12/10/10

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

PRINTED: 11/18/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 11/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY CARE CENTER	60 MAGNOLIA CASPER, WY 82604

(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 The following common abbreviations are used throughout this document: CDM: Certified Dietary Manager CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RD: Registered Dietitian RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used	F 000	**F 224** **The Facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This will be accomplished by:** **A) Residents #11, 16, 73, and 141, will have timely assistance during meals.** **B) Residents #11, 46, 138 and 162 will have individualized, meaningful activities.** **C) Residents # 5,13, 28, 38, 79, 80 108, and 141 will have meaningful activities provided by adequate activity personnel.** **D) Residents # 11 , 33, and 162 will Have timely interventions and assessments to address significant, unplanned weight loss.** **E) Residents #3, 46,108, and 159 Will have timely response to call lights.** **C) All residents will be offered Bedtime snacks.** **D) Nursing Staff will receive Instruction to above infractions.** **E) Additional personnel will be added to activity department.** **F) All staff instructed to respond To resident call lights.**	12/18/10
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIAT N The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and reviews of facility documentation and records and residents ' medical records the facility failed to ensure that all residents (#3, #5,	F 224		

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

Jill Elliott RN CNA/Admin Asst 11-24-10

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.

Received
Wyoming Dept of Health
NOV 24 2010
Office of Healthcare Licensing and Surveys

Accepted w/ Changes made per Jill Elliot, NHA on 12/10/10 @ 1:45pm. POC - 12/18/10
Changes: pg 4, pg 6, pg 20,

QR 12/10/10

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F 224	Continued From page 1 #11, #13, #16, #28, #33, #38, #46, #73, #79, #80, #108, #138, #141, #159 and #162) were free from neglect. Findings were: 1. Refer to F241 for details regarding the failure to provide residents #11, #16, #73, #141 with timely assistance during meals. 2. Refer to F248 for details regarding the facility ' s failure to provide residents #11, #46, #138, and #162 with individualized, meaningful activities. In addition, the facility failed to ensure there were adequate activity personnel to provide a program of meaningful activities for residents #5, #13, #28, #38, #79, #80, #108, and #141. 3. Refer to F325 for details regarding the facility ' s failure to ensure residents #11, #33, and #162 had timely interventions and assessments to address significant, unplanned weight loss. 4. Refer to F353 for details regarding the failure of the facility to ensure adequate staff to respond to call lights. In addition, please see specific information for residents #3, #46, #108, and #159. 5. Refer to F368 for details regarding the facility ' s failure to offer snacks at bedtime to all residents on 2 of 2 observed units.	F 224	G) **Additional nursing staff will be Added to roster.** H) **Nursing Administration will Monitor meal services to assure that all residents are receiving meal service in a timely manner, making adjustments as indicated.** I) **Nursing Administration will Assign staff to offer HS snacks and monitor compliance of such, making adjustments as indicated.** J) **Facility Dietician will perform Weight audits on each resident with assessment and intervention to be implemented as indicated.** K) **The facility will implement a new Mechanism for identifying and reporting resident suspected weight loss.** L) **The facility will explore a change in dining room service allowing for a more efficient delivery and assistance of meals.** M) **Audit tools will be developed and deployed to address the identified deficient areas.** N) **The above interventions will Be presented to the Quality Assurance team, for evaluation and analysis for a minimum of 6 months.**	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of incident reports, review of policy and procedure, and staff interview, the facility failed to complete a	F 226		

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F 228	Continued From page 2 thorough investigation for 2 of 4 injuries of unknown origin, involving non-sample resident #91 and one sample resident (#170). The findings were: 1. Review of the "bruise incident report" dated 8/19/10 showed resident #91 was reported as having a bruise of unknown origin. The report did not include the location of the bruising, however, it included a quote from the resident that alleged it may be from staff handling him/her "too hard...some of them are rough." Further review showed seven staff members were listed on the report as having worked with the resident in the past 48 hours. However, two of these staff were not interviewed because they were on vacation starting the date of the report (8/19). Furthermore, the report failed to document any conclusions as to the causative factors related to the bruising. Interview with the DON on 11/3/10 at 11:12 AM revealed the facility did not retain original notes from any of the interviews. The DON also stated the two staff members were not interviewed when they returned to work regarding the bruises found on this resident. 2. Review of the "bruise incident report" dated 5/9/10 showed resident #170 had bruising below the left eye, to the side of the nose and top bridge of the nose. The report showed the resident was unable to recall how the bruise occurred. The area of the report for listing names of staff who worked with the resident in the past 48 hours was left blank. In addition, the area for interviews of staff showed one CNA was interviewed; however, the interview note stated "CNA states no injury noted on 3/11." The back side of the report form was designed for the follow up; however, this section, as well as the signature and date line	F 226	**F 226** **The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This will be accomplished by:** **A) Abuse Investigation policy will be revised to address the need for documenting all statements.** **B) Nursing staff will be instructed to the thorough completion of bruise reporting assessment to include a documented thorough interview process including possible causative factors related to the bruising.** **C) Resident # 91 will be interviewed to determine if there are continued concerns about "too hard/rough". This interview will be documented.** **D) All bruise reports will be reviewed by the Nursing Administration team for elements demonstrating a complete investigation was conducted. Immediate re-education administered when warranted.** **E) Nursing Administration will report status of findings at quarterly QA meetings for a minimal period of 6 months.**	**12/18/10**

