Received new bed with adjustment controls on 1/4 rail - will remove when hand control arrives - Instructed on use - staff to keep down when not in use." There was no indication that the fit of the rails to the mattress was assessed. On 12/8/10 at 12:20 p.m., staff member B, DON, stated that the beds new to the facility and had bed controls located on the side rails. On 12/8/10 at 12:45 p.m., staff member F, maintenance, stated the facility had ordered hand controls for the hospital beds. They arrived approximately 1 week ago but he had not as yet attached them to the beds.	F 272	and transfer devices. 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be done weekly for 1 month, then quarterly to ensure all residents using positioning and transfer devices have had a comprehensive assessment. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 272	Continued From page 34 2. Resident #1 was admitted on 4/9/10 with diagnoses that included secondary Parkinsonism, dementia with Lewy bodies, paralysis agitans, congestive heart failure, sleep apnea, anemia, renal failure, hypertension, glaucoma, depressive disorder, colostomy, and ulcer of heel and mid foot. Resident #1 was observed to be dependent on staff for transfer using a mechanical lift, and was dependent for ADLs. An Evaluation for Use of Side Rails was completed on 10/4/10. The section on -"Why is the use of a side rail(s) being considered?" documented for "bed adjustment. New bed - 1/4 rail has adjustment controls". This form lacked assessment entries in the following areas: -"Identify all that contribute to the resident's need to use side rail(s)": sub sections included 'Physical, Cognitive, and Security' which identified specific indications under each sub section; -"Additional Considerations" section was not completed to indicate if the rail was a restraint, if bowel and bladder continence was an issue, if the resident was on medications that require increased safety measures, fluctuations in consciousness, decline in cognitive status, or delirium. The assessment showed the rail would not impede the resident's freedom of movement and would not obstruct the resident's view; -"Recommendations" section was blank. -The "Recommended Type" stated 1/4 partial rails for the left and right upper bed. The section documenting that the side rail precautions had been discussed with the resident or family was	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 272	Continued From page 35 not filled out. The "Comments" section read, "Received new bed - 1/4 rails have adjustment controls - will replace [with] hand controls when they arrive - staff instructed to leave down when not in use." The form was signed by the social service designee, but did not contain a date when it was signed. The areas for physician order and plan of care updated were blank. There was no indication that the fit of the rails to the mattress was assessed. On 12/8/10 at 12:45 p.m., staff member F stated the facility had ordered hand controls for the hospital beds. They arrived approximately 1 week ago but he had not as yet attached them to the beds. 3. Resident #12 was admitted on 11/22/01, and readmitted on 12/31/08. Diagnoses included diabetes, dementia with behavior disturbance, esophageal reflux, duodenal obstruction, constipation, benign prostatic hypertrophy without obstruction, and insomnia. Resident #12 was observed to be independent with ambulation and transferring. An Evaluation for Use of Side Rails was completed on 8/16/10. The section on -"Why is the use of a side rail(s) being considered?" documented for "Positioning. New beds purchased - controls on rails - will remove rails hand controls come in". The section to identify what contributes to the	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 272	Continued From page 36 resident's need to use side rail(s) showed under the physical section the rails were for positioning. The cognitive and security sections were blank. The section to identify whether the rail(s) would assist the resident in bed mobility, transfer, and other were all checked in the 'no' column. The recommended type of rail was marked as 1/4 partial rail on the left side, to be used "when resident is in bed and needs adjustment." The form also contained a date for reevaluation on 11/10/10. On 12/8/10 at 12:45 p.m., staff member F stated the facility had ordered hand controls for the hospital beds. They arrived approximately 1 week ago but he had not as yet attached them to the beds.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 279	Continued From page 37 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to ensure 1 (#4) of 11 sampled residents had a care plan that included measurable objectives, and included all services needed to maintain the highest practicable well-being. Findings include: Resident #4 was admitted to the facility on 10/18/07; diagnoses included alcohol dementia, seizure disorder, brain injury, anxiety disorder, and brain aneurysm. According to the 11/30/10 MDS, the 52 year old resident triggered for in depth review in the areas of cognitive loss, ADL function, psychosocial well-being, behavior, nutrition, dental, pressure ulcers and medications. Under the area of mood, the MDS documented the resident as having little interest in or pleasure in doing things, being down, depressed and/or hopeless on almost a daily basis. Under behavior, the resident was documented with delusions; however, this was not further defined or documented elsewhere in the medical record. No other behavior problems were noted on the MDS. At the time of the survey, the resident was prescribed an antipsychotic medication Seroquel, and an antianxiety medication Ativan. The resident had a legal guardian in place. a. History of psychoactive medication use and behaviors According to a 9/13/10 physician assistant note, the resident 's Depakote (seizure medication) was	F 279	Plan of Correction F279 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #4 has had his care plan revised so it includes measurable objectives and includes services to maintain his highest practicable well-being. How other resident's identified as having the potential to be affected by the deficient practice: An audit of all resident's care plans has been completed to determine they have measurable objectives and include services that maintain each residents' highest practicable well-being. What measures and changes put into place to ensure deficient practice does not recur: Staff will receive training on the need to develop care plans with measurable objectives and services that maintain residents' highest practicable well-being. Training will be conducted on 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 279	Continued From page 38 recently discontinued (8/31/10) due to elevated laboratory results. Seroquel, an antipsychotic medication, was initiated by the physician assistant due to an increase in the resident's behaviors following the discontinuance of the Depakote. Behaviors included calling counselors, social workers and family members; anger and belligerence towards staff and sneaking cigarettes. Prior to 9/14/10, the resident was not prescribed any antipsychotic medications. According to the September MAR, Seroquel was initiated at 25 mg twice a day (total of 50 mg daily) starting on the afternoon shift of 9/15/10 for the diagnosis of anxiety/agitation. In addition Seroquel was prescribed 25 mg as needed for episodes of severe agitation on 9/13/10. On 9/21/10, Seroquel was increased to 50 mg in the morning and 100 mg at bed time (total of 150 mg daily) for alcohol persistent dementia according to the MAR. The dose of the Seroquel was decreased on 10/10/10 to 50 mg twice daily (total of 100 mg daily). On 10/22/10, the dose of Seroquel was increased to 100 mg twice daily (total of 200 mg daily). At the time of the survey, the resident was receiving 200 mg of Seroquel daily. b. Interviews The resident was interviewed on 12/8/10 at 10:45 a.m. He stated he had been living in the facility for a few years and would like to be discharged. He stated his rights were being violated because he was not free to leave. He stated he received medications for his seizures and was aware of some changes in his seizure medication regimen. The resident stated (incorrectly) he was being administered Seroquel for seizures.	F 279	Audits will be conducted on all residents initially, then quarterly per resident to ensure care plans are developed with measurable objectives, and services to maintain residents' highest practicable well-being. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 279	Continued From page 39 The social services director, staff member C, was interviewed on 12/6/10 at 1:30 p.m. and verified the resident's desire to go to Great Falls. She stated the resident was doing well until approximately 6 months ago when behaviors started to increase after his medication was changed due to labs showing problems with his liver function. A meeting was held on 12/7/10 at 4:50 p.m., with administrative staff including the administrator, staff member A, the DON, staff member B, social service/activity director, staff member C, and the MDS coordinator, staff member E. Staff were informed of the lack of a care plan for the resident to address psychoactive medication use and were asked to provide any additional information that could be found. No additional information was provided by the exit conference on 12/9/10 at 12:30 p.m. or thereafter. c. Care planning The resident's use of the psychoactive medications Seroquel and Ativan was not addressed on the care plan. There was no information on the care plan to assist staff in monitoring for adverse reactions or other potential complications from the medications. There was no information regarding the goals of the medication use and approaches to be taken by staff.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 280	Continued From page 40 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 3 (#s 7, 8 and 10) of 11 sampled residents had care plans that were revised as resident needs and objectives changed. Findings include: 1. Resident #10 was admitted on 11/27/09 and readmitted on 10/22/10 with diagnoses that included congestive heart failure, aortic stenosis, cerebrovascular accident, depressive disorder, psychosis, dysphagia, edema, renal failure, tachycardia, atrial fibrillation, and dementia with behavior disturbance. Record review showed resident #10 had been on Seroquel, an antipsychotic, 25 mg twice daily and at bedtime. This medication was discontinued on 10/25/10. The resident did continue on sertraline, an antidepressant, 100 mg daily. The care plan, which was updated on 11/24/10, showed the	F 280	Plan of Correction F280 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #7 has had his care plan reviewed and revised regarding the use of the side rail. Resident #8 has had her care plan reviewed and revised regarding the use of psychoactive medications. Resident #10 has passed away. How other resident's identified as having the potential to be affected by the deficient practice: An audit of all resident's care plans has been completed to determine they are reviewed and revised as the residents' needs and objectives changed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 280	Continued From page 41 resident as receiving an antidepressant and psychotic drugs on a regular basis. At the time of this care plan update, resident #10 was no longer receiving antipsychotic medications. The care plan was not updated with this change. The care plan for nutrition issues had the house supplement, 4 ounces three times daily with meals, added on 12/7/10. The care plan goal for nutrition issues listed "maintain existing weight over the next 90 days." The goal did not address what this weight range should be, although the staff was to report a weight loss of more than five pounds to the dietitian, and the resident was on the Nutritional Risk Program. During the evening facility update meeting on 12/7/10 at 4:50 p.m., staff member E, the MDS Coordinator, stated the weights for the MDS assessments are located in the weight book. The dietary manager is responsible for completing the nutrition section of the MDS. The coordinator was asked about the care plan goals of maintaining existing weight that is present on the care plans of residents with weight issues, and how they are able to tell what that existing weight would be. The coordinator stated it would be more efficient to have the weight listed on the care plan. 2. Resident #7 was admitted to the facility on 5/17/10. Diagnoses included aneurysm, arterial disease, pain in limb, neoplasm, hypertension, fracture neck of femur, Kaposi's Sarcoma, anxiety state, dementia with behavior disturbance, and insomnia. On 12/8/10 at 8:30 a.m., a quarter side rail on the exit side of the bed, was observed in the raised	F 280	What measures and changes put into place to ensure deficient practice does not recur: Staff will receive training on the need to review and revise care plans as the residents' need and objectives change. Training will be conducted on 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be conducted on all residents initially, then quarterly per resident to ensure care plans are reviewed and revised as the residents' needs and objectives change. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 280	Continued From page 42 position. An Evaluation for Use of Side Rails was completed on 10/4/10. The section on -"Why is the use of a side rail(s) being considered?" documented for "bed adjustment. New bed has controls in 1/4 side rail". The "Comments" section read, "Received new bed with adjustment controls on 1/4 rail - will remove when hand control arrives - Instructed on use - staff to keep down when not in use." The Care plan was not revised to include the use of the side rail. 3. Resident #8 was re-admitted to the facility 5/12/10. Diagnoses included constipation, insomnia, depressive disorder, dementia without behavior, and difficulty walking. Her care plan was developed 6/16/10 and updated 11/26/10. A review of the comprehensive care plan dated 11/26/10, revealed the resident received psychoactive medications on a regular basis. However, according to the MAR, resident #8 had not received Zyprexa since 7/22/10. The Care plan was not revised to indicate that the resident no longer received a psychoactive medication.