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

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WY Dept of Health
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Healthcare Licensing and Surveys

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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
	535025	A. BUILDING _____ B. WING _____	C 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

RW 3-4-13

(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: CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse MDS- Minimum Data Set RN-Registered Nurse CAA-Care Area Assessment Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and/or execution of the response and plan of correction do not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information	F 164	Tag 164- It is the intention of the facility to provide the resident with personal privacy includes accomodations, medical treatment, written and telephone communications, personal care, visitis, and of family and resident groups. Corrective Action: Education with CNA and Therapist on the Right to Privacy and on providing privacy for residents during care on or before compliance date. ID of Others: Observations from Ambas sadors/designee on providing privacy during cares completed on or before compliance date. System/Measure: SDC /designee will provide Education to facility staff on providing privacy to residents during cares. Drape and dress resident appropriately. Use a close door, drawn curtain or both to shield resident during all personal care and treatment procedures.	

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

Jennifer Reaume | NHA | 2/25/13

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.

POC accepted 3-4-13 at 9:00 AM - Jennifer Reaume notified.

Rae Anne White RD

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F 164	Continued From page 1 contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure privacy was maintained during personal care for 1 of 15 sample residents (#32). The findings were: Observation on 1/28/13 at 3:20 PM showed resident #32 was assisted to his/her room for incontinence care. The resident was assisted to bed where his/her clothing and incontinence brief were removed. At 3:28 PM, therapist #1 entered the resident's room and left the door to the room wide open to the hallway. The resident was unclothed from the waist down, visible to any person who might pass by his/her room. Interview with CNA #1 who was providing perineal care at the time revealed she should have covered the resident with a sheet to maintain the resident's privacy.	F 164	Random observations of staff providing privacy during cares by Ambassadors weekly x4 than a random audit monthly x 2 . Activities Director/designee will review any concerns regarding privacy during monthly resident council x 3months. Monitoring: The NHA/Designee will track and trend observations to determine patterns based on a observations and determine the effectiveness of interventions. The results of this review will be shared with the QAPI committee. Tag 170 It is the intention of the facility to provide the resident with the right to privacy in written communications, including the right to send and receive mail that is unopened. Corrective Action: As of February 2, 2013 mail has been delivered to residents on Saturday. ID of Others. Activities Director will do Random interviews of family/ residents to see if they are receiving mail timely. System/Measures: NHA/designee will provide Education to Activities and facilities Managers on Duty on delivering mail on Saturday on or before compliance date.	
F 170 SS=E	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by:	F 170		

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F 170	Continued From page 2 Based on resident and staff interviews, the facility failed to deliver Saturday's mail to residents within twenty-four hours of delivery. The resident census was 90 at the time of the survey. The findings were: During a confidential interview on 1/29/13 at 2:30 PM, nine residents revealed they did not receive mail on weekends and they would like to have their mail delivered. Interview with the receptionist on 1/29/13 at 4:30 PM revealed that on Saturday, the mailman placed the mail in a locked mailbox in the front lobby. The Saturday mail was then delivered to residents the following Monday. Interview with the activities director on 1/30/13 at 10:05 AM verified mail was not delivered to residents on Saturday or Sunday.	F 170	Activities Director/designee will track residents weekly who receive mail on Saturdays x 4 than random x 2 months. Activity Director/designee will announce in monthly resident council that mail is delivered on Saturdays as long as the post office delivers. Monitoring: The Activities/Designee will track and trend audits to determine patterns based on reviews and determine the effective ness of interventions. The results of this review will be shared with the QA&A	
F 272 SS=D	483.20(b)(1) 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 resident assessment instrument (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;	F 272	Committee monthly x3. QA&A committee will evaluate the effectiveness of this plan and will implement additional interventions, as needed, to ensure continued compliance Date of Compliance: Tag 272- It is the intention of the facility to conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each residents functional capacity. Corrective Action: Admission Assessment for resident # 26 was completed on or before date of compliance.	03/12/13