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F 226	Continued From page 3 were left blank. Interview with the DON on 11/3/10 at 11:12 AM verified the report lacked all necessary information to be considered a thorough investigation. 3. Review of the policy and procedure for investigating unexplained injuries revised in 10/28/04 referred to the guidelines established in the "Abuse Investigations" policy and procedure. According to the "Abuse Investigations" policy and procedure (revised 7/23/02,) injuries of an unknown source were to be promptly and thoroughly investigated. The procedure showed the person reporting the incident, any witness to the incident, the resident, other staff who may have been involved within the involved time frame, and family and other residents were to be interviewed as appropriate. However, review of the guidelines for conducting these interviews failed to address the need for documenting any statements other than those of a witness.	F 226	**F 241** **The facility will 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 will be accomplished by:** **A) Residents # 11, 16, 73 & 141 will receive dining/eating assistance in a timely manner.** **B) The facility will explore a change in dining room service allowing for a more efficient delivery and comprehensive level of assistance during meals.** **C) Nursing Administration will inservice nursing staff to above deficiencies.** **D) Nursing Administration will monitor meal services to assure that all residents are beneficiaries to a timely meal with necessary assistance rendering re-education as warranted.** **E) The above audit results will be reviewed at Quarterly Quality Assurance meetings for a minimum of 6 months.**	**12/18/10**
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, staff interview, resident interview, and medical record review, the facility failed to provide a dignified dining experience for one of eight sample residents (#11) and three non sample residents (#16, #73, #141) who required dining assistance. The findings were:			

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F 241	Continued From page 4 1. Review of the medical records and current nursing assessments revealed residents #11, #73 and #141 required assistance with eating that ranged from extensive to total dependence. Observation in the central dining room on 11/1/10 revealed the three residents were positioned at the same table at 6:16 PM waiting to be served the evening meal. At that time, staff gave each resident a drink of water and/or other beverage, placed the glasses/cups on the table in front of the residents, and departed. Continued observation revealed the residents did not receive additional assistance until staff served the individual meals as follows: Resident #11 was served at 6:55 PM (forty minutes elapsed); resident #73 was served at 7:05 PM (fifty minutes elapsed); and resident #141 was served at 7:30 PM (one hour and fifteen minutes elapsed). During a confidential interview on 11/1/10 at 7:30 PM with an alert and oriented resident it was revealed s/he had observed dependent residents sitting and waiting for assistance at meal times for prolonged periods of time for the past two months. During an interview on 11/3/10 at 11:40 AM, the DON stated she was aware of the problems with delayed meal service. She stated the facility was in the process of making staffing changes to address it, but acknowledged it continued to be a problem. 2. Observation of the evening meal on 11/1/10 at 4:55 PM revealed resident #16 was seated in his/her wheelchair at an assisted dining table on the south unit. At that time the resident stated to the surveyor s/he was ready to eat. At 4:57 PM the dietary aide responded to the resident's request for food by stating s/he had to wait for the CNAs to come in at about 5:30 PM to assist with	F 241		

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F 241	Continued From page 5 dining. During this observation there were other residents in the dining room who had their meals and were eating independently. The resident continued to sit at the table. At 5:16 PM the resident again asked for a meal and was again told s/he needed to wait for the CNAs. The resident remained in the dining room looking around at the other residents who were eating. The resident's expression was observed to be a deep frown. After the CNAs brought in other residents who required assistance, resident #16 was served his/her meal at 5:45 PM, fifty minutes after his/her first request. The assistance the resident received was observed to be for set-up help only. The resident took several bites of the food and independently left the dining room. Observation on 11/2/10 at 7:50 AM and on 11/3/10 at 7:55 AM showed the resident was seated at the assisted table with no staff present to assist. During both observations it was noted that when the resident was served each morning meal, the resident ate without staff assistance. Interview with LPN #1 on 11/3/10 at 7:55 AM revealed the resident required set-up help and supervision for dining. She stated the resident often came to the dining room early and was served his/her meal without having to wait for staff to provide assistance.	F 241	**F 248** **The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. This will be accomplished by:**	**12/18/10**
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 248	**A) Residents # 5,11,13,28,38, 46, 79,80,108,138, 141 & 162 will have an individualized activity program based on respective activity assessment.** **B) Activity personnel will be inserviced to the above infractions.** **C) Additional personnel will be added to Activity department.** **D) As each resident assessment period is realized, all residents will have a comprehensive assessment and individualized care plan crafted.** **E) Resident participation in activities will be documented and evaluated.** **F) Audits of resident assessments and care plans**	

as a need is identified

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F 248	Continued From page 6 by: Based on observation, review of the activity calendar and resident council minutes, medical record review, and staff and resident interview, the facility failed to ensure there was an individualized activity program that met the needs of 4 of 8 sample residents (#11, #46, #138, #162). In addition, the facility failed to ensure adequate activity personnel to provide enough activities to meet the needs of residents on 2 of 4 units (south, central), including supplemental residents #5, #13, #28, #38, #79, #80, #106, and #141. The findings were: 1. The following concerns on the south unit were identified: A. Review of the 10/22/10 annual MDS assessment for resident #138 showed a problem with activities was triggered, which required further assessment. Section V of the assessment indicated activities would be included on the care plan. The following concerns were identified: a. Review of the care area assessment (CAA) for activities showed it was not a comprehensive assessment. There lacked an analysis of findings. Furthermore, the CAA referred to "Activity 10/28/10- Tab in chart." However, further medical record review showed nothing during that timeframe in the activities section in the chart. During an interview on 11/3/10 at 8:40 AM, the activity director stated there was no activity assessment. b. Review of the current care plan, dated 10/23/10, showed the area of activities was not addressed. There were no goals or approaches to ensure the needs of the resident were met. On 11/3/10 at 8:40 AM, the activity director confirmed there was no care plan for activities. The director	F 248	**will be conducted to determine efficacy of the activity program(s) with adjustments made to the program as warranted.** **G) The above audit results will be reviewed at Quarterly Quality Assurance meetings for a minimum of 6 months.**	