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and	F 281	Plan of Correction F281	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 281	Continued From page 43 staff interview, the facility failed to meet professional standards of quality regarding medication administration procedures for 2 (#s 2 and 8) of 11 sampled residents, and 1 (#14) of 6 supplemental residents. Findings include: 1. Resident #8 was re-admitted on 5/12/09 with diagnoses including constipation, insomnia, depressive disorder, dementia without behavior, and difficulty walking. She was started on Zyprexa on 6/23/10. Nursing staff stopped administering Zyprexa on 7/22/10. There was no physician's order in Resident #8's medical file to discontinue Zyprexa. On 12/9/10 at 10:20 a.m., staff member B, the DON, stated there was no physician's order to discontinue the Zyprexa. 2. During record review for supplemental resident #14, the record showed the resident was admitted on 6/28/05 with diagnoses that included hypothyroidism, dementia with behavior disturbance, convulsions, brain injury, abnormal posture, constipation, and seizures. During record review, the November MAR was reviewed. The review showed resident #14 had a physician's order for HCL (hydrochloride) with Pepsin 650 mg before meals that began on 6/22/10. Per nursing documentation on the MAR, this medication was circled by the nurse beginning on 11/21/10 at the 4:30 p.m. dose. The 7:30 and 11:30 a.m. doses had "NA" written in the space for the nurse's initial. The NA meant the medication was not available. This medication was listed as NA through the end of November, and continued (NA) until the 12/6/10 4:30 p.m. dose.	F 281	Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #2 will receive her medication timely and medication administration will be conducted according to professional standards. Resident #8's Zyprexa has been discontinued. Her medication administration will be conducted according to professional standards. Resident #14 will receive her medication timely and medication administration will be conducted according to professional standards. How other resident's identified as having the potential to be affected by the deficient practice: An audit of all residents will be conducted to ensure medication administration is to be conducted according to professional standards. What measures and changes put into place to ensure deficient practice does not recur: Licensed nursing staff will receive training on medication administration principles, policies and procedures. Training will be conducted 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be conducted weekly for 1 month, then quarterly to ensure medication administration is being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 281	Continued From page 44 Review of the Interdisciplinary Progress Notes between 11/22/10 and 12/9/10, showed a notation by the nurse on 11/30/10. This notation read, "...call to wife about ordering Pepsin HCL." This notification of the wife, who supplied the medication for the resident, was not made until nine days after the medication was not available. The medication was noted as received on 12/6/10 at 1:45 p.m. The wife was notified of receipt of the medication. HCL with Pepsin is a digestive enzyme which is used as a supplement to aid digestion for people who are deficient in secretory digestion enzymes. It is useful for people with a compromised gastrointestinal system and especially for people who experience constipation, according to the Intensive Nutrition Inc. web site. The facility policies were reviewed, but this medication was not provided by the pharmacy, so those policies did not apply. It was unclear why the nurses waited 11 days to notify the wife the medication needed to be reordered. Attempts to interview the charge nurse during survey were unsuccessful. 3. Record review showed resident #2 was admitted on 12/24/07 with diagnoses that included dementia with psychosis, lumbago, T(thoracic) -11 compression fracture, pelvic joint pain, anxiety, depression, hypertension, congestive heart failure, osteoarthrosis, and pain of the thoracic spine. Review of the August MAR showed Fosamax was written on the MAR to be administered weekly, beginning on 8/4/10. The medication was noted	F 281	provided according to professional standards. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 281	Continued From page 45 on the MAR to begin on 8/11/10, but there was nothing documented until 8/17/10. On that date, the nurse circled their initial, and wrote on the bottom of the form that the Fosamax was not available. The Fosamax was circled on 8/23, 8/24, and 8/25/10. On 8/31/10, the medication was given, 27 days after it was ordered. Review of the physician telephone order sheets showed on 8/4/10, the physician ordered Fosamax 70 mg once a week. A notation on the order stated it was faxed to the pharmacy on 8/23/10. On 8/13/10, the nurse documented the resident returned from a physician appointment with new orders that were faxed to the pharmacy. On 8/21/10, the nurse documented the physician was in the facility for rounds. On 8/23/10, the nurse documented "Per pharmacy, no order rec'd [received] for Fosamax. Order faxed to pharmacy now." There was no documentation of the physician being notified that the Fosamax was not available and had not been administered, although he had seen the resident twice during this period. The facility policies on Receiving Pharmacy Products and Services from Pharmacy were reviewed. There were seven policies related to pharmacy services that were provided by the facility. According to policy 1.0 Providing Pharmacy Products and Services, the pharmacy is available twenty four hours a day, 7 days a week. According to policy 5.1 Receipt of Routine Deliveries, "...2.5 If any item ordered is not received, a Facility designee should check for a communication slip indicating: (1) back orders; (2) ordered-too-soon notifications; (3) drug-drug interactions; (4) formulary changes; or (5) any other communication explaining the reason a	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 281	Continued From page 46 medication or item was not delivered. Facility should contact the Pharmacy if Facility is not clear as to the reason for the missing items or medications...Facility should document any delivery discrepancies."	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and observation, the facility failed to prevent recurrent development of a pressure ulcer, evaluate, assess, or revise the interventions as appropriate to prevent new pressure sores from developing for 1 (#9) of 11 residents. In addition, the facility failed to accurately document pressure ulcers for 5 (#s 1, 8, 15, 16 and 17) of 2 sampled and 3 supplemental residents. Findings include: 1. Resident #9 was admitted to the facility on 4/7/08. Diagnoses included coronary artery anomaly, trans-cerebral ischemia, insomnia, peripheral vascular disease, iron deficiency anemia, Meniere's disease, constipation, esophageal reflux, hypertension, and a pressure ulcer on the buttock.	F 314	Plan of Correction F314 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #9 has been provided with necessary treatment and services to prevent any other development of pressure sores and to promote the healing of her current wound. The facility is accurately documenting the wound status of residents 1, 8, 15, 16 and 17's pressure sores. How other resident's identified as having the potential to be affected by the deficient practice: All residents have been audited and assessed to ensure the	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 314	Continued From page 47 The review of the clinical record for resident #9 showed that there was a pressure sore on her right upper buttock on 12/31/09. A further review of the record determined that there was a Pressure Ulcer Scale for Healing Tool (PUSH), dated 4/26/10, that recorded the ulcer dimensions at 1.3 cm x 0.7 cm (centimeter). On 8/6/10, there was a note on the August treatment record, and an Interdisciplinary Progress Note stating that the resident's ulcer had healed. No PUSH tools were found in the record after the 4/26/10 date. A 9/3/10 Interdisciplinary Progress Note revealed new orders for the treatment of a pressure ulcer to the upper right buttock had been added to the treatment sheet. No information in the progress note related to stage or dimensions was found. A 9/20/10 progress note described the wound as "scabbed area on (right) buttock at 1 cm x 0.5 cm". On 9/29/10, an Interdisciplinary Progress Note stated that a skin evaluation was done with resident #9's bath. The note stated that, "Rt [right] buttucks (sic) wound 1 cm x 0.7 cm wound bed beefy edges dk [dark] pink scant serous drainage". The care plan for pressure ulcers with a start date of 3/5/10, stated that a complete skin assessment should be done and recorded weekly. The Interdisciplinary Progress Notes did not have a recorded skin assessment from 8/6/10, the date when the ulcer was healed, through 9/3/10, when new orders were received for treatment of the upper right buttock ulcer. On 10/25/10, an Interdisciplinary Progress Note stated that resident #9 was showered and a skin	F 314	facility is providing the necessary treatment and services to prevent the development of and promote the healing of pressure sores. What measures and changes put into place to ensure deficient practice does not recur: Staff will receive training on Cedar Wood Villa's skincare protocol Training will be conducted on 1/4/11 and 1/11/11. How our plan is monitored, achieved and sustained, and integrated into the QA system. Audits will be done weekly to ensure compliance with Cedar Wood Villa's skin care protocol. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 314	Continued From page 48 assessment was completed. The assessment recorded 0.7 cm x 0.5 cm right buttocks wound. The wound bed was described as "pinkish edges & surrounding skin pink, sm [small] amount serous drainage with shower". From the 10/25/10 note through the last entry in the Interdisciplinary Progress Notes on 12/8/10, there were no further entries in the Interdisciplinary Progress Notes concerning the pressure ulcer. The medical record revealed that resident #9's pressure ulcer was healed on 8/6/10 and that a new pressure ulcer developed in the same area on 9/3/10. According to the 9/15/10 quarterly MDS, the resident required extensive assistance of one staff member with ADLs including bed mobility, transfers, and dressing. The resident required limited assistance of one staff member for toileting; she was not able to balance while standing without physical assistance. The resident did not walk during the observation period. The resident had a partial loss of voluntary movement on one side of her neck, to both legs and to one of her feet. The care plan for treatment and prevention of pressure sores was not updated when the facility stated that the ulcer was healed on 8/6/10. The plan of care was not updated when the new pressure ulcer on the right buttock recurred on 9/3/10. No information was found in the clinical record of the facility evaluating and monitoring the impact of interventions or revision of interventions to address declines in resident #9's ability to transfer, reposition, and ambulate.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 314	Continued From page 49 A review of the medical record revealed an Interdisciplinary Progress Note dated 8/29/10 that indicated the development of an open area on resident #9's left knee. The note stated, "...from immoblizer (sic) - open area .8 cm x .9 cm with 95% beefy wound bed 5% yellow slough with mod. serous drainage - reddness (sic) around area 3cm x 4cm...". A further note on 8/30/10 showed a new order for wound care daily. No further Interdisciplinary Progress Notes were found related to the open area on resident #9's left knee. On 12/9/10 at 10:40 a.m., resident #9 was noted sitting in her recliner with her feet up. The charge nurse removed the resident's shoe and sock to review the right second toe. The toe was covered with a bandage. On 12/9/10 at 11:58 a.m., resident #9 was in the bathroom. The charge nurse removed the dressing from the area on the resident's buttock. The dressing had been changed on 12/8/10, but the edges of the dressing were rolled up and peeling. The area on the buttock was noted to be approximately 2 inches by 3/4 inch, with an open area on the left side of the wound that was approximately 1 cm. There was no redness or exudate noted on the area. The nurse cleansed the area and applied a new dressing. Resident #9's care plan was not updated to include the treatment for the pressure sore on her left knee. 2. Staff member A, the administrator was interviewed on 12/9/10 at 9:20 a.m., and stated the facility recently discovered that one of the nurses did not complete pressure ulcer	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 314	Continued From page 50	F 314		

treatments (change dressings) when she said she did and marked pressure ulcers healed when they were not. The administrator stated this nurse was suspended as of this week.

Based on the Census and Conditions form completed during the survey, for 6 of 8 residents, the pressure ulcers were developed while the residents were in the facility.

3. Following the interview with staff member B, the DON, the list of residents with pressure ulcers, taken from the Skin and Weight Meeting minutes, was compiled and the nurse surveyor accompanied staff member H, charge nurse, on rounds to inspect these residents on 12/9/10 beginning at 10:30 a.m.