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F 272	Continued From page 3 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to perform a comprehensive assessment for 1 of 18 sample residents (#26). The findings were: Resident #26 was admitted to the facility on 1/3/13 with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure, and aftercare for a traumatic hip fracture. Review of the medical record showed there was no MDS assessment completed for this resident. During an interview with unit manager #1 on 1/30/13 at 11:45 AM, she verified this resident did not have an admission MDS assessment completed. She further said the facility had been having difficulty with staff	F 272	ID of Others: An audit was completed on or before date of compliance of the last 30 days to identify admission comprehensive assessments that have not been done. System/Measures : Admission assess ments will be completed promptly upon MDS Coordinator will be hired and trained according to the RAI manual on completion of Admission assessments (Chapter 2 page 2-15). The interview process has begun and will continue until the appropriate candidate is hired. MDS support staff will assist with completion of comprehensive assessments and the RCMC(Regional Care Management Coordinator) will review completion timeliness with the IDT on or before date of compliance. An updated MDS schedule will be provided to the IDT on a weekly basis to review and provide any schedule changes. The NHA/designee will review the MDS calendar daily Monday thru Friday with the IDT to determine if assessments have been completed. Monitoring: Data obtained by way of	

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F 272	Continued From page 4 turnover in the MDS department which had resulted in assessments not being completed in a timely manner.	F 272	review will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee by NHA /designee. The QAPI committee will	
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the admission MDS assessment was completed within 14 days as required for 3 of 18 sample residents (#12, #27, #32). The findings were: 1. Review of the medical record for resident #27 showed s/he was admitted to the facility on 12/12/12. Review of the admission MDS assessment showed it was not completed until 1/15/13, 34 days after admission. 2. Review of the medical record for resident #32 showed s/he was admitted to the facility on 12/16/12. Review of the admission MDS assessment showed it was not completed until 1/24/13, 39 days after admission. 3. Review of the medical record showed resident #12 was admitted on 9/20/12. Review of the	F 273	evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Date of Compliance: Tag 273-It is the intention of the facility to conduct a comprehensive assessment of a resident within 14 calendar days after admission. Corrective Action: Resident #12's Admission MDS was completed on 3/11/13. Resident #27's Admission MDS was completed on 3/11/13. Resident #32's Admission MDS was completed on 3/11/13. ID of Others: An audit was completed on or before date of compliance of the last 30 days to determine the number of Admission assessments completed untimely. Those residents were reviewed to determine if a Significant Change Status Assessment (SCSA) was indicated. System Measures: Admission assessments will be completed promptly upon admission no later then day 14 (Z0500B) as well as the CAA's (V0200B2).	03/12/13

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F 273	Continued From page 5 admission MDS assessment showed it was signed as completed on 11/15/12, 56 days after admission. 4. Interview with unit manager #1 on 1/30/13 at 11:55 AM revealed the facility had been having problems with keeping the MDS position filled since February 2012 and as a result, the MDS assessments were not up to date.	F 273	A new MDS Coordinator will be hired and trained according to the RAI manual on completion of Admission assess ments (Chapter 2 page 2-15). The interview process has begun and will continue until the appropriate candidate is hired. MDS support staff will assist with completion of comprehensive assess ments and the RCMC will review completion timeliness with the IDT on or before date of compliance utilizing Chapter 2 of the RAI Manual. An updated MDS schedule will be provide to the IDT on a weekly basis to review and provided any schedule changes. The NHA/designee will review the MDS calendar daily Monday thru Friday with the IDT to determine if assessments have been completed. Any SCSA's identified will be scheduled on or before date of compliance in order for the IDT to review thoroughly and complete accurately. Monitor: Data obtained by way of review will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee by NHA/designee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a quarterly MDS assessment was completed every 92 days for 4 of 18 sample residents (#40, #57, #85, #93). The findings were: 1. Review of the MDS assessments for resident #40 showed s/he had an initial MDS assessment completed on 6/6/12. According to the MDS assessment schedule, a quarterly MDS assessment was due by 9/2/12. However, the assessment was not completed until 9/26/12 (24 days late). The next quarterly was due by 12/27/12. This quarterly was completed on 1/21/13 (25 days late). 2. Review of the admission MDS assessment for resident #93 showed s/he had a significant	F 276		