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F 248	Continued From page 7 stated the resident "doesn't need a care plan." c. During an interview on 11/2/10 at 1:05 PM, when asked about activities, the resident replied activities "suck." The resident stated two activity aides were gone, so the south and central units were "ignored." The resident stated there were not enough group activities to keep her busy, and the facility did not provide one-to-one activities. The resident stated she was "bored." During an interview on 11/3/10 at 8:40 AM with the activity director and both activity aides, they stated with regards to activities for the resident, "It'll never be enough." d. Review of the medical record showed no participation records or other documentation to show the resident's participation in activities or what his/her response to an activity was. As a result, there was no evaluation as to whether or not the facility was meeting the activity needs of this resident. B. Observation during the survey from 11/1/10 through 11/3/10 showed resident #46 did not participate in group activities. Review of the 9/2/10 quarterly activity assessment showed the resident wanted to choose for him/herself the daily activities and liked to be in his/her room. The following concerns were identified: a. Review of the care plan dated 9/2/10 showed the only goal for activities was "resident will attend/participate in 1-2 out of room activities per week." The approaches listed were not individualized, but rather a listing of potential activities, such as "1:1 visits with activity aide; family or friends visits prn [as needed]...computer in room...pet therapy." b. During an interview on 11/2/10 at 12:45 PM, the resident stated "Activities have gone downhill." The resident stated s/he did not	F 248		

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F 248	Continued From page 8 participate in many group activities because s/he was not interested in what they had to offer. The resident further stated they didn't offer one-to-one activities and "I do get bored." During an interview on 11/3/10 at 8:40 AM, the activity director and both activity aides confirmed the activities offered to the resident were "not enough." c. Review of the medical record showed no participation records or other documentation to evidence the resident's participation in activities or his/her response to an activity. Thus, there lacked an evaluation as to whether or not the facility was meeting the activity needs of the resident. C. Review of the medical record for resident #162 showed s/he was newly admitted to the facility on 10/6/10. Periodic observations during the survey from 11/1/10 to 11/4/10 revealed the resident did not participate in any group activities. Interview with the resident on 11/3/10 at 8:30 AM revealed s/he did not know what there was to do for activities, but stated s/he was "okay." Review of the medical record showed no documentation related to activities. Upon request an activities interview from section F of the MDS 3.0 was provided by the facility. Review of this data collection tool showed the resident did not think it was very important to be around animals or to do things with groups of people. However, according to the care plan dated 10/10/10, the approaches for this resident consisted of a list of activities that could be selected and included: "pet therapy" and "large group activity." Interview on 11/3/10 at 11:55 AM with the activities director revealed there was no additional assessment documentation to review. D. Observation on the south unit during the	F 248		

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F 248	Continued From page 9 survey from 11/1/10 through 11/3/10 showed numerous residents (#5, #108, #28, #38, #13, #79) were seated in the lounge area and not engaged in any activities. Review of the activity calendar for 11/2/10 and 11/3/10 showed only one group activity was offered each day. Review of the care plans for residents #5, #13, #28, #38, #79 and #108 revealed the care plans were not individualized. The plans showed all residents had a similar goal, which was to attend/participate in a certain number of out-of-room activities per week. Furthermore, the approaches consisted of a listing of potential activities that were not specific to each resident. E. During an interview on 11/3/10 at 8:40 AM, activity aide #1 stated on the south unit it was "very sad...residents just sitting around." During the interview, the activity director stated there was no activity aide for the south unit. She stated they were trying to work out how activities on the south unit would be covered and would probably have activity aide #1 cover that unit. 2. The following concerns on the Central unit were identified: A. Review of the 9/14/10 activity assessment for resident #11 showed s/he had hearing difficulties, did not stay long for activities due to the level of dementia, and "likes for staff to visit with her." Further review showed "watching television" was not a preference for this resident. Review of the 9/22/10 plan of care revealed interventions regarding staff visits was lacking. Observation on 11/1/10 at 7:45 PM after the evening meal, showed the resident was not involved in group or one-to-one activities. The resident was observed	F 248		