The following residents were observed:
- At 10:43 a.m., resident #8 was noted in the beauty shop. The surveyor was unable to review her reported wounds on the buttocks;
- At 10:46 a.m., resident #16 was noted lying in bed with her feet elevated on a pillow. The left second toe was observed. The area did not have a dressing. There was a small scab noted on the knuckle of the toe where the toe was bent above the other toes. The resident stated she had that area on her toe off and on for a while. She stated she would need special shoes to prevent it from recurring, but doesn't want them.
- At 10:50 a.m., resident #17 was observed sitting in his recliner. He stated he had a couple of sore toes. He further clarified both of his big toes were sore. The charge nurse removed the resident's shoes and socks on both feet. The right great toe had no areas of redness and no open areas. The resident stated that toe didn't hurt anymore. The left great toe was noted to have a bandage on the outer aspect of the toe. The dressing was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 314	Continued From page 51 dated. Staff member H stated she thought it was documented as being changed yesterday. The resident stated that toe didn't really hurt either. - At 10:44 a.m., resident #15 was observed sitting in her wheelchair at the bedside. The nurse removed the slipper from the left foot and opened the end of the support hose to allow inspection of the toes. The resident was reported to have an open area on the second toe, but the toe was not reddened and did not have an open area. - At 11:42 a.m., resident #1 was observed being lifted in the mechanical lift by the CNA. While he was up being toileted, the nurse inspected his buttocks. An occlusive dressing over a DuoDerm dressing was noted on his buttock. The dressing was dated 12/8/10. It was intact and the nurse declined to remove it for fear of causing more damage to his skin. - At 12:00 p.m., resident #8 was noted in the dining room at her table. A Physician Progress Note dated 10/28/10, read, "Gluteal cleft lesion. This has been treated by wound care here at the nursing facility. This appears to be healing. She currently has a 3 mm (millimeter) x .5 mm area of central abrasion that is continued to be evaluated by nursing staff. It is anticipated to resolve completely." An 11/29/10 Interdisciplinary Progress Notes documented, on 11/29/10 at 10:00 a.m., "While doing skin checks after shower noted superficial red areas L & R cleft of buttocks - noted in skin book..." The facility failed to accurately assess and document pressure ulcers.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 52 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff, family, resident interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible related to the following: resident to resident incidents, side rail use, and falls for one (#7) of 11 sampled residents; medications at bedside for two (#s 5 and 6) of two sampled residents; and a floor register heater at a high temperature. Findings include: 1. Resident #7 was admitted to the facility on 5/17/10. Diagnoses included aneurysm, arterial disease, pain in limb, neoplasm, hypertension, fracture neck of femur, Kaposi's Sarcoma, anxiety state, dementia with behavior disturbance, and insomnia. Behaviors: The resident was physically aggressive towards other residents when he thought these residents were his wife. Interdisciplinary Progress Notes read: -"7/6/10 Reported to this nurse that resident was physically trying to pull another resident out of her bed thinking that he was his wife... -7/15/10 ...Became quite agitated et [and] angry c [with] this RN when removed from female res. [resident] room p [after] almost running over her feet (he thought she was his wife)... -7/21/10 This resident very agitated - thinks	F 323	Plan of Correction F323 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #7's behavior has been evaluated, analyzed and interventions have been developed. He is being monitored and documented appropriately. His plan of care has been updated to address the resident's behavior of thinking other residents are his wife and reduce the resident to resident incidents. Resident #7's fall history has been analyzed and care plan interventions are in place to reduce the risk of falls. Resident #7 does not currently have side rails. Resident #5 is deceased. Resident #6 is no longer self-administering medications. Handrails have been installed in the south hallway. The baseboard register in room N16 has been replaced.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 53 another resident [resident name] is his wife. He becomes very angry whenever I, or anyone else, move her around... -7/24/10 ...Res. has been [increasingly] agitated since 1000 [10:00 a.m.] this am; going into female res. rooms et attempting to touch them... -8/5/10 Res has been very agitated since ac [after] lunch, looking for spouse, et upsetting other female residents by going too close to them et/or touching them... -9/30/10 Res. has become more agitated today as day has progressed; was behind female resident in w/c whom he thought was his dtr [daughter], et began kicking @ [at] the back of her w/c to move her along. Staff moved this female resident away from Res. et into DR [dining room] as it was almost supper time. Res. followed female resident into DR et was grabbing female res.' wrist roughly in an attempt to get her to go c him. Staff attempted to redirect res. but became angry et did not want to let go of female res... -10/7/10 Resident quite agitated this evening following several of the other female residents thinking they were his wife... -10/8/10 10:00 a.m. Following several female residents saying 'that's my wife'. Staff had to remove res. from vicinity of female residents as he was banging into them c his w/c... -10/8/10 10:30 a.m. Res. agitated this AM; looking in another male re. room who was sleeping stating 'that man is screwing my wife - what would you do if you were a man & he was screwing your wife?' Res. also kicking female res. in back of w/c to propel her as this is his 'wife'... -10/9/10 ...Chasing p [after] female res. thinking they were his wife. When staff attempt to keep him out of female res. rooms, who don't want him in their rooms, he kicks their doors to try to get	F 323	How other resident's identified as having the potential to be affected by the deficient practice: All residents and the environment have been audited and assessed to ensure the resident environment remains as free of accident hazards as possible. What measures and changes put into place to ensure deficient practice does not reoccur: Audits will be done weekly for 1 month, then quarterly to ensure Cedar Wood Villa's resident environment remains as free of accident hazards as possible. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained. How our plan is monitored, achieved and sustained, and integrated into the QA system:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 54 in... -11/9/10 Did note that res did think that another res was his wife and was following her around... -11/12/10 Resident very agitated thinking many of the female residents are his wife... -11/14/10 2100 Res thought another res was his wife et would not leave res alone until she was moved. Then res was looking for her et going into other res rooms." The documentation lacked indication of the effect resident #7's behaviors had on other residents, whom he thought were his wife. Review of the October, November and December 2010 Behavior/Intervention Monthly Flow Records documented that Aggression and Yelling were monitored with the following behaviors: -October 2010 - 2 incidents of aggression on 10/10/10; -November 2010 - no behavior documented; and -December 2010 - no behavior documented. There was no documentation of monitoring the resident's specific behavior of thinking other residents were his wife and his behaviors related to this thought process. A handwritten note on a 5/27/10 care plan read, "Mood State: unhappy c [with] placement Dementia - inability to process placement. Goals: [Resident name] will have fewer episodes of agitation towards family and staff Interventions: 1) Encourage family to explain reasons for placement. 2) Provide cueing during episodes of anger explain where family is and what is happening 3) Hearing difficulties New H.A. [hearing aide] ordered to receive 7-27-10." The care plan lacked any changes or additions to the Mood care plan and there was not a Behavior care plan. There was nothing to address this	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 55 resident's behavior of thinking other residents were his wife and his behaviors related to this thought process. On 12/8/10 at 10:05 a.m., staff member E, MDS coordinator, stated that she was aware that the Behavior Monitoring forms were not filled out. This was a continuing issue. She also stated that staff often called resident #7's wife to assist with calming him down. Staff member E did not feel that this was an appropriate intervention. The facility failed to identify resident specific behavior (resident to resident encounters where the resident thought other residents were his wife) and there was no indication that this behavior was evaluated, analyzed, or interventions developed. The care plan lacked identification and tracking of resident specific behaviors affecting other residents, there were no interventions identified to reduce the resident to resident incidents, and there was no monitoring for effectiveness of current interventions or modification of the interventions when necessary. Falls: Interdisciplinary Progress Notes documented falls on the following dates: -7/16/10 at 4:45 a.m., the resident was found sitting on the floor by the bed. No apparent injuries; -7/23/10 at 9:25 a.m., the resident was found on the floor of his room, sitting on his buttocks in front of a chair. The resident was assessed and no injury observed; -8/6/10 at 6:40 a.m., the resident had an unwitnessed, non-injury fall . He was found on the floor of his room sitting on buttocks; apparently he slid out of his w/c;	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 56 -8/15/10 at 6:00 a.m., he was found on the floor; -9/6/10 at 4:10 p.m., he was found in front of the bed, stated he was laying down; -10/7/10 at 9:40 p.m., put to bed and then found sitting on the floor at bedside; -10/11/10 at 4:40 p.m., he was found sitting on the floor; -11/9/10 at 9:47 a.m., the resident was found on the floor. The w/c had tipped over and he had a small superficial abrasion to his right forearm with 2 small bruises; and -11/19/10 at 8:00 p.m., the resident was found sitting on the floor at bedside after being placed in bed. A Fall Risk Assessment documented, "Total score of 10 or above represents HIGH RISK." The following total scores were documented: -7/7/10 the score equaled 18 and the 7/23/10 score equaled 19. A Fall Risk Evaluation form documented, "A resident who scores a 10 or higher is at risk. Consider ENVIRONMENTAL RISK factors in resident's interventions." The following scores were documented: on 7/23/10 the score equaled 26, on 8/19/10 the score equaled 24, and on 11/12/10 the score equaled 22. The back of this form read, "Intervention 8/4/10 OT [occupational therapy] consult has been placed 2 [secondary] to [increased] falls." On 8/19/10 "OT to order 'lap buddy' for resident; will cont [continue] to monitor." On 11/12/10, the Intervention was to "see care plan." A Care Plan Report, with a date range of 4/5/10 - 6/10/10, read, "Problems: History of falls within past 30 days. Goals: [Resident name] will maintain current level of mobility with no increase	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 57 in the incidence of falls/injuries. Goal Date: 8/17/10. Interventions: Assist [Resident name] to wear non-slick footwear that fits, Keep areas free of obstructions to reduce the risk of falls or injury, Keep nurse call light within easy reach. Instruct [resident] to use call bell or call out for assistance, and Keep personal items within easy reach; bed to be in lowest position with wheels locked. " There was no indication that the resident's multiple falls were assessed. The care plan had not been reviewed or revised with interventions to reduce the risk of falls since it's inception on 5/27/10, and except for the OT evaluation, there was no indication of monitoring of the current interventions for effectiveness and modification. On 12/8/10 at 1:15 p.m., resident #7's wife stated that she requested a mat on the floor due to the resident's multiple falls, but one was never provided. On 12/8/10 at 10:05 a.m., staff member E stated there was not a falls committee and that falls were reported to staff member A, administrator. On 12/8/10 at 12:20 p.m., staff member B, DON, stated that falls were included in the discussion during the weekly Skin - Nutrition - Pain meeting, especially if there were multiple falls. On 12/8/10 at 4:45 p.m., during the facility information exchange meeting, additional information regarding resident #7's fall assessments and interventions was requested. No information regarding the falls was received prior to exiting the facility on 9/9/10 at 1:00 p.m. Side Rails: On 12/8/10 at 8:30 a.m., a quarter side rail on the exit or door side of the bed, was observed in the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 58 raised position. An Evaluation for Use of Side Rails was completed 10/4/10. This form documented that this bed was new to the facility bed and had adjustment controls on the 1/4 side rail. The Comments section read, "Received new bed with adjustment controls on 1/4 rail - will remove when hand control arrives - Instructed on use - staff to keep down when not in use." On 12/8/10 at 12:20 p.m., staff member B, DON, stated that risks and benefits of the side rail had not been discussed with the family. On 12/8/10 at 12:45 p.m., staff member F, maintenance, stated the facility had ordered hand controls for the hospital beds. They arrived approximately 1 week ago, but he had not as yet attached them to the beds. On 12/8/10 at 1:15 p.m., resident #7's wife stated that the resident had not fallen out of bed since the side rail had been up. The resident received the first new bed purchased from the old hospital so the resident wouldn't fall out of bed. She did not remember being informed of the risks and benefits of the side rail. The facility failed to identify the risk of the bed rail. There was no documentation of resident specific use of the bed rail, how the rail fit the mattress, and the impact of the rail on the resident. The care plan lacked documentation on the use of the rail and there was no monitoring on the effectiveness of the side rail. 2. Medications at bedside: A) Resident #5 was admitted to the facility on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 59 12/17/08. Diagnoses included dementia with psychosis, macular degeneration, and depressive disorder. The Physician Order Sheet with a Renewal Period of 11/1/10 through 11/30/10, documented the following medications to be kept either at the bedside or in a locked box: -Systane 1-2 drops Eye PRN. May keep at bedside in locked box (Warnings: for external use only. If swallowed, get medical help or contact a Poison Control Center right away); -Sore-No-More Topical PRN. May keep at bedside in locked box (Warnings: Do not put into your eyes, do not ingest, do not apply to open wounds); -Tums 2 tabs by Mouth one time daily. Give 2 tabs to be left at bedside every day; -Vicks Vapor Rub as directed, PRN, May keep at bedside in locked box (Warnings: For external use only; avoid contact with eyes. If swallowed, get medical help or contact a Poison Control Center right away.); and -may have mentholatum and skin creams at bedside PRN. On 12/9/10 at 11:15 p.m., the surveyor and staff member H, charge nurse, observed the following medications in the resident's room: -On top of the dresser: Vaseline, Sore-No-More, and Mineral Ice; -In the unlocked drawer of the bedside table: Clear Eyes and Systane, mentholated rub, Eucerin Cream, Calazime Antibiotic Ointment, sore throat spray, and Chloraseptic. The medications were not kept in a locked box. B) Resident #6 was admitted to the facility on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 60 7/14/10. Diagnoses included dementia with behavior disturbance, liver disorder, insomnia, diabetes, psoriasis, wound disruption, and pain in limbs. The Physician Order sheet with a Renewal Period of 10/1/10 through 10/31/10, documented the following medications to be kept at the bedside: -Clobex Topical Lotion 0.05% BID (Warning: Too much of the drug passing through your skin may cause harm to the adrenal glands. Other possible side effects include mild burning, itching, redness, acne, hair loss, thinning of skin, and widening of small blood vessels in the skin) ; -Triamcinolone 0/1% apply to psoriasis lesions on feet BID (Warnings: Avoid getting this medication in your eyes, mouth, and nose, or on your lips. Avoid using on open wounds. Can cause allergic reactions); -Vectical 3 mcg/g topical ointment BID (Warnings: Avoid contact with eyes, lips and face).; and -TAC Cream continuous. On 12/8/10 at 10:30 a.m., resident #6 stated that he did apply the above listed creams as necessary. These were kept on his bedside table and were not locked. 3. During general observations of the facility on 11/9/10 at 10:05 a.m., the south hallway was observed to have no handrails between rooms S (south)12-S14 and S11-S13 on either side of the hallway. The distance between the rooms was approximately 8 feet. In the area where there were no handrails, there was a change in the floor surface from hard surface to carpet. 4. On 12/9/10 at 11:15 a.m., the surveyor observed a large crack under the window in room	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 323	Continued From page 61 N (North)16. The wall was hot to the touch. The baseboard register was hot to the point that the surveyor could not touch it without discomfort. An infra-red thermometer was used to determine a surface temperature of 212 degrees Fahrenheit (F), the temperature was then confirmed again at 212 degrees F several minutes later. The room thermostat was set in the comfort level of the scale. 5. On 12/9/10 at 11:20 a.m., staff member F was interviewed concerning the missing hand rails and the high temperature of the baseboard heater in room N16. The staff member stated that there had been work done on the hallway area and that the rails had not been put up. Staff member F also stated that the heat registers had cut-off elements. Staff member F removed the element from N16 and showed the surveyor the cut-off temperature of 210 degrees. A temperature of 210 degrees could cause immediate burns if touched.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 325	Continued From page 62 by: Based on observation, staff interview, record review and facility policy review, the facility failed to ensure that 1(#3) of 11 sampled residents maintained body weight. Residents #3 experienced unplanned weight loss. Findings include: Policy Review The Weight and Assessment Intervention policy was provided by the facility on 12/9/10 at 7:45 a.m. The policy showed, "...2. Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record. 3. Any weight change of greater than or less than 5 pounds within 30 days will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. 4. The Dietitian will respond within 24 hours of receipt of written notification. 5. The Dietitian will also review the unit Weight Record by the 15th of the month to follow individual weight trends over time...Significant Weight Changes are defined as: a. more or less than 5% within 30 days; and b. more or less than 10% within 6 months. 7. If the weight change is desirable, this will be documented and no change in the care plan will be necessary. 8. If a weight loss meets the definition of Significant, the Dietitian should discuss with the Interdisciplinary Team if a Significant Change MDS is necessary...10. Interventions for undesirable weight loss should focus first on food (e.g., extra food, snacks, calorie-dense food, etc). Liquid nutritional supplements, per facility formulary, may be considered if resident caloric intake remains inadequate to stabilize or increase weight."	F 325	Plan of Correction F325 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #3 has been re-assessed by the dietician. Interventions are in place to ensure that he maintains acceptable parameters of nutritional status, unless his clinical condition demonstrates it is not possible. His physician has been notified of his weight status. His plan of care has been updated. How other resident's identified as having the potential to be affected by the deficient practice: All residents have been audited and assessed to ensure that each resident maintains acceptable parameters of nutritional status, unless the resident's clinical condition demonstrates that this is not possible. What measures and changes put into place to ensure deficient practice does not reoccur: Staff will receive training on Cedar Wood Villa's nutrition protocol. Training will be conducted; 1/4/11. How our plan is monitored, achieved and sustained, and integrated into the QA system: audits will be done weekly to ensure compliance with Cedar Wood Villa's nutrition protocol. The Quality Assurance committee will be responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 325	Continued From page 63 1. Resident #3 was admitted to the facility on 11/19/07; diagnoses included dementia without behavior, agitation, ankle ulcer, and limb pain. The resident was observed during the survey to be thin in appearance (first observed on 12/6/10 at 1:45 p.m.) a. Nutritional assessment and interventions An annual nutritional assessment was completed by the dietitian on 10/25/10, and his usual weight range between 135 - 140 pounds (lbs). He was recorded as consuming an average of 66% of meals. He was documented as receiving a supplement once daily. The resident had a physician's order initiated on 5/22/09 for house nourishment once daily in the morning with the breakfast meal. This was the only nutritional intervention in place to increase caloric intake. The resident received a regular diet. b. Weights According to weight records, the resident was weighed monthly with the following progression: --8/2/10 - 138 lbs --9/4/10 - 139 lbs --10/4/10 - 134 lbs --11/8/10 - 132 lbs --12/5/10 - 125 lbs; a reweigh was taken on 12/7/10 and the resident's weight was 127 lbs. The policy directed a reweigh within 24 hours; a 48 hour delay elapsed. The policy also directed dietitian notification immediately and dietitian	F 325	monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 325	Continued From page 64 documentation within 24 hours; this was not adhered to. As of 12/8/10, three days had elapsed since the weight of 125 lbs; the dietitian had not been notified as of 2:30 p.m. c. Failure to notify the physician and dietitian There was no physician or dietitian notification of the weight of 125 lbs or reweigh of 127 lbs as of 12/8/10 at 2:30 p.m. A skin/nutrition/pain meeting was held on the afternoon of 12/8/10 and a recommendation was made at that time to call the dietitian, start weekly weights, and provide a nutrition drink once a day, which was already in place, and to serve extra snacks (following the surveyor bringing this information to the facility's attention.) There was no indication from the 12/8/10 minutes the physician would be notified. The most recent dietitian note was dated 10/25/10. Per review of the skin/nutrition/pain meeting minutes, the resident had not been reviewed previously in this meeting. d. Care plan The 10/14/10 care plan included the problem of the resident requiring supervision and cueing with meals. The goal was for no weight loss to occur (his weight was 134 lbs at this time). Interventions included allowing adequate time to eat; providing cues and encouragement; monitoring food intake at meals; documenting percentage eaten; if he did not like the food served bringing something different; giving one food at a time if confused. The 10/14/10 care plan also included a second nutritional problem "potential alteration in nutrition	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 325	Continued From page 65 due to cognitive loss (regular diet). [Resident's name] has a preference to eat sweets instead of the meal being served." The goal was for the resident to maintain weight and consume at least 75% of the meal being served. Interventions included offering substitutes for uneaten food; reporting a weight loss of greater than 5 lbs to the dietitian and nurse, dietitian evaluation quarterly and as needed, cueing the resident; serving the dessert after the meal. e. Meal observations The resident ate at a table in the main dining room for residents who were independent with meals. The resident was observed to be able to feed himself; however, his meal intake was poor. Staff were not observed to cue him to eat more or offer him additional or alternate foods when he did not eat what was served. 1) 12/7/10 breakfast Breakfast meal service was scheduled to start at 7:30 a.m. The resident did not come to the dining room for breakfast. The CNA assigned to the resident was interviewed. She stated at 8:30 a.m., that the resident was served a tray in his room due to a refusal to get up. The resident's meal intake was not documented on the meal intake record. 2) 12/7/10 lunch The resident was served turkey, corn, potatoes, baked peach slices, 4 ounces of milk and water at 1:05 p.m. He fed himself, eating 50% of the turkey, none of the corn, none of the potato, half the milk and 100% of the peach dessert. The resident got up and left the dining room at 1:15 p.m. The resident was not cued to eat more or offered alternates for the corn and potato of which	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 325	Continued From page 66 he ate none. The resident was served the dessert with the meal (peaches) rather than after the meal per care plan instructions. The resident's documented meal intake was 25%. 3) 12/8/10 breakfast The resident's meal tray was observed on the dining room table at 8:15 a.m. and again at 8:45 a.m. His meal consisted of a 4 ounce supplement, egg, coffee cake, cheerios, 4 ounces of juice and 8 ounces of milk. The resident's documented meal intake was 50%. The CNA to whom the resident was assigned, was interviewed on 12/8/10 at approximately 11:00 a.m. regarding the breakfast meal. She stated the resident was served his breakfast meal tray in his room and ate some of it around 9:30 a.m. She stated he did not like eggs and did not eat the eggs. The food preference board observed in the dietary department did not identify the resident as disliking eggs. f. Staff interviews The dietary manager, staff member D, was interviewed on 12/8/10 at 2:30 p.m. She stated she had not been aware of the resident's weight loss, but now that she was she would notify the dietitian. A weight meeting was held later on this date; see above. The charge nurse, staff member J, was interviewed on 12/7/10 at 2:10 p.m. and stated the resident recently experienced an upper respiratory infection and was treated with antibiotics. The CNA caring for the resident, staff member K, was interviewed on 12/7/10 at 3:45 p.m. She	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 325	Continued From page 67 stated the resident was ill recently but doing better now. She stated she was unaware whether he received supplements as she worked the afternoon shift and he did not receive any supplements or extra nutritional interventions on her shift. g. Meal intake records showed the resident's average intake was poor with a decline during the period of weight loss. There were no interventions to increase overall nutritional intake (such as fortified meals, extra foods, in between meal supplements/interventions, etc) initiated since the 4 ounces of supplement that was started in 5/09. 1) Meal intake records were calculated for October 2010 and revealed the resident's overall average meal intake was 50%, with 55% average intake for breakfast, 47% average intake for lunch and 48% average intake for supper. 2) Meal intake records were calculated for November 2010 revealed the resident's average meal intake was 42%, with 41% for breakfast, 45% for lunch and 41% for supper. 3) Meal intake records were calculated for December 2010 (through 12/8/10 lunch) revealed the resident's average meal intake was 27%, with 40% for breakfast, 30% for lunch, and 10% for supper. The trend of reduced intake starting in 11/2010 had not been identified by the facility. 3. The dietary manager was interviewed on 12/8/10 at 2:00 p.m. and stated the consultant dietitian came into the facility once a month and reviewed a computer print out of weights at that	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 325	Continued From page 68 time. She stated the dietitian gave her suggestions and ideas for interventions. She stated the dietitian and herself decided if residents were to be weighed monthly or weekly. The dietary manager stated she had been employed at the facility for a year and the plan was for her to take the class to become a certified dietary manager. The dietary manager stated the facility weight meeting occurred once a week although there were some weeks in which the meeting did not occur. 4. Administrative staff, including the administrator, DON, DM, MDS coordinator, and social service/activity director were asked in meetings on 12/7/10 at 4:50 p.m. and 12/8/10 at 4:40 p.m. to provide minutes from the previous weekly skin/nutrition/pain meetings. Minutes were provided on 12/9/10 for the 12/8/10 meeting only. There was a lack of evidence that previous weekly meetings occurred.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 329	Continued From page 69 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to ensure 2 (#s 7, and 9) of 11 sampled residents' drug regimens were free from unnecessary drugs. Specifically, non-pharmacological interventions were not implemented prior to psychoactive drug use, behavior monitoring did not show significant concerns to warrant antipsychotic medication use, PRN medication use lacked indiction for use and efficacy of the medication, doses exceeded recommended levels, and psychoactive medications were increased without adequate indication. The findings include: 1. Resident #7 was admitted to the facility on 5/17/10. Diagnosis included aneurysm, arterial disease, pain in limb, neoplasm, hypertension, fracture neck of femur, Kaposi's Sarcoma, anxiety state, dementia with behavior disturbance, and insomnia. The December 2010 MAR documented the following psychotropic medications ordered: -7/15/10 Seroquel 50 mg QD for dementia with behavior disturbance;	F 329	Plan of Correction F329 Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #7 has had his psychoactive medications reviewed to ensure that they are not used in excess dose for excessive duration, without adequate monitoring, and without adequate indications for their use, or in the presence of adverse consequences. Non pharmacological interventions will be implemented prior to initiating PRN psychoactive medication. Behavior monitoring is being conducted. His plan of care has been updated. Resident #9 has had her psychoactive medications reviewed to ensure that they are not used in excessive dose, for excessive duration, without adequate monitoring, and without indications for their use in the presence of adverse consequences. Behavior monitoring is being conducted. Non pharmacological	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 329	Continued From page 70 -10/1/10 Zyprexa 5 mg QD for anxiety state; and -11/5/10 Ativan 1 mg as needed two times max (maximum) for anxiety state. Ativan was originally ordered on 5/25/10 1 mg for dementia with behavior disturbance, every 8 hours for agitation PRN. Upon review of the MAR for 12/1/10 through 12/8/10, Ativan was provided on seven days of the eight days. On 12/4/10, the MAR documentation state Ativan was provided for agitation and the result was effective. Agitation was not defined. On seven of the seven days the Ativan was administered between 8:00 p.m. and 8:30 p.m. There was no documentation in the Interdisciplinary Progress Notes, the Behavior Monitoring Sheet, or on the MAR, of an indication for use of the Ativan (except for 12/4/10), non-pharmacological interventions attempted prior to the use of the Ativan, or monitoring for efficacy and adverse consequences. Review of the November 2010 MAR, documented Ativan had been administered daily between 7:00 p.m. and 9:00 p.m. The MAR, the Interdisciplinary Progress Notes, and the Behavior Monitoring Sheet lacked documentation on 13 days when Ativan had been administered. There was no documentation as to the reason and efficacy of the Ativan, documentation of non-pharmacological interventions attempted prior to the use of the Ativan, or monitoring for efficacy and adverse consequences. Ativan was administered 17 time for increased agitation and restlessness. Resident specific behaviors for agitation and restlessness were not identified. In addition, there were no indications of non-pharmacological interventions attempted prior to the use of the Ativan.	F 329	interventions are implemented. Her plan of care has been updated. How other resident's identified as having the potential to be affected by the deficient practice: All residents psychoactive medications have been evaluated to ensure that they are not used for excessive duration, without adequate monitoring and without adequate indications for there use, or in the presence of adequate indications for there use, or in the presence of adverse consequences. Non pharmacological interventions will be implemented prior to psychoactive drug use. What measures and changes put into place to ensure deficient practice does not reoccur: Staff will receive training on unnecessary medications. Training will emphasize that the medication therapy is based upon: An adequate indication for use; Use of appropriate dose; Provision of behavioral interventions and GDR; Use of appropriate duration; Adequate monitoring; monitoring for adverse consequences and using non pharmacological interventions prior to implementation or PRN use. Training will be conducted on 1/4/11 and 1/11/11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be done all residents on psychoactive medications initially, then on all residents with an MDS even weekly, to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 329	Continued From page 71 Upon review of the October 2010 MAR, Ativan was administered on 29 of 31 days in the month with documentation on 14 of 17 times that the medication had been administered between 7:00 p.m. and 9:00 p.m. The MAR, the Interdisciplinary Progress Notes, and the Behavior Monitoring Sheet lacked documentation on 12 days when the Ativan had been administered. There was no documentation as to the reason and efficacy of the Ativan, documentation of non-pharmacological interventions attempted prior to the use of the Ativan, or monitoring for efficacy and adverse consequences. Documentation on the MAR stated that Ativan was administered 17 times for increased agitation and restlessness. Resident specific behaviors for agitation and restlessness were not identified. In addition, there was no indication of non-pharmacological interventions attempted prior to the use of the Ativan. An adverse consequence of Ativan is that it may increase risk of confusion, sedation, and falls. This resident did have multiple falls (refer to F323). 2. Resident #9 was admitted to the facility on 4/7/2008. Diagnoses included coronary artery anomaly, trans cerebral ischemia, insomnia, peripheral vascular disease, iron deficiency anemia, Meniere's disease, constipation, esophogeal reflux, hypertension, urinary tract infection, pressure ulcer buttock, and anxiety state. During record review, the 10/19/10 consultant report from the pharmacist documented that the pharmacist had requested a gradual dose	F 329	ensure that the medication therapy is based upon; An adequate indication for use; Use of appropriate dose; Provision of behavioral interventions and GDR; Use of appropriate duration; Adequate monitoring and monitoring for adverse consequences. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 329	Continued From page 72 reduction of the resident's Ativan, 0.25 mg TID to 0.25 mg BID. The report also stated that there were no reports of anxiety or agitation issues per nursing and provider notes. The consultation report was faxed to the physician on 11/4/10 and the recommendation was accepted and signed by the provider on 11/5/10. The physician's telephone order sheet from 11/8/10 had a change in Ativan from TID to BID. On 11/19/10, a telephone order changed the 0.25 mg BID order back to the original 0.25 mg TID. A review of the Interdisciplinary Progress Notes from 11/2/10 through 11/30/10 had recorded one instance of what the nurse described as "Resident agitated" on 11/30/10. There were no other nursing notes that indicated agitation during the time frame of the increase back to the higher dose for the Ativan. The November Behavior/Intervention Monthly Flow record was reviewed. There were no indications of behaviors recorded on the form during the the month for resident #9. The record did not show the use of non-pharmacological interventions or adequate indications for its use before an increase in the Ativan was completed on 11/19/10.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 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	F 364		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 364	Continued From page 73 by: Based on observations, record review, and staff and resident interviews, the facility failed to provide palatable food. Specifically, the facility failed to: --Ensure food was at adequate temperatures for residents who received meals off of the meal cart, and for residents receiving pureed diets. --Ensure condiments were provided to enhance palatability. --Ensure food was prepared appropriately and recipes were followed. --Ensure food service practice consistently enhanced palatability; cold foods were served on heated plates. Findings include: 1. Food was not prepared appropriately and/or recipes were not followed a. The toast served for breakfast on 12/7/10 was observed to be placed in a deep full steam table pan. It was stacked multiple pieces deep and was soggy/limp in appearance. b. French dip sandwich Observations of the evening meal were made on 12/7/10. The French dip sandwich consisted of a couple of thin slices of beef on a hot dog bun. No au jus (beef broth) was served with the sandwich. There was nothing on the bread to decrease the dryness of the sandwich (mayonnaise etc). The dietary manager was interviewed on 12/8/10 at 2:00 p.m. and stated the French dip sandwich did include au jus (beef broth served with the sandwich). She stated it was a new cook on duty	F 364	Plan of Correction F364 Corrective action accomplished for residents found to have been affected by the deficient practice: Residents affected by the deficient practice will received food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. How other resident's identified as having the potential to be affected by the deficient practice: All other residents will also received food prepared by methods that conserve nutritive value flavor, and appearance; and food that is palatable, attractive and at the proper temperature. What measures and changes put into place to ensure deficient practice does not reoccur: Dietary staff will receive training on food preparation. All food will be prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Education provided on 1/4/11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Food preparation audits will be conducted weekly to ensure all food is prepared by methods that conserve nutritive value,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 364	Continued From page 74 who may not have known to serve the au jus with the sandwich. The recipe for the French dip sandwich was reviewed. According to the recipe the sandwich consisted of two ounces of sliced beef served on a hot dog bun with a 2 ounce serving of au jus (beef stock/soup base) served with the sandwich. 2. Condiments were not consistently provided to enhance the flavor of meals On 12/7/10 for the breakfast meal, residents who ate in their rooms off of the south cart (approximately 6 residents) did not receive and were not offered condiments per the menu such as salt, pepper, sugar or sugar substitute with their meal of cereal oatmeal, scrambled eggs with cheese, toast, and coffee. Milk was not served with the hot cereal. On 12/7/10 for the evening meal, residents were served a french dip sandwich, cream of potato soup, chilled beets and fruit. With the exception of one resident in the main dining room, residents were not served crackers with the soup per the menu to enhance the soup. On 12/8/10 for the breakfast meal, residents who ate in their rooms off of the south cart (approximately 6 residents) did not receive and were not offered condiments per the menu such as salt, pepper, sugar or sugar substitute with their meal of scrambled eggs, coffee cake, hot (Ralston) cereal, and coffee. Milk was not served with the hot cereal. On 12/8/10 for the lunch meal, nine trays were observed to be placed onto the south cart. Staff	F 364	flavor, and appearance; and food that is palatable, attractive and at the proper temperature. The Quality Assurance team will be responsible for monitoring the ongoing effectiveness of the changes to ensure correction is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 364	Continued From page 75 began serving the meals at 12:30 p.m. All plates were loaded onto the cart at 12:37 p.m. There were no salt and pepper or any other condiments on the cart. The meal consisted of meat balls with gravy, garlic mashed potatoes with gravy, capri mixed vegetables, and cherry cobbler. 3. Temperatures of meals served to residents who received meal trays off the south dining room cart and those receiving pureed diets were inadequate. Menu items were not prepared in a manner enhancing palatability. a. Meal trays on south cart Observations of two meals revealed a time frame of approximately 30 minutes to dish up and serve for the 8 - 10 residents who ate in the south dining room or in their rooms. The cart was not insulated to assist in maintaining food temperatures. The ceramic/china plates were placed into metal heated bases and a plastic insulated lid was placed over the plates. Two test trays were evaluated at the time the last resident was served his/her meal from the south/room cart. 1) On 12/8/10 for breakfast, dietary staff began serving the meals for the south cart at 7:30 a.m.; the cart was completely loaded at 7:35 a.m. A dietary staff member wheeled the cart to the nurses' station at 7:35 a.m. A CNA then wheeled it to the entrance of the south dining room at 7:36 a.m. There were no residents in the dining room at this time. The CNA started serving the trays at 7:38 a.m. The last resident's tray was served at 7:58 a.m. and the regular diet test tray was evaluated at this time. The scrambled eggs were dry and crumbly. The temperature was 98	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 364	Continued From page 76 degrees F, lukewarm to the palate. The milk was 52 degrees F, cool but not cold to taste. The juice was 61 degrees F, slightly cool but not cold to taste. The metal base in which the plate was placed was slightly warm to touch; it was not hot. 2) On 12/8/10 for the lunch meal, nine trays were observed to be placed onto the south cart. Staff began serving the meals at 12:30 p.m. All plates were loaded onto the cart at 12:37 p.m. The cart was wheeled to the entrance of the south dining room at 12:45 p.m. The meal consisted of meat balls with gravy, garlic mashed potatoes with gravy, capri vegetables, cherry cobbler, juice and/or milk. Coffee was not included on the cart for residents eating in their rooms, although it was on the menu and served to residents in the dining rooms (main and south). All residents were served at 12:58 p.m. and the regular diet test tray was evaluated at this time. Inadequate temperatures included vegetables at 116 degrees F; they were faded in color and mushy. Refer to F371 for failure to maintain these vegetables at appropriate temperature. The meat balls were dark brown and hard on the outside and were bland and lukewarm to taste; they were 117 degrees F. The juice was 62 degrees, slightly cool but not cold to taste. The milk was 61 degrees and slightly cool but not cold to taste. The temperature of the metal plate warmer was checked; it was 74 degrees, not warm to touch. b. Pureed diets The three residents who were served pureed diets were served meals that were not adequately hot when leaving the tray line. Foods would be at no greater temperatures than those on the tray line. Refer to F371.	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 364	Continued From page 77 On 12/7/10, temperatures were measured on the trayline at 8:00 a.m. at the end of the meal service by the surveyor. The pureed egg was 126 degrees F; the pureed toast was 119 degrees F. On 12/7/10 temperatures were measured at the start of the trayline meal service at approximately 12:30 p.m. The cook was prepared to initiate serving; the surveyor asked if temperatures could be taken. The temperature of the pureed turkey was 100 degrees F; the pureed corn was 128 degrees F. The cook reheated the turkey; however, did not reheat the corn prior to serving. 4. Food service practice did not consistently enhance palatability; hot and cold foods were served on heated plates. On 12/7/10 during the evening meal service beginning at approximately 5:30 p.m., residents were observed to be served both hot food consisting of the french dip sandwich and chilled beets on a heated plate. The dietary manager, staff member D, was interviewed on 12/8/10 at 2:00 p.m. She stated the beets should have been served in a small bowl and not on the heated plate. 5. Resident Council and the group meeting Review of the September 2010 Resident Council Minutes indicated that there was a concern with food, especially the chicken. On 12/7/10 at 2:30 p.m., during the group meeting, there were multiple concerns expressed regarding the food. One resident, who ate in the South dining room, stated his food was always cold. Another resident who ate in the South dining room stated his food was not always hot enough. There were concerns expressed regarding the lack of variety and no choice at	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 364	Continued From page 78 breakfast. Some of the residents were served biscuits and gravy and had never eaten biscuits and gravy before and did not like them. There was concern expressed regarding the tough meat. 6. Resident interviews On 12/8/10 at 10:30 a.m., during a resident interview, he stated that the meat was difficult to cut and chew and that the vegetables were overcooked. On 12/8/10 at 10:55 a.m., during a resident interview, the resident stated that the cooks did not know how to cook meat, it was tough. This resident stated s/he was unable to cut the meat with a knife and was unable to pull it apart with his/her fingers.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 observations, staff interviews, and record review, the facility failed to ensure food was stored and served under sanitary conditions. Specifically, the facility failed to: --Ensure frozen foods were maintained at proper	F 371	Plan of Correction F371 Corrective action accomplished for residents found to have been affected by the deficient practice:	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 79 temperatures; --Ensure the kitchen environment (a post, the ice machine, the Robot Coupe processor) was maintained in good repair; --Ensure sanitizer solutions were maintained at the proper concentrations; --Ensure tray line pureed food temperatures were within safe parameters; and --Ensure trayline meal service was conducted to minimize cross contamination. The findings include: 1. Frozen foods were not maintained at frozen temperatures Two reach-in freezers were consistently above zero degrees Farenheit (F); foods were not maintained in a frozen state. a. Reach-in freezer #6 temperatures were checked and found inadequate as follows: --12/6/10 at 1:15 p.m. = 2 degrees F --12/6/10 at 4:20 p.m. = 25 degrees F --12/7/10 at 8:00 a.m. = 4 degrees F --12/7/10 at 12:55 p.m. = 8 degrees F A package of sliced turkey breast was observed in freezer #6 on 12/7/10 with approximately one inch of ice crystals within the package showing foods had not been maintained in a frozen state. b. Reach-in freezer #5 temperatures were checked and found inadequate as follows: --12/6/10 at 1:15 p.m. = 10 degrees F --12/6/10 at 4:20 p.m. = 9 degrees F --12/7/10 at 8:00 a.m. = 9 degrees F --12/7/10 at 12:55 p.m. = 10 degrees F A package of broccoli was observed on 12/6/10 at 1:15 p.m. and a package of capri vegetables on 12/7/10 at 8:00 a.m. in freezer #5. Both packages	F 371	All unsanitary areas noted in the survey have been addressed and corrected. The facility now maintains a sanitary environment in the food preparation areas and storage areas. How other resident's identified as having the potential to be affected by the deficient practice: All areas of the facility used for storage, preparation, distribution and service of food have been assessed to ensure it is completed under sanitary conditions. What measures and changes put into place to ensure deficient practice does not reoccur: Staff education provided regarding proper storage, preparation, distribution and service of food under sanitary conditions. Education provided on 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Sanitation audits will be conducted twice a week by the Dietary Manager. The Quality Assurance team will be responsible for monitoring the ongoing effectiveness of the changes to ensure correction is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 80 of vegetables contained significant ice crystals showing foods had not been maintained in a frozen state. c. Temperature logs Per review of the freezer temperature logs, temperatures were taken twice daily. 1) Freezer #5 The temperature log for freezer #5 revealed temperatures were below zero until early October 2010. In 10/10, there were 46 out of 62 opportunities in which temperatures were documented above zero, the highest being 18 degrees F. In November 2010, there were 41 out of 60 opportunities in which the temperatures were documented above zero, the highest being 14 degrees F. In December 2010 (through morning on 12/8/10), the temperatures were above zero 15 out of 15 opportunities, the highest being 12 degrees F. 2) Freezer #6 The temperature log for freezer #6 revealed temperatures were frequently above zero for July - October 2010. There were 120 instances in which temperatures were above zero out of 151 opportunities during this time period; the highest temperature was 14 degrees F. In 11/10, there were 53 out of 60 opportunities in which the temperatures were documented above zero, the highest being 10 degrees F. In 12/10 (through morning on 12/8/10), the temperatures were above zero 15 out of 15	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 81 opportunities, the highest being 12 degrees F. d. Staff member D, the dietary manager, was interviewed on 12/6/10 at 1:20 p.m. She stated she was aware the freezer temperatures for #5 and #6 were too high and that the logs showed consistent temperatures above the desired temperature of zero or colder. e. Staff member F, The maintenance person, was interviewed on 12/8/10 at approximately 10:30 a.m. He stated he had not been notified of the freezer temperatures being too high for freezer #5 and #6 until this day. 2. The kitchen, including equipment, was not maintained in good repair a. Post During the facility tour on 12/6/10 at 1:00 p.m., at 4:30 p.m. and on 12/7/10 at 12:55 p.m., a post connected to the counter/steamtable serving area was observed to be disintegrating beneath a layer of sheeting that was coming apart at the seams (corners). Pieces of sheet rock had already crumbled off on the corner and additional crumbling had the potential to contaminate food being prepared and/or served. The dietary manager was interviewed on 12/6/10 at 1:00 p.m. and stated the maintenance man was aware of the need for this repair. Staff member D stated on 12/8/10 at 2:00 p.m. that she notified the maintenance man the previous week about the need to repair the post. She stated there was no system or formal process in the facility for notification of repairs needed, such as a work order. b. Ice machine The ice machine located in the kitchen was	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 82 observed on 12/6/10 at 1:30 p.m., at 4:30 p.m. and on 12/7/10 at 8:05 a.m. and at 1:00 p.m. There were rusty areas of several inches in length on the stainless steel surface that was located directly above the ice. c. Robot Coupe food processor The Robot Coupe processor was observed on 12/7/10 at 1:00 p.m. and on 12/8/10 at 12:10 p.m. There were approximately 8 pieces of masking tape across the handle onto the outside of the bowl making it an uncleanable surface. Staff member D was interviewed on 12/7/10 at 1:00 p.m. She stated the handle was broken and tape was needed on the handle or the Robot Coupe would not work. The dietary manager stated it had been that way for a couple months and that a new bowl was needed as the handle itself could not be replaced. She stated it was expensive to order a new bowl. She stated she did not have any documentation of her research into ordering or replacing the Robot Coupe handle or bowl. On 12/8/10 at 2:00 p.m., staff member D was interviewed. She stated she had received approval to replace the Robot Coupe bowl. 3. Sanitizer solutions were not maintained at required concentrations a. Reference " 37.110.215 - Equipment and utensil cleaning and sanitation ... (6-8) Wiping cloths separation and use limitation - Soiled wiping cloths ... must be stored in a sanitizer solution at all times, with the proper sanitizer concentration in the solution ... Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit ...(14) The food contact surfaces of all equipment and utensils must be sanitized by ... (b) immersion for at least 30 seconds in a clean	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 83 solution containing at least ... (c) immersion for at least 30 seconds in a clean solution containing no more than 200 parts per million of quaternary ammonium compound used by following manufacturer's instruction; ...When chemicals are used for sanitization, they must not have concentrations higher than the maximum permitted. " " 37.110.231 - Toxic Materials ... (6) Sanitizers, cleaning compounds or other compounds intended for use of food contact surfaces may not be used in a way that leaves a toxic residue on such surfaces or that constitutes a hazard to food employees or other persons. " b. Observations revealed sanitizer levels of the wiping cloth solution were not at correct levels. According to the manufacturer's instructions for the Quaternary ammonia solution, levels were to be maintained with 200 - 400 ppm (parts per million). On 12/6/10 at 4:20 p.m., the wiping cloth solution was too high at 600 ppm. On 12/7/10 at 12:55 p.m., the solution did not contain any sanitizer. There were a number of wiping cloths in the solution at the time during lunch meal service. 4. Tray line pureed foods were not maintained at required temperatures a. Reference According to Montana Administrative Rules for Food Service Establishments, Title 37,Chapter 110, Subchapter 2, Montana Department of Public Health & Human Services Health Policy and Services Division, page 12, 110.206 FOOD STORAGE AND PROTECTION, "The internal temperature throughout potentially hazardous foods requiring hot storage must be 135°F (57.2°C) or above except during necessary periods of preparation." b. Observations	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 84 On 12/7/10, temperatures were measured on the trayline at 8:00 a.m. at the end of the meal service by the surveyor. The pureed egg was 126 degrees F; the pureed toast was 119 degrees F. On 12/7/10, temperatures were measured at the start of the trayline meal service at approximately 12:30 p.m. The cook was prepared to initiate serving; the surveyor asked if temperatures could be taken. The temperature of the pureed turkey was 100 degrees F; the pureed corn was 128 degrees F. The cook reheated the turkey; however, did not reheat the corn prior to serving. Although the turkey was reheated, it was not stirred to ensure the temperature was consistent throughout and meeting the minimum requirement of 165 degrees F (Montana Administrative Rules for Food Service Establishments, Title 37,Chapter 110, Subchapter 2, Montana Department of Public Health & Human Services Health Policy and Services Division, 37.110.207 FOOD PREPARATION, p. 14 "Potentially hazardous food reheated in a microwave oven for hot holding must be reheated so that all parts of the food reach a temperature of at least 165 degrees F and the food is rotated and stirred, covered, and allowed to stand covered for 2 minutes after reheating.") 5. During meal service, staff placed serving utensils on the counter versus keeping them in a sanitary location. On 12/7/10 starting at 7:45 a.m., observations were made in the kitchen including the entire meal service for breakfast. A scoop was used to dish up jelly from a large container onto the residents' individual plates. In between serving, the scoop was placed on the stainless steel	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 85 counter (a potentially unclean surface.) On 12/7/10 at 12:30 p.m., lunch meal service was observed. During the meal, the scoop for the baked peach slice dessert was placed on the counter between serving. 6. Hair restraints On 12/8/10 at 7:30 a.m., a nursing staff member with medium length hair in a pony tail was observed to walk through the kitchen, entering in a door near the dish machine and exiting through a door by the dietary manager's desk. This staff member did not have a hair net or other hair restraint in place. On 12/8/10 at 12:35 p.m., two nursing staff members were observed to walk through the kitchen, entering in a door near the dish machine and exiting through a door by the dietary manager's desk. Neither of these staff members had hair nets or other hair restraints in place.	F 371		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure that 3 (#s 6, 7, and 9)	F 387	Plan of Correction F387	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 387	Continued From page 86 of 11 sampled residents received timely physician visits as required. Findings include: 1. Resident #9 was admitted to the facility on 4/7/08. Diagnoses included coronary artery anomaly, trans cerebral ischemia, insomnia, peripheral vascular disease, iron deficiency anemia, Meniere's disease, constipation, esophogeal reflux, hypertension, urinary tract infection, pressure ulcer buttock, and anxiety state. The review of the clinical record stated a physician visit in July 2010, a visit to the physician's office on 8/23/10, and a note in the interdisciplinary progress notes from 11/17/10 that stated the doctor was in for rounds with no changes. A further review of the medical record found no signed progress notes from the 11/17/10 doctor rounds. The visit on 11/17/10 was over 60 days from the last visit on 8/23/10. 2. Resident #7 was admitted to the facility on 5/17/10. Record review documented that the resident was seen by a physician for review of total plan of care on 6/4/10. He was seen on 6/25/10, 7/1/10, 7/8/10, and 7/15/10, due to swelling and nondisplaced fractures of the third and fourth metacarpals. There was no indication the resident's total program of care, including medications and treatments were reviewed on these visits. The medical record lacked indication that the resident was seen by a physician until 11/17/10. There was no progress note in the chart by the physician for this visit. The resident was not seen by a physician at least once every 30 days for the first 90 days after admission. There was no documentation of a	F 387	Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #6 will be seen by the physician at least once every 60 days. Resident #7 will be seen by the physician at least once every 60 days. Resident #9 will be seen by the physician at least once every 60 days. How other resident's identified as having the potential to be affected by the deficient practice: All residents physician visits have been audited to ensure visits are completed timely. What measures and changes put into place to ensure deficient practice does not reoccur: Staff education provided regarding requirement for physician visits on 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Physician visit audits will be conducted monthly by the Quality Assurance team to ensure visits are conducted timely. The Quality Assurance team will be responsible for monitoring to ensure correction is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 387	Continued From page 87 physician visit in August 2010. In addition, there was no documentation that the resident was seen at least once every 60 days after the first 90 days. There was a lack of physician visits from 7/15/10 until 11/17/10, a time period of 125 days. This resident was on psychoactive medications, including as needed Ativan, had multiple bruising, exhibited behaviors, and had multiple falls. (Refer to F225, F323, and F329). 3. Resident #6 was admitted to the facility on 7/14/10. Record review documented that the resident was seen by a physician on 7/26/10. He was seen by a physician assistant on 9/17/10, a time period of 65 days. The resident was not seen every 30 days for the first 90 days after admission. This resident had a diagnosis of diabetes and on 9/17/10, the physician assistant documented that the resident's blood sugar was nearly 500.	F 387		
F 388 SS=D	483.40(c)(3)-(4) PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to	F 388	Plan of Correction 388	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 388	Continued From page 88 ensure one (#6) of 11 sampled residents, had alternating personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist. Findings include: Resident #6 was admitted to the facility on 7/14/10. Record review documented that the resident was seen by a physician on 7/26/10. He was seen by a physician assistant on 9/17/10 and again on 10/15/10. There were no alternating visits between the physician and the physician assistant. This resident had a diagnosis of diabetes and on 9/17/10, the physician assistant documented that the resident's blood sugar was nearly 500.	F 388	Corrective action accomplished for residents found to have been affected by the deficient practice: Resident #6 will have alternating personal visits by the physician and visits by the physician assistant. How other resident's identified as having the potential to be affected by the deficient practice: All residents physician visits have been audited to ensure visits are complete according to 483.40(c)(3)-(4). At the option of the physician, required visits after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist. What measures and changes put into place to ensure deficient practice does not reoccur: Staff education has been provided regarding personal visits by the physician and alternate physician assistant, nurse practitioner or clinical nurse specialist. The education was conducted on 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Physician visit audits will be conducted monthly by the Quality Assurance team to ensure visits are conducted according to 483.40(c)(3)-(4). At the option of the physician, required visits after the initial visit, may alternate between personal visits by the physician and visits by a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 388	Continued From page 89	F 388	physician assistant, nurse practitioner or clinical nurse specialist. The Quality Assurance team will be responsible for monitoring to ensure correction is maintained.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 90 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide an environment that prevented the transmission of disease and infection by handwashing and/or sanitizing by the nursing staff during the meal service. The facility failed to ensure that linens were handled so as to prevent the transmission of disease and infection. Findings include: 1. During the evening meal observation on 12/7/10, the charge nurse was observed assisting resident #1 with his meal. She pushed his wheelchair closer to the table, maneuvered his hand to hold the fork, and helped him to take a bite of his meat. The nurse then went to resident #10 and helped her eat a bite of meat. The nurse had the resident try to use a built-up spoon to eat the fruit cocktail, but the resident was unable to do that. The nurse replaced that spoon with a regular spoon. The nurse returned to resident #1, put a piece of meat on his fork, and put the fork in his hand. At no time during this observation did the nurse sanitize her hands between assisting these two residents. 2. During the morning meal observation on 12/8/10, a CNA was observed changing a soiled clothing protector for a resident, then sitting to assist a dependent resident with the meal. The CNA stood up and went to another resident and put sugar in his cereal. After that was completed, the CNA returned to a dependent resident and	F 441	Plan of Correction F441 Corrective action accomplished for residents found to have been affected by the deficient practice: Cedar Wood Villa has infection control policies and procedures in place to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for affected Cedar Wood Villa residents. Nursing staff will complete proper hand hygiene during meal service, and facility staff will handle linen properly. How other resident's identified as having the potential to be affected by the deficient practice: All residents will be provided infection control services which allow a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. What measures and changes put into place to ensure deficient practice does not recur: Staff education will be provided regarding infection control practices, hand hygiene and linen handling. The training will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 91 touched her shoulder to wake her up and offered hot chocolate. The CNA was observed to pick up the toast for resident #10 with her bare hands to apply the jelly. The CNA continued to assist residents with their meals, with removing soiled clothing protectors, adjusting clothing, and assisting them with wheelchairs. At no time during any of these observations did the CNA sanitize or wash her hands between tasks. A bottle of sanitizer was observed on the table where resident #1, #10 and four other dependent residents sat. There was also a wall-mounted sanitizer dispenser noted on the wall outside the kitchen doorway, which was within 10 feet of the table where resident #10 sat. 3. At 8:26 a.m., during the observations noted above, the companion was noted picking up soiled clothing protectors from resident tables. The companion stacked the soiled clothing protectors on her left arm, which allowed them to come in contact with her uniform and the skin of her arm from above the elbow to the wrist. When the clothing protectors had been placed into the soiled linen cart, the companion began removing the carafes of coffee, hot chocolate, and water to the kitchen area. At no time during this observation did the companion sanitize or wash her hands.	F 441	conducted 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be done weekly for 1 month, then quarterly to ensure compliance with infection control policies and procedures to help ensure a safe, sanitary and comfortable environment is maintained and to help prevent the development and transmission of disease and infection. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 465	Continued From page 92 by: Based on observation and staff interview, the facility failed to provide a safe, sanitary, and functional environment. Findings include: During general observations of the facility, beginning on 12/9/10 at 9:45 a.m., the hand rails outside the following rooms were noted to have gouges, splintered areas and areas of exposed wood. On the north hallway, rooms N1, N2, N3, N5, N6, N7, N9, N11, and N12. The rails between P(Private) 3 and P4 were splintered, had exposed areas of bare wood and gouges, as well as the rails outside rooms S (South)5 and S16 on the south hallway. The handrails were rough to the touch, and had sharp enough areas to cause slivers, and due to exposed wood, the rails were uncleanable surfaces. At approximately 11:00 a.m., staff member F, the facility maintenance person, was interviewed concerning the condition of the handrails. He stated that he usually attempts to refinish the rails on a monthly basis. On 12/9/10 at 10:15 a.m., the facility laundry was observed. The paint was chipped and pealed away exposing the wall board underneath along the wall on the dirty side of the room next to the washers. There were holes in the wall from the clothing carts parked in the area. The paint was peeled away to the wallboard on the wall to the left of the folding area on the clean side of the laundry. There were several boxes containing resident supplies including toilet paper that were stored on the floor between the washing machines and the wall.	F 465	Plan of Correction F465 Corrective action accomplished for residents found to have been affected by the deficient practice: The hand rails have been refinished and repaired. The facility laundry area wall have been repaired and painted. Resident supplies are stored properly. How other resident's identified as having the potential to be affected by the deficient practice: All areas in the facility have been assessed to ensure the facility provides a safe, functional, sanitary and comfortable environment for the residents, staff and the public. What measures and changes put into place to ensure deficient practice does not recur: Staff education will be provided regarding ensuring a safe, functional, sanitary, and comfortable environment is maintained. Training was conducted on 1-4-11. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be done weekly to ensure compliance with adequate environmental conditions exist and the facility is safe, functional, sanitary and comfortable. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide firmly secured handrails on each side of the south hallway. Findings include: On 12/9/10 at 10:00 a.m., during the general observations of the facility it was noted that there were no hand rails between rooms S (South)11-S13 and S12 - S14 on the south hallway. The approximate distance between the rooms was 8 feet. There was a change in the floor surface in the area, from a hard surface to carpeted surface. On 12/9/10 at approximately 11:20 a.m., staff member F, the maintenance person, was interviewed concerning the missing handrails. The staff member stated that there had been recent construction in the area, and that handrails had not been placed on the section of hallway.	F 468	Plan of Correction F468 Corrective action accomplished for residents found to have been affected by the deficient practice: All corridors have firmly secured handrails on each side. How other resident's identified as having the potential to be affected by the deficient practice: All corridors have firmly secured handrails on each side. What measures and changes put into place to ensure deficient practice does not recur: Staff education provided on the need for all corridors to have firmly secured handrails on each side. Training was conducted on 12-28-10. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be done monthly to ensure compliance the requirement that all corridors have firmly secured handrails. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 468	Continued From page 94	F 468	sustained.	
F 493 SS=G	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on staff, resident, and family interviews, record review, policy review, and observations, the facility's governing body failed to ensure that the established policies and implementation of the policies were followed by the facility staff, specifically regarding F314 (Pressure Ulcers) and F325 (Nutritional Status). Findings include: F314 S/S G Based on staff interview, record review and observation, the facility failed to prevent recurrent development of a pressure ulcer, evaluate, assess, or revise the interventions as appropriate to prevent new pressure sores from developing for 1 (#9) of 11 residents. In addition, the facility failed to accurately document pressure ulcers for 5 (#s 1, 8, 15, 16 and 17) of 2 sampled and 3 supplemental residents. F325 S/S G Based on observation, staff interview, record review and facility policy review, the facility failed to ensure that 2 (#s 3 and 10) of	F 493	Plan of Correction F493 Corrective action accomplished for residents found to have been affected by the deficient practice: The governing body will ensure the facility will follow and implement established policies and procedures in order to prevent recurrent development of a pressure ulcer, evaluate, assess, and revise the interventions as appropriate, and to prevent new pressure sores from developing for resident #1. The governing body will ensure the facility will follow and implement established policies and procedures for the accurate documentation of pressure sores for residents 1, 8, 15, 16 and 17. The governing body will ensure the facility will follow and implement established policies and procedures in order to for resident #3 to maintain body weight.	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 493	Continued From page 95 11 sampled residents maintained body weight. Both residents experienced unplanned weight loss. Resident #10 experienced significant weight loss and resident #3's weight loss resulted in him being underweight.	F 493	Resident #10 has passed away. How other resident's identified as having the potential to be affected by the deficient practice: All residents will be assessed to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates they were unavoidable, and a resident having a pressure sore receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. All residents will also be assessed to ensue that they maintain acceptable parameters of nutritional status, such as body weight and protein levels unless the resident's clinical condition demonstrates that this is not possible. What measures and changes put into place to ensure deficient practice does not recur: The facility staff will receive training and education on the policies and procedures for pressure sore prevention, treatment and services necessary to heal existing wounds. The facility staff will also receive training and education on the policies, procedures and clinical protocol for nutrition and unplanned weight loss. In-service on 1-4-11 and 1-11-11. How our plan is monitored, achieved and sustained, and integrated into the QA system:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 493	Continued From page 96	F 493	Audits will be conducted to ensure compliance with the policies, procedures, and clinical protocol for pressure ulcer prevention and treatment, and compliance with policies, procedures and clinical protocol for managing nutrition and weight loss. The Quality Assurance committee will be responsible for monitoring the outcome of the audits to ensure correction is sustained.	
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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 by: Based on record review and staff interview, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for five (#s 1, 5, 6, 7, and 8) of 11 sampled residents. Findings include: 1. Resident #1 was admitted on 4/9/10 for short-term respite. Diagnoses included secondary	F 514	Plan of Correction F514 Corrective action accomplished for residents found to have been affected by the deficient practice: Cedar Wood Villa has corrected the clinical records for resident's #1, 5, 6, 7 and 8 to ensure that each resident's clinical records are complete, accurate	1/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 514	Continued From page 97 Parkinsonism, dementia with Lewy bodies, paralysis agitans, congestive heart failure, sleep apnea, anemia, renal failure, hypertension, glaucoma, depressive disorder, colostomy, and ulcer of heel and mid foot. Record review showed resident #1 had an allergy to aspirin. This was noted on the admission physician orders, on the outside of the chart, on all the MARs, and all the physician recapitulation orders that were included in the chart. The resident had a physician's order for aspirin 81 mg daily. This order was noted on the original admission orders, and continued through December 2010. An Interdisciplinary Progress Note dated 12/7/10 showed staff member B, the DON, had contacted the spouse regarding the aspirin allergy. The wife stated he had a "bad reaction" to a "massive" dose of aspirin he received after a heart attack. On 12/8/10, the nurse contacted the physician's office for clarification on the aspirin allergy. The aspirin allergy was removed from his record. The facility had taken no action regarding this until notified by the surveyors. No documentation of the discrepancy was noted in the medical record or in the pharmacist's drug regimen reviews during the resident's stay. Resident #1 was admitted for a 3-week respite stay in April. He was still a resident of the facility as of the survey dates. No documentation in physician progress notes of the resident becoming a long-term resident. A note was found in the Social Services section of the chart. An Abuse Risk Form dated 7/7/10 noted, "Family member chose to have [resident name] remain in facility for his safety due to family unable to meet	F 514	and organized. Resident #1's aspirin allergy status has been updated. Resident #5's record has been updated for the indication of use and efficacy of the Ativan, Tylenol and Lortab. The behavior flow sheet is being utilized. Resident #6's assessment has been completed. Resident #7's record has been updated with the indication for the use of and efficacy for the use of Ativan, Tylenol and Lortab. Resident #8's Zyprexa order and records has been updated. How other resident's identified as having the potential to be affected by the deficient practice: Clinical records for all residents of Cedar Wood Villa will by maintained in accordance with accepted professional standards to ensure that the medical records are complete, accurate, readily accessible and systematically organized. What measures and changes put into place to ensure deficient practice does not recur: Nursing Staff have been in-serviced on policies and procedures to ensure that clinical records are maintained in accordance to accepted professional standards and practices and that the clinical records are complete, accurate, readily accessible and organized. How our plan is monitored, achieved and sustained, and integrated into the QA system: Audits will be done monthly to ensure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 514	Continued From page 98 his needs." The care plan dated 11/22/10 had "No eye exam scheduled at this time due to short stay" as an intervention for Visual Function. 2. Resident #5's Self Administration of Medication Assessment Form dated 12/17/08 did not include a diagnosis and was not signed by the staff member completing the form. This was the only Self Administration of Medication Assessment in the chart. The resident did have medications in her room. Resident #5's December MAR indicated the resident received PRN Lortab daily from 12/4/10 through 12/8/10. There were three of six possible times that the efficacy of the medication was not documented. On 12/7/10, there was no documentation of the need for the medication or the efficacy. 3. Resident #7's Physician Order Sheet for August, September, October and November 2010, indicated that on 6/18/10 Tylenol ES (extended strength) 500 mg 1 to 2 tabs Inhalation PRN was ordered. The August Physician Order Sheet had a check mark by this medication, indicating that it had been transferred to the MAR. The September through November Physician Order Sheets had this medication yellowed out with a note by the medication that read, "Never Ordered". The Physician Order Sheets were not revised to delete this medication and to note that Tylenol tabs are not inhaled. Resident #7's December 2010 MAR lacked indication for use and efficacy of the following	F 514	clinical records are complete, accurate, readily accessible and organized. The Quality Assurance Committee will be responsible for monitoring the outcome of the audits to ensure that correction is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 514	Continued From page 99 medications: -Ativan 1 mg PRN was administered on 12/1/10 and 12/2/10; -Tylenol ES 500 mg PRN was administered on 12/2/10 and 12/3/10; and -Lortab 325;5 mg;mg PRN was administered on 12/4/10. Resident #5's November 2010 MAR lacked indication for use and efficacy of the following medications: -Ativan 1 mg PRN was administered on 1, 2, 3, 4, 9, 10, 11, 17, 18, 23, 24, 27, and 30; -Tylenol ES 500 mg PRN was administered on 2, 3, 5, 14, 16, 24, and 29; -Lortab 325;5 mg;mg PRN was administered 1, 2, 10, 17, 22, 25, 26, 27, 28 and 29. Resident #5's Behavior/Intervention Monthly Flow Record was blank for 12/10. The behaviors monitored were yelling and aggression. The resident had been administered Ativan seven days for agitation. 4. Resident #6's Self Administration of Medication Assessment lacked diagnosis and staff signature. 5. Resident #8 was re-admitted to the facility on 5/12/09. Her diagnoses included constipation, insomnia, depressive disorder, dementia without behavior, and difficulty walking. Resident #8 received physician orders to begin Zyprexa on 6/23/10. The nursing staff at the facility stopped administering Zyprexa on 7/22/10. The monthly physician order sheets from August 2010 to November 2010 were reviewed. The signed monthly physician orders included Zyprexa	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275053	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR WOOD VILLA	1 S OAKS RED LODGE, MT 59068

(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 514	Continued From page 100 tablets 2.5 mg by mouth at bedtime. The MARs from August 2010 to December 8, 2010 were also reviewed. The MARs included a line for documenting the administration of Zyprexa one time per day. These lines were blank. On 12/9/10 at 10:20 a.m., staff member B, the DON, stated there was not a physician's order to have discontinued the administration of Zyprexa or to remove Zyprexa from resident #8's MAR.	F 514		