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F 276	Continued From page 6 change MDS assessment completed on 3/5/12. Review of the entire medical record and discussion with unit manager #1 on 1/30/13 at 11:55 AM verified no MDS assessments were completed since 3/5/12. According to the MDS assessment schedule, a quarterly assessment should have been completed by 9/5/12 and another quarterly assessment by 12/6/12. 3. Review of the MDS assessment for resident #85 showed s/he had a significant change assessment completed 2/24/12. No further assessments were completed between 2/24/12 and 1/30/13, 341 days. Quarterly MDS assessments were due in May 2012, August 2012, and November 2012. 4. Resident #57 was admitted to the facility on 9/10/10. The most current MDS quarterly assessment was dated 9/28/12. No quarterly MDS assessment was provided for December, 2012. The quarterly assessment was 34 days past due at the time of this survey. 5. Interview with unit manager #1 on 1/30/13 at 11:55 AM revealed the facility had been having problems with keeping the MDS position filled since February 2012 and as a result, the MDS assessments were not up to date.	F 276	compliance monthly for three months. Date of Compliance: Tag 276-It is the intention of the facility to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Corrective Action: An quaterly MDS Assessment was completed for resident #40 on 1/21/13. An appropriate MDS Assessment (SCSA) has been scheduled for resident #57 with an ARD of 3/7/13 An appropriate MDS Assessment has been scheduled for resident #85 with an ARD of 3/1/13. Corrective Action: Resident #93 was a closed record review. ID of Others: An audit was completed on or before date of compliance of the last 90 days to determine the number of quarterly assessments incomplete or completed untimely. Those residents were reviewed to determine if a Significant Change Status Assessment (SCSA) was indicated or a quarterly assessment scheduled. System Measures: Quarterly assess ments will be completed based on the ARD (A2300) and completion (Z0500B) of the most recent Admission or Annual	03/12/13
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	F 279		

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F 279	Continued From page 7 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 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 medical record review and staff interview, the facility failed to develop a care plan for 2 of 18 sample residents (#27, #50). The findings were: 1. Review of the medical record for resident #50 showed s/he was admitted on 11/6/12 with diagnoses of hypertension, chronic obstructive pulmonary disease, and past hip fracture. Further review of the medical record showed no plan of care was developed for the entire 62 days the resident was in the facility. The resident was discharged on 1/31/13 without a care plan. Interview with unit manager #2 on 1/30/13 at 10:45 AM verified there was no comprehensive care plan developed for this resident. 2. Review of the medical record for resident #27 showed s/he was admitted on 12/12/12 with diagnoses including diabetes. Review of the	F 279	assessment. If a resident does not have a SCSA (Significant change in status) a minimum of three quarterly assessments will be completed each 12 month period. The ARD will be schedule within 92 days of the previous OBRA assessment. Quarterly assessments will be completed no later then 14 days after the ARD. A new MDS Coordinator will be hired and trained according to the RAI manual on completion of Admission assessments (Chapter 2 page 2-25 – 2-26). The interview process has begun and will continue until the appropriate candidate is hired. MDS support staff will assist with completion of quaterly assessments and the RCMC will review completion timeliness with the IDT utilizing Chapter 2 of the RAI Manual. An updated MDS schedule will be pro vide to the IDT on a weekly basis to review and provide any schedule changes. The NHA /designee will review the MDS calendar daily Monday thru Friday with the IDT to determine if assessments have been completed. Any quarterly assessments identified will be scheduled on or before date of compliance in order for the IDT to review thoroughly and complete accurately. Monitor: Data obtained by way of review will be reviewed and analyzed for	

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F 279	Continued From page 8 12/12/12 admission nursing assessment showed the resident had no pressure ulcers upon admission. Review of the 1/15/13 admission MDS assessment showed the resident was at risk for skin breakdown. Review of the 1/2/13 nursing notes timed at 12 noon showed there was a blister on the resident's left heel. The wound care team assessed the pressure ulcer on 1/2/13 and determined it was a stage II pressure ulcer. The pressure ulcer measured 2.5 by 3.0 centimeters. Review of the medical record showed the resident was identified as at risk for pressure ulcer development upon admission. However, review of the care plan showed specific interventions were not developed until after the pressure ulcer was identified. Interview with the wound care nurse/DON on 1/31/13 at 11:35 AM verified a care plan for prevention of pressure ulcers with specific interventions should been developed upon admission.	F 279	patterns and trends and reported monthly to the facility QAPI committee by NHA/designee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months. Date of Compliance: Tag 279-It is the intention of the facility to develop a comprehensive care plan for each resident. The care plan must describe the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. Corrective Action: Discharge of resident #50 on 1/31/13.	03/12/13
F 281 SS=D	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 observation, medical record review and staff interview the facility failed to follow physician's orders for 2 of 18 residents (#44, #57). The findings were: 1. Resident #57 was admitted to the facility on 9/10/10 with diagnoses including dementia, incontinence of urine and feces, and osteoporosis. A physician's order dated 8/3/12	F 281	Id of Others: An audit will be completed on residents admitted to facility for month of February 2013 to ensure comprehensive care plans are completed on or before date of compliance. Systems Measures: RCMC/designee will provide education to the IDT on or before date of compliance on providing compre hensive care plans timely upon admission. DON/designee will complete a audit of newly admitted residents to ensure care plans are implemented timely. Monitoring: The DON/Designee will track and trend audits and determine patterns based on a review of Comprehensive care plans of new admits	