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F 248	Continued From page 10 to doze as s/he sat in the recreation/lounge area positioned in front of the television and surrounded by at least eight other residents who were also dozing. Observation on 11/2/10 from 6:30 AM until 10:30 AM showed the resident was positioned in the recreation/lounge area in front of the television with other residents both before and after breakfast. The only activity provided during that time was Bible reading presented by a volunteer. However, per observation this resident did not participate. At 1 PM, s/he was observed positioned in the recreation/lounge area dozing in front of the television set. Observation from 7:40 PM until 8:35 PM revealed s/he was again positioned in front of the television. The only activity provided after the evening meal, from 7:45 PM to 9:45 PM, was a crossword puzzle activity presented by a volunteer. Three residents participated but these did not include residents #11. B. Review of the 9/05/10 quarterly MDS assessment for resident #80 showed the resident had severe cognitive impairment and poor vision, and was totally dependent on staff for all activities of daily living. According to the 9/7/10 care plan, weekly activities included one-to-one activities with all activities, music and book club in the resident's room, family visits and touch therapy. Observation on 11/1/10 at 7:45 PM after the evening meal, revealed the resident was not involved in group or one-to-one activities. S/he dozed as s/he sat in the recreation/lounge area positioned in front of the television set and surrounded by at least eight other residents who were also dozing. Observation on 11/2/10 from 6:30 AM until 10:30 AM, showed the resident was positioned in the recreation/lounge area in front of the television with other residents both before and	F 248		

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PRINTED: 11/18/2010
FORM APPROVED
OMB NO. 0938-0391

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F 248	Continued From page 11 after breakfast. Continued observation showed s/he was not present during the only activity, Bible reading that was provided during that time. At 1 PM, s/he was again positioned in the recreation/lounge area and was noted to be dozing in front of the television set. Observation from 7:45 PM to 9:45 PM showed s/he was in bed asleep and did not participate in the evening crossword puzzle activity presented by a volunteer. C. Review of the 8/4/10 activity assessment for resident #141 revealed s/he was cognitively impaired and his/her activity preferences include exercise, family visits, watching television, music and conversation. Review of the documentation on the October 2010 activity log showed staff provided activities for the resident on three days during a fifteen day period from 10/16 -10/31/10. Further review revealed staff did not provide any activities for this resident during the three consecutive weekends during that time period. Observation on 11/1/10 at 7:45 PM revealed the resident did not participate in the evening activity because s/he was eating his/her evening meal during the activity. Observation on 11/2/10 from 6:30 AM until 10:30 AM, revealed s/he was positioned in the recreation/lounge areas in front of the television with other residents before and after breakfast. The only activity provided during that time was Bible reading presented by a volunteer, and the resident was observed to be dozing during the activity. At 1PM, s/he was positioned in the recreation/lounge area dozing in front of the television. Observation from 7:40 PM until 8:35 PM revealed s/he was again positioned in front of the television. Continued observation from 8:35 PM until 9:45 PM showed s/he was asleep in bed during the evening crossword	F 248		

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F 248	Continued From page 12 puzzle activity. D. Interview with CNA #7 on 11/1/10 at 7:45 PM revealed the usual routine on the central unit was to position the residents in the television lounge area after the evening meal until staff had an opportunity to "put the residents to bed." Interview on 11/2/10 at 8:45 PM with NA #1 showed s/he had never been involved with resident activities. Interview on 11/3/10 at 9:45 AM with CNA #6 revealed direct care staff were busy with other care duties and did not have time to offer or provide activities for cognitively impaired residents. Interview on 11/3/10 at 10 AM with RN #1 revealed direct care staff were involved with resident activities whenever they had time, but frequently other tasks left little or no time for activities. The RN also stated that whenever staff had time to provide activities the activity was not based on individualized resident preferences. 3. Interviews with twenty-four residents on 11/3/10 at 10:10 AM revealed all twenty-four were unhappy with the quality of the activities program, verifying that there was not enough to do. A comparison of the October and November 2010 activity calendars showed a decrease in the number of group activities offered for November. Review of the 9/1/10 resident council minutes showed the following comments "...South resident said we wish they wouldn't get rid of the activity people, it wouldn't be the same....South resident said activities are needed, they need to keep the activity staff so residents can have the quality activities they are used to."	F 248		

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PRINTED: 11/18/2010
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F 248	Continued From page 13 4. On 11/3/10 at 8:40 AM the activity director (who had been in the position about two weeks at the time of the interview) and both activity aides were interviewed. They stated that there used to be four activity aides (one for each unit), but in October two of the positions were cut (the aides for the central and south units). The director stated the department was only budgeted for two positions, and they currently had three. All three activity staff stated there was not enough staff in the department to meet the activity needs of the residents. They confirmed that fewer activities were scheduled for November. When asked if they did one-to-one activities, the staff stated it was difficult to do with only three staff. When asked for documentation, the staff was only able to provide evidence of one-to-one activities for the east unit. When asked about participation logs, the staff stated there were no logs for the south unit, and the nursing staff kept the log for the central unit. Furthermore, the director confirmed that the goals for the care plans were similar for all residents. When asked, "How does having a resident attend an out-of-room activity two to three times per week ensure the facility is meeting the needs of the resident?", the activity director did not reply.	F 248	**F 282** **The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. This will be accomplished by:**	**12/18/10**
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 282	**A) Residents # 11,33, & 94 will receive denture care, toileting assistance and dining assistance in accordance to plan of care.** **B) Nursing Staff will be inserviced to above infractions.** **C) Charge nurses will monitor all residents for adherence to resident plan of care addressing any identified infractions.** **D) Nursing Administration will Audit random samples of resident care compliance with plan of care** **E) The above audit results will be reviewed at Quarterly Quality Assurance meetings for a minimum of 6 months.**	

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F 282	Continued From page 14 and staff interview, the facility failed to ensure care was provided in accordance with the written plan of care for 2 of 8 sample residents (#11, #33) and one supplemental resident (#94). The findings were: 1. Observation on 11/2/10 at 7:55 PM revealed resident #33 was sleeping in bed when CNA #1 removed his/her top dentures for cleaning. After cleaning the dentures, the CNA took the dentures to the nurses station where they were then stored. Interview with the aide revealed this was the normal procedure for storing the resident's dentures. Review of a memo to staff which was posted in the resident's bathroom showed the dentures were to be stored in the resident's bathroom. The date on the memo was 7/19/10. Interview with the DON on 11/3/10 at 1:45 PM verified the memo was part of the residents' care plan and should be followed. 2. Refer to F309 for details regarding the facility's failure to provide toileting assistance according to the plan of care for resident #11. 3. Refer to F312 for details regarding the facility's failure to provide dining assistance for resident #94.	F 282	**F 309** **Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. This will be accomplished by:** **A) Residents # 11, will receive offer of toileting assistance in accordance to plan of care.** **B) Nursing Staff will be inserviced to above infractions.** **C) Charge nurses will monitor all residents for adherence to resident toileting plan of care addressing any identified infractions.** **D) Nursing Administration will Audit random samples of resident care compliance with plan of care** **E) The above audit results will be reviewed at Quarterly Quality Assurance meetings for a minimum of 6 months.**	12/18/10
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure staff provided toileting in a timely manner in order to promote bowel continence for 1 of 6 sample residents (#11) who were incontinent. The findings were: Review of the 9/20/10 quarterly MDS assessment for #11 revealed the resident had episodes of urinary incontinence, was continent of bowel, and required extensive assistance with toileting. Review of the care plan showed approaches included: offer to toilet resident every two to three hours during the day. Continuous observation on 11/2/10 from 6:35 AM until 10:15 AM (three hours and forty minutes) revealed the resident sat in a wheelchair in the television area and was not checked for incontinence or provided an opportunity to use the toilet. Observation of the CNA #8 who provided personal care for this resident at 10:15 AM revealed the resident had been incontinent and his/her disposable brief was soiled with feces and urine. Interview with the CNA on 11/2/10 at 1PM revealed staff usually checked the resident for incontinence before getting up and after transfers to bed. The CNA also stated sometimes the resident was incontinent of urine and/or feces and other times s/he wasn't and sometimes staff assisted the resident to the toilet and other times they did not.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312	**F 312** **A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by:** **A) Residents #94 and 144 will receive dining assistance.** **B) Nursing Staff will be inserviced to above infractions.** **C) Charge nurses will monitor all residents for assistance with dining addressing any identified infractions.** **D) The facility will explore a change in dining room service allowing for a more efficient delivery and comprehensive level of assistance during meals.** **E) Nursing Administration will Audit random samples of resident dining services compliancy.** **F) The above audit results will be reviewed at Quarterly Quality Assurance meetings for a minimum of 6 months.**	12/18/10

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F 312	Continued From page 16 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure two supplemental sample residents (#94, #144) received dining assistance in a timely manner. The findings were: 1. According to the 9/12/10 quarterly MDS, resident #94 was cognitively impaired and required limited assistance with eating. Review of the corresponding plan of care showed the resident had hearing difficulties, was legally blind with useful vision only two feet, and required set up assistance and cues to enable him/her to eat independently. Observation on 11/1/10 at 6:05 PM showed staff had positioned the resident at the dining room table and placed a bowl of soup, a plate of food and glasses of water and juice in front of him/her. Continued observation showed staff that were present in the dining room assisted other residents and periodically touched resident #94's shoulder to asked if s/he was awake. None of the staff were observed cueing, prompting or assisting the resident until 6:50 PM (forty-five minutes later). At that time when CNA #9 offered assistance, the resident refused to eat and staff wheeled the resident out of the dining room. 2. Observation at 12:12 PM of the midday meal on the east unit showed resident #144 was seated with his/her meal on the table. At that time, the resident was sleeping, and it appeared that the resident's food was untouched. Eighteen minutes later at 12:30 PM CNA #4 cued the	F 312		

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F 312	Continued From page 17 resident to wake up and eat. After being cued the resident took several bites of the food.	F 312	F 315	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care to promote continence for 1 of 3 sample residents (#11) who were incontinent of bladder. The findings were: Refer to F309 for details regarding the facility's failure to provide toileting assistance for resident #11.	F 315	**The facility will ensure that a resident Who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This will be accomplished by:** **A) Resident #11 will receive care to promote continence.** **B) Nursing Staff will be inserviced to above infractions.** **C) All residents will receive care to promote continence.** **D) Charge nurses will monitor residents to assure that residents receive proper toileting assistance taking immediate corrective action for identified care deficits.** **E) Nursing Administration will develop an auditing tool to monitor resident toileting program effectiveness.** **F) Nursing Administration will report monitoring results at Quarterly Quality Assurance meetings for a minimum of 6 months.**	12/18/10
F 325 SS=E	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	F 325		

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F 325	Continued From page 18 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure 3 of 4 residents (#33, #162, #11) who were identified as having a significant weight loss were assessed timely, and had interventions put into place to prevent further weight loss. The findings were: 1. Review of the medical record for resident #33 showed the weights listed on the vital signs flow sheet indicated the resident had a 7.2 lbs (pound) weight loss in five days. Observation on 11/1/10 at 4:57 PM revealed the resident's meal was on the table and appeared to be untouched. At that time the resident was seated in a lounge chair in the common area. Continued observation until 6:10 PM (1 hour and 13 minutes) revealed the resident did not sit at the table or eat the meal. At no time during the observation was the resident redirected or encouraged by staff to eat the meal. Interview with the dietary aide on 11/1/10 at 4:57 PM revealed the resident comes in and out of the dining room, she further stated the resident was not redirected because s/he usually ate well, and drank a lot of hot cocoa. From 10/21/10 to 10/26/10, (five days) the resident dropped from 136.3 lbs to 128.1 lbs. Further review of the 8/10/10 nutrition data collection summary showed the resident had been having steady weight decline, his/her weight was down at that time 8.6 % in the last 180 days. According to this summary, the RD was notified for a review due to the continued weight loss; however, review of the	F 325	**F 325** **Residents will 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; and receives a therapeutic diet when there is a nutritional problem. This will be accomplished by:** **A) Residents #33, 11 & 162 will be nutritionally assessed and have interventions put in place to address any identified deficits.** **B) Nursing Staff, Dietician and Director of Dietary will be inserviced to above infractions.** **C) Charge nurses will monitor all residents for assistance with dining addressing any identified infractions.** **D) The facility will explore a change in dining room service allowing for a more efficient delivery and comprehensive level of assistance during meals.** **E) Nursing Administration will Audit random samples of resident dining services compliancy.**	**12/18/10**

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F 325	Continued From page 19 record showed there had been no review by the RD's as of the date of survey. Review of the care plan with a problem date of 10/26/10 revealed the resident had increased calorie needs due to wandering. The care plan also showed the resident had impaired cognition that affected consumption of foods/fluids. There was no mention of weight loss in the care plan. The care plan approaches were to provide diet as ordered, nursing staff to encourage fluids, monitor weights and monitor labs. Interview with RN #5 revealed she had written a communication to the dietary department. The date on the original communication was 10/27/10, but was not yet posted in the resident's record. The nurse stated the slip had two copies a pink carbon copy that went to the CDM who then put the yellow copy in the RD's mailbox. The following concerns were identified with the follow up to this identified significant wt loss: a. Interview with the CDM on 11/2/10 at 10 AM revealed she was aware of the weight loss; however, she did not keep a copy of the communication slip. She reviewed her records and revealed she had not yet made any notes regarding the issue. The CDM stated the process was to collect information and refer the case to the RD. She stated the timeline was to address the issue as soon as it was identified. She further stated she was concerned the weight may be in error, however had been busy and had not requested a re-weigh. She stated she would get a re-weight that day. At 10:18 AM that day the residents weight was reported as 128.6 lbs. the CDM stated an assessment was needed to determine why the resident was losing weight. She thought she remembered putting the yellow copy in the RD's mailbox; however, this could not be verified as the RD was out of town.	F 325	**F) Facility Dietician will perform weight assessments on each resident with interventions implemented as indicated.** **G) The Chief Nursing Officer will perform random audits of residents weights, assessments, and care planning interventions.** **H) The above audit results will be reviewed at Quarterly Quality Assurance meetings for a minimum of 6 months.** I) facility will develop and implement a wt procedure to identify and address wt variances. management	

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F 325	Continued From page 20 b. Interview via telephone with the RD on 11/3/10 at 9:38 AM revealed she was not aware of this resident's recent weight loss. 2. Review of the medical record showed resident #162 was admitted to the facility on 10/6/10. Observation on 11/1/10 at 6 PM revealed the resident was served a room tray, required some assistance for set-up, and then ate without assistance. Review of the resident's weights since admission showed the resident was experiencing a significant, unplanned weight loss. From 10/8/10 to 10/22/10 the resident went from 219.3 lbs to 198.6 lbs, a loss of 20.7 lbs (10.4% wt loss) in 14 days. Review of the admission MDS assessment with an ARD of 10/10/10 showed the resident triggered for a potential problem related to nutrition. Further review of the record showed there was no assessment done related to nutrition for this resident. Interview with the CDM on 11/3/10 at 9:46 AM revealed she was not aware of the weight loss for this resident. She also verified at that time a nutritional assessment could not be found for this resident. 3. Interview with the RD by telephone on 11/3/10 at 9:38 AM revealed the facility's system related to nutritional assessments was limited by time constraints. She also stated the facility lacked a team to track and monitor residents who were identified with significant weight loss. 4. Review of the nutrition profile for resident #11, completed by the RD, showed the last documented RD intervention, dated 1/4/10, was "added additional Ensure [dietary supplement] at breakfast." Further review showed this addition was an increase from Ensure two times daily to one with every meal. Review of the vitals and	F 325		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 11/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY CARE CENTER	60 MAGNOLIA CASPER, WY 82604

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F 325	Continued From page 21 weight record for the resident showed s/he had the following weight fluctuations from May to October 2010: 145 pounds (lbs) on 5/13/10, 133.6 lbs on 6/17/10, 135 lbs on 7/3/10, 127.7 lbs on 8/30/10, 120.2 lbs on 9/16/10, 124 lbs on 9/30/10, 129 lbs on 10/11/10 and 121.2 lbs on 10/28/10. Review of the 6/20/10 quarterly MDS assessment showed the resident had experienced a significant weight loss of 5% or more over the previous thirty days. However, review of 9/12/10 quarterly MDS assessment (three months later) showed weight loss was no longer a concern for this resident. Review of the care plan showed the following interventions were to be implemented to address the resident's nutritional needs: dietary per physician's orders and weigh two times a week. Further review revealed dietary and nursing staff were responsible for monitoring for signs and symptoms of Crohn's disease and exacerbation for dietary modification as needed. According to the October 2010 treatment record, the resident developed two stage 2 pressure sores that month. Review of the physician's orders on 10/26/10 showed orders for calorie counts for three days due to two newly developed pressure sores and weight loss. Observation of CNA #8 providing personal care for the resident at 10:15 AM on 11/2/10 confirmed the presence of two "healing" stage 2 pressure sores. Each pressure sore was documented as approximately a 1x1cm area of redness. The following concerns were noted: a. Review of vitals and weight record showed twice weekly weights were not consistently recorded for June to October 2010. b. Review of the June and September 2010 quarterly nutrition data collection forms completed by the CDM showed no information regarding the need for an RD assessment or additional	F 325		

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F 325	Continued From page 22 interventions. c. Review of the documentation in the May 2010 to October 2010 nutritional supplement consumption records showed the total daily amount consumed was zero to one half of the amount recommended by the RD on the following days: twenty days in June, twenty-nine days in July, thirty days in August, twenty-two days in September and twenty-nine days in October. d. Review of the medical record showed no nutritional assessments had been completed by the RD from 6/20/10 to 11/03/10, and the three-day calorie count had not been implemented as ordered. e. The CDM verified, in interview on 11/3/10 at 9 AM, that the three day calorie count had not been implemented and the nutritional assessments had not been completed. She further stated she was not aware of the weight fluctuation/loss, pressure sores, and related physician's orders, therefore; she had not reported it to the RD.	F 325		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353	**F 353** **Residents will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest level practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessment and individual plans of care. This will be accomplished by:** **A) Residents #11, 16, 73, 141, 94 & 144 will receive timely meals and/or assistance with meals.** **B) Residents # 3,46, 108, & 159 will have call lights answered in a timely fashion** **C) Nursing Staff, will be inserviced to above infractions.** **D) All staff will receive notice of a policy change requiring assistance from all departments and employees to respond to resident call lights.** **E) Additional nursing staff will be added to the nursing roster.**	**12/18/10**

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F 353	Continued From page 23 section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, review of the staff schedule and resident council minutes, and staff and resident interview, the facility failed to ensure it had adequate staff to serve meals timely to 1 of 8 sample residents (#11) and 3 non-sample residents (#16, #73, #141). In addition, two supplemental residents (#94, #144) did not receive timely assistance with dining. Furthermore, call lights were not answered timely for at least four residents (#3, #46, #108, #159) and interviews with staff and residents indicated there were not enough staff. The findings were: 1. The following concerns from residents regarding staffing were identified: A. Interviews with twenty-four residents on 11/3/10 at 10:10 AM revealed twenty-one residents interviewed thought the facility was lacking adequate numbers of staff to provide care and services. The examples provided when asked what services and care needs suffered were: a. Call lights were not being answered timely. Two residents stated they had to wait for help to get off the toilet, one resident waited five hours, the other one hour. Two other residents stated	F 353	**F) Re-organizing of the nursing roster with appropriate allocation of staff for a comprehensive 24 hour coverage.** **G) Nursing Administration will monitor staffing ratios and make adjustments when necessary and report results at Quarterly Quality Assurance meetings for a minimum of 6 months.**	

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F 353	Continued From page 24 they were forced to wait in there own excrement for "many hours" because staff were not available to assist them. b. Meal service was talked about as a concern by 6 out of twenty-four residents interviewed. It was stated that it often took two hours to get people fed in the dining room on the east and central units. Refer to F241 for details regarding the facility's failure to serve meals timely to residents. Refer to F312 for details regarding the facility's failure to provide timely assistance with eating for resident's who require assistance. B. Confidential interview with a resident on 11/2/10 at 9:50 AM and 12:45 PM revealed the facility did not have enough staff to care for the residents. The resident stated call lights were slow, and that on 11/1/10 s/he was not put to bed until midnight because the facility was short of staff. C. Confidential interview with a resident on 11/2/10 at 1:05 PM revealed the facility did not have enough staff. The resident stated s/he was sometimes left sitting in feces because there was not enough staff to assist him/her. The resident also stated call lights were frequently "ignored." D. Review of the 10/6/10 resident council minutes revealed the following comments by residents: a. "South resident said there are thirty-eight residents on south and if they have eight residents per CNA we need four CNAs on south" b. "East resident said we are very under staffed, and can't get done what needs to get done" c. "South resident said you don't see the	F 353		

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F 353	Continued From page 25 CNAs standing around, they are working hard but three is not enough aides to cover south station" d. "Central resident said we need six CNAs on central with the neighborhoods." 2. Observation and review of the staffing board on the south unit on 11/1/10 at 5:10 PM revealed there were three CNAs scheduled. According to the resident directory, there were thirty-eight residents on the south unit. The following concerns were identified: a. At 5:57 PM, resident #46 put on his/her call light. The three CNAs were in the dining room at that time. At 5:58 PM, one CNA (#1) started to pass out room trays. The CNA walked past the resident's room twice, and did not answer the call light. At 6:06 PM (9 minutes later), a nurse (who was in orientation) answered the call light. During an interview at 6:25 PM, CNA #1 stated it was tough to answer call lights during meals because there were only three CNAs. b. At 6:28 PM resident #108 put his/her call light on. A nurse (RN #1) and two CNAs (#2, #3) were observed near the nursing station. The two CNAs went into another resident's room. The nurse remained in the hallway, but did not answer the call light. At 6:37 PM, the resident approached the surveyor and said, "I need to go to the bathroom real bad." At that time, CNA #2 walked by, and at 6:37 PM (9 minutes) the CNA answered the resident's call light. c. Confidential interviews with two residents on the south unit revealed "nurses do not answer call lights." d. During a confidential interview, a CNA stated nurses do not help answer call lights. The CNA stated they were unable to answer call lights timely because they did not have enough staff. The CNA further stated s/he went home	F 353		

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F 353	Continued From page 26	F 353		

teary-eyed because s/he wasn't able to provide the care needed to residents. S/he stated there were usually three staff on the south unit, and that was not enough staff.

e. During a confidential interview, another CNA stated the facility did not have enough staff. The CNA stated they "can't do everything," and that some nurses did not answer call lights because "They don't think it's their job."

3. Observation on the south unit on 11/2/10 at 9 AM revealed resident #108 had his/her call light on. RN #2 walked by the resident's room, but did not answer the call light. Another nurse (RN #3) was standing in the hallway, and did not answer the call light. At 9:06 AM, RN #2 walked by the resident's room again, and did not answer the call light. The resident propelled him/herself out of the room and at 9:07 AM told RN #1 s/he needed to go to the bathroom. The RN told the resident she would find an aide to help. At 9:08 AM, CNA #10 approached the resident, but stated she was working the east unit, so she would find another aide. At 9:10 AM, the resident told the housekeeper in the hallway s/he needed to use the bathroom. The housekeeper told CNA #5, who assisted the resident at 9:11 AM.

4. Observation on 11/2/2010 on the central unit showed resident #159 waited from 6:35 AM until 7 AM (twenty-five minutes) for a response to his/her call light to request pain medication.

5. Observation on 11/2/10 revealed resident #3 waited from 7:14 AM until 7:26 AM (twelve minutes) for a response to his/her call light to request assistance to the bathroom.

6. Interview with the DON on 11/3/10 at 11:40 AM

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F 353	Continued From page 27 revealed staffing needs were determined based on specific numbers of employee hours for each unit rather than resident acuity. A review of the October and November 2010 staffing schedules with the DON verified that acuity was not a factor in determining the number of staff required to meet the residents' needs.	F 353		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, review of resident council minutes, and resident and staff interview, the facility failed to ensure that each resident who wanted a bedtime snack received one in 2 of 2 units observed for bedtime snacks. The findings were: 1. Observation on the south unit on 11/1/10 from	F 368	**F 368** **The facility will ensure that residents will be offered snacks at bedtime daily. This will be accomplished by:** **A) All Residents will be offered a bed time snack.** **B) Nursing Staff will be inserviced to above infractions.** **C) Nursing Administration will develop a policy by which bedtime snacks are offered.** **D) Nursing Administration Team will monitor the offering of bedtime snacks with infractions immediately addressed.** **E) Nursing Administration will report results at Quarterly Quality Assurance meetings for a minimum of 6 months.**	**12-18-10**

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F 368	Continued From page 28 after the evening meal until 7 PM and on 11/2/10 from 7:45 PM until 10 PM revealed staff did not offer snacks to residents. Observation revealed there was a cart with a tray which contained some snacks located at the entrance/exit to the dining room. On 11/2/10 at 9:25 PM, licensed practical nurse (LPN) #1 and certified nurse aide (CNA) #1 were asked about bedtime snacks. Both stated that residents could take a snack from the cart when exiting the dining room after the evening meal. The LPN also stated there were sandwiches available "if a resident asks." Neither one could explain how they ensured bedtime snacks were provided to residents who were cognitively impaired and might not be able to ask for snacks. 2. Observation on 11/2/10 at 8:40 PM in the east unit common area showed a dietary aide put out a tray that contained snacks. The tray was placed on top of a high dresser in the area near the nurses station window, an area not easily accessible to residents in wheelchairs. There were a few residents in the area that were seated and napping in their wheelchairs. The aide did not attempt to offer any snacks at that time. Continued observation until 9:04 PM revealed the snacks were not taken by any residents or offered to any residents by staff. Interview on 11/2/10 with LPN #2 at 9:36 PM revealed the snack tray was put out for residents to help themselves. She stated if residents were not able to get to the tray, the staff would offer them a snack if the residents let the staff know they wanted one. 3. Interviews with residents during the survey from 11/1/10 to 11/3/10 revealed evening snacks were not offered or always available. Twelve resident interviews revealed evening snacks were	F 368		

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F 368	Continued From page 29 not offered or passed in a way to ensure residents who wanted a snack received one. Several of these residents mentioned the last couple of days was the first they had seen a snack tray in quite a while. The resident interviews revealed when a tray was set out for residents to take a snack, some people would "hoard" them so there was none left for others. 4. A confidential interview with a resident on 11/2/10 at 12:45 PM revealed there were no snacks at bedtime. The residents further stated, "Last night was the first time I've seen them on the cart." The resident stated staff did not offer snacks to residents at bedtime, so s/he kept food in his/her room. 5. Review of the 10/6/10 resident council meeting minutes revealed "South resident said she would like to see Cheetos, Doritos, and snacks passed out or offered at supper time. Offering one at a time so people don't take five or six and leave none for the rest of us. It needs to be monitored." In addition, "East resident said there are no more snacks anymore and it's not fair to us."	F 368		