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F 281	Continued From page 9 showed the resident was supposed to receive 90 cc (cubic centimeters) of a house supplement (nutritional supplement) twice a day between meals and the amount consumed to be recorded. The following concerns were identified: a. Review of the MAR dated 8/3/12 through 1/9/13 showed the resident received a house supplement twice a day between meals. The amount consumed was not recorded. b. Interview with unit manager #1 on 1/31/13 at 8:35 AM revealed the amount of house supplement the resident consumed was supposed to be recorded on the MAR. Unit manager #1 verified the amount of the nutritional supplement the resident consumed had not been recorded on the MAR. c. Interview with the dietitian on 1/31/13 at 8:50 AM revealed nurses were supposed to record the amount of house supplement the resident consumed on the MAR. The dietitian said the house supplement had been increased based on the amount the resident consumed while, at the same time, she verified the amount of supplement consumed was not recorded. d. Interview with the DON on 1/31/13 at 11:20 AM revealed the resident was supposed to receive a nutritional supplement twice daily. The DON further revealed she expected nursing staff to record the amount of the nutritional supplement the resident consumed on the MAR as per the physician's order. 2. Review of the medical record for resident #44 showed on 9/12/12 the physician ordered albuterol sulfate 0.083% 2.5 mg/3 ml (milligrams per milliliter) per nebulizer for shortness of breath every 1 hour PRN. On 10/1/12 an additional order was written that showed the same medication	F 281	and determine the effectiveness of interventions. The results of this review will be shared with the QAPI Committee monthly. QAPI committee will evaluate the effectiveness of this plan and will implement additional interventions, as needed, to ensure continued compliance Date of Compliance: Tag 281-It is the intention of the facility to provide services that meet professional standards of quality. Corrective Action :House supplements has been recorded by percentage on #57 on 3/1/13. Clarification of Albuterol order for resident #44 was obtained on 2/23/13. Id of Others: Audit was completed by nursing on or before date of compliance to ensure current residents on House Supplements are being documented by percentage consumed. An audit was completed by Nursing on or before date of compliance for residents currently on Albuterol Nebs to ensure orders are written correctly. System Measures: SDC/ designee to provide Education to licensed nursing staff the importance of recording house supplements and clarifying Albuterol orders for accuracy. Monday thru Friday telephone orders will be reviewed for new Albuterol and	03/12/13

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F 281	Continued From page 10 was ordered every 4 hours PRN. Both PRN orders, every 1 hour PRN and every 4 hours PRN, remained as active orders on the MAR from October 2012 through January 2013. Interview with unit manager #2 and the staff development coordinator on 1/31/13 at 8:40 AM verified having the two different orders remain active at the same time was confusing for staff. They further said the order should have been clarified with the physician. 3. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician.	F 281	house supplements by nursing. Unit Managers/designee will audit Medication Administration Record to Ensure House supplements are recorded with percentage and Albuterol orders are transcribed accurately weekly x 4 then random audit x 2 months. Monitoring: The Unit Manager/ Designee will track and trend audits and determine patterns based on a review of Medication Administration Record, and determine the effectiveness of interventions. The results of this review will be shared with the QAPI Committee monthly x 3. QAPI committee will evaluate the effectiveness of this plan and implement additional interventions, as needed, to ensure continued compliance.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards 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, medical record review, and staff interview, the facility failed to ensure effective supervision and interventions were in place to prevent falls for 2 of 18 sample residents (#90, #93). The facility's failure to provide timely assessments and consistent intervention resulted in harm for resident #93. The findings were:	F 323	Date of Compliance: F323-It is the intention of the facility to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action: Resident #93 was a closed record review. Resident #90 was reassessed for fall risk and care plan updated with current fall prevention interventions in place. Interventions include night light, low bed with mat, tabs alarms on bed and wheel chair,	03/12/13

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F 323	Continued From page 11 1. Review of the 3/5/12 significant change MDS assessment (most recent assessment) for resident #93 showed s/he had a fall since admission. Review of the fall risk evaluation performed on 3/27/12 and again on 5/20/12 showed the resident scored 20 (a total score of 10 or above represents high fall risk). The following concerns with fall management were identified: a. Review of the medical record showed inconsistent information in regard to the resident's transfer and mobility capability and the extent of assistance the resident required. The following inconsistencies with assistance requirements were identified: i. Review of the 3/5/12 significant change MDS assessment showed the resident required limited assistance of one staff for mobility. ii. Review of the 5/20/12 resident transfer evaluation showed the resident required a mechanical lift for transfers. iii. Review of the undated resident care cardex worksheet showed the resident required stand by assistance when ambulating secondary to balance problems. Review of the 3/5/12 care plan showed the resident required stand by assistance for transfers most of the time. iv. Review of the 3/5/12 care plan for falls showed the resident was on the falling star program and interventions included encouraging the resident to ask for assistance, provide wheelchair assistance as needed, and offer to toilet frequently. v. Interview with the DON on 1/31/13 at 11:35 AM verified the inconsistencies and said she thought the resident was "mostly independent" in mobility. b. Review of the physician's notes dated	F 323	provided high back wheel chair, scooped mattress, medication adjustments or labs were drawn recently. The Care Cardex was updated and staff were reminded of this importance of following the plan of care. Identification of Others: The IDT will complete an audit by 3/4/13 for residents who have had falls during the month of January 2013 to determine whether appropriate interventions are in place to prevent future falls. IDT will complete an audit by 3/4/13 of the medical record of current residents to ensure fall risk assessments are up to date. Discrepancies will be corrected. Systemic Measures: Residents with falls will be assessed by a licensed nurse for injury, MD and family will be notified of the fall and a post fall review started. The licensed nurse will communicate the fall via the 24-hour report. The IDT will review resident falls within 24-72 hours at the morning IDT meeting to determine the root cause of the fall. Once a root cause is identified, the IDT will modify the plan of care and treatment approach to minimize future falls. The resident care specialist Cardex will be updated to reflect the plan of care. Residents will be assessed for fall risk upon admission, quarterly, annually, and with significant change using the fall risk assessment and care plans in place for	

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F 323	Continued From page 12 9/27/12 showed the resident had dizziness, falling, difficulty with ADL's (activities of daily living), and gait disturbances. Review of the 10/25/12 physician's notes showed the resident had increased fatigue, restlessness, a slower gait, and continued difficulty with ADL's. Review of the 10/27/12 nursing notes timed at 1:50 AM showed the resident was weak, was stumbling, and required hands on assistance with a gait belt for transfer and ambulation rather than the usual standby assistance or supervision. Review of the physician's notes dated 12/18/12 showed the resident continued to have gait disturbances and falls, weakness, ataxia (lack of coordination of movements), dizziness, generalized pain, involuntary movements, lightheadedness, numbness, tinnitus (ringing in the ears), vertigo and visual disturbances. Review of the 1/1/13 nursing notes timed at 9 PM showed the resident was "very unsteady". The following concerns were identified: i. Review of the medical record showed no evidence the resident was re-assessed for safety in regard to mobility after it was noted by the physician that the resident began having dizziness, gait disturbances, and falls in September 2012. The most recent MDS assessment was completed in March 2012 and the most recent fall assessment was in May 2012. ii. Review of the current care plan and resident care cardex showed no evidence it had been updated to reflect the resident's decline, as noted by the physician. The most recent care plan for falls was dated 3/5/12, six months prior to the physician's notation of the resident's decline. iii. Review of the 1/2/13 post-fall review showed the resident was walking unassisted, fell	F 323	residents at risk for falls. Residents with actual falls will be reviewed weekly during the At-Risk Review Meeting to ensure residents with falls have appropriate interventions and treatments to minimize future falls. IDT will be educated by the Regional Clinical Director on the post fall review process, how to determine root cause based on trends, and the importance of implementing interventions/care plans for residents with falls that mitigate the possibility of future falls. Education will be done on or before the date of compliance. Licensed nurses will be re-educated on the above fall system by the SDC/Designee on or before the date of compliance. Monitoring: The DON/Designee will track and trend falls and repeat falls, determine patterns based on a review fall risk assessments, and determine the effectiveness of interventions. The results of this review will be shared with the QAPI Committee monthly. QAPI committee will evaluate the effectiveness of this plan and will implement additional interventions, as needed, to	

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F 323	Continued From page 13 after tripping over another resident's wheelchair, and broke his/her hip. Interview with DON on 1/31/13 at 11:35 AM revealed the resident subsequently died at the hospital. 2. Review of the the medical record showed resident #90 was admitted 8/12/12 with diagnoses including mental retardation, senile dementia, arthritis, and depression. The resident was identified as being at high risk for falls on the 8/19/12 initial MDS and on the subsequent 11/18/12 quarterly assessment. Both assessments showed the resident required one person assist for transfers/ambulation, had impaired decision making ability, and had impaired short and long term memory. Review of the fall risk evaluations dated 9/8/12, 12/7/12, 1/8/13, and 1/24/13 showed the resident had a high risk for falls with scores of 16-23 (total score of 10 or above represents high risk). Review of the medical record showed the resident had 14 falls between 10/3/12 and 1/14/13. The following concerns were identified: a. On 10/3/12 at 1:30 AM the resident was found on the floor near the bed after staff heard the bed alarm. The resident stated s/he was trying to get to the wheelchair. Review of the recommendations from the post-fall evaluation dated 10/15/12 included the following: continue the falling star program, continue to keep alarms on the bed and wheelchair, have the resident wear non-skid socks in bed, and ensure the night light in the bathroom was turned on at bedtime. Further review of the medical record showed on 10/3/12 at 3:25 AM the staff again responded to the bed alarm and witnessed the resident falling to the floor. The resident was observed by staff to	F 323	ensure continued compliance. Date of Compliance:	03/12/13

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F 323	Continued From page 14 "bump [his/her] head on dresser." Review of the 1/21/13 care plan showed no evidence leaving the night light on at night was included in the care plan. b. On 10/23/12 at 10:45 AM the resident was found on the bathroom floor. The wheelchair alarm did not sound but the resident did pull the emergency call light. Review of the post-fall evaluation dated 10/24/12 showed the following recommendations: continue to keep the alarm on the wheelchair and make sure it was attached and working, and to continue the falling star program. Review of the medical record revealed no evidence staff checked the alarm on the wheelchair to determine why it did not alarm at that time. c. On 10/24/12 at 11:30 PM the resident was found on the floor by the bed "messing with the pressure alarm box to [his/her] wheelchair." Review of the post-fall evaluation dated 10/25/12 showed no evidence earlier recommendations had been implemented such as wearing non-skid socks while in bed or whether the bed alarm was functioning properly. One new intervention was recommended which was to place a fall mat next to the resident's bed. Review of the 1/21/13 care plan showed this recommendation was not added to the care plan as an intervention. d. On 10/28/12 at 7:45 AM the resident was observed sleeping in his/her wheelchair at the nurses' desk and "jerked self awake, pitched out of wc [wheelchair]." Review of the 10/29/12 post-fall evaluation showed the only new recommendation was to assist the resident to bed when s/he "falls asleep" in the wheelchair. Review of the 1/21/13 care plan showed this intervention was not added. e. On 12/13/12 at 9:45 PM the resident	F 323		

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F 323	Continued From page 15 was found on the floor next to the bed. Review of the post fall evaluation dated 12/14/12 showed no evidence the resident was assessed to determine if the recommended interventions had been implemented to possibly prevent this fall. There was no evidence the bed alarm was working or the resident had on his/her non-skid socks while in bed. Continued review of the post-fall evaluation showed the only recommendation was to "allow resident to adjust to new room mate, if unsuccessful will eval [evaluate] for room change." f. On 12/15/12 at 9:45 PM the resident was found sitting on the floor mat next to the bed. There was no evidence the bed alarm was assessed to determine if it was properly working. Review of the 12/17/12 post-fall evaluation showed recommendations were to follow all current interventions and to obtain an occupational therapy (OT) evaluation. Review of the 12/21/12 OT evaluation showed the core issue related to falls was the resident's poor safety awareness. Continued review of the OT assessment showed a goal to increase the resident's safety awareness, however, no new interventions were developed or implemented over the next four weeks of therapy. g. On 12/25/12 at 6 AM the resident was found sitting on the floor by the bed. There was no evidence the bed alarm was assessed to determine if it was properly working. Review of the 12/26/12 post-fall assessment showed recommendations were to continue using the high-low bed, the fall mat next to the bed, the alarm to the wheelchair, and for "staff to encourage res [resident] to use call light for assistance." h. On 12/28/12 at 9:40 AM the resident	F 323		

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F 323	Continued From page 16 was found on the floor by the door to his/her room. Review of the post-fall evaluations dated 1/28/12 and 1/3/13 showed no new recommendations were made. i. On 1/6/13 at 5 AM the resident was found on the floor by the bed. Review of the post fall evaluation dated 1/7/13 showed no new recommendations were made. j. On 1/6/13 at 2 PM the resident was found on the floor in the resident's room near the wheelchair and bed. Review of staff documentation showed "alarm was not sounding, but seems to work after we put back". Review of the post-fall evaluation dated 1/7/13 showed no new recommendations. k. On 1/8/13 at 7:15 AM the resident was found on the floor by the wheelchair. Review of the 1/8/13 nursing notes showed the resident received a laceration to the forehead and nose, and a "ST [skin tear] to (L) wrist and bruise to (L) side." Review of the 1/10/13 post-fall evaluation showed "will attempt tabs alarm to chair instead of pressure to decrease agitation. " However, review of the 1/21/13 care plan showed no evidence this was added to the care plan or any other interventions were implemented to try to decrease the resident's agitation. Review of the entire medical record showed no evidence staff assessed the impact of the resident's agitation on his/her frequent falls. l. On 1/11/13 at 4 PM the resident was found on the floor in front of the wheelchair near his/her room. Review of the 1/14/13 post-fall evaluation showed no additional recommendations were made except to encourage the resident to rest in bed when s/he was tired. Review of the 1/21/13 care plan showed this intervention was not incorporated	F 323		

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F 323	Continued From page 17 into the plan. m. On 1/14/13 at 11 AM the resident slid to the floor during an assisted transfer from the wheelchair to the bed. Review of the 1/15/13 post-fall evaluation showed one new intervention which was to obtain a pharmacy consultation to determine if medications were a contributing factor in the resident's multiple falls. On 1/15/13 at 12:18 PM, an e-mail was sent to the pharmacy representative requesting a medication evaluation for the resident related to his/her frequent falls. The same request was made again 1/28/13 at 9:04 AM because the pharmacist had not yet responded. The pharmacist replied by e-mail on 1/28/13 at 2:41 PM, 13 days after requested. n. Review of the 1/21/13 care plan and the care plan reviews dated 1/10/13, 1/14/13 and 1/24/13 showed no evidence the interventions recommended by the fall team on their post-fall evaluations were incorporated into the plan. Recommendations that were not included were: leaving the night light on in the bathroom, assuring all alarms were working, using a high-low bed, placing a fall mat by the bed, and addressing how the resident's agitation impacted his/her falls. Interview on 1/31/13 at 11:15 AM with the DON revealed staff were aware of the resident's frequent and multiple falls. The DON said "[s/he] has been a hard one". The DON verified not all recommended interventions were included on the care plan. Review of the facility policy, Fall Management dated August, 2012 showed falls were communicated to the IDT (interdisciplinary team) by the nursing 24 hour report. The responsibilities of the IDT team included the review of all falls	F 323		

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F 323	Continued From page 18 within 24-72 hours; revisions to the plan of care; and placing and removing residents from the falling star program. According to the same policy, the falling star is a "visual identifier/reminder" program to recognize residents at risk for falls.	F 323	Tag 368-It is the intention of the facility to offer snacks at bedtime daily. Corrective Action : HS snacks are offered to current residents since 3/1/13. ID of Others: Ambassador /designees will conduct Random Interview of current residents to determine if the residents were offered HS snack daily. System Measures: SDC/designee will provide Education to nursing and dietary staff of importance of offering HS snacks daily to current residents on or before date of compliance. Activity Director/designee will review with residents during resident council if they are they are being offered HS snacks daily. Ambassador/designee will do weekly audits to see if residents received their HS snacks daily x 4 weeks than random monthly audits x 2. Monitoring: The Unit Manager/Designee will track and trend audits and determine patterns based on a review that will determine the effectiveness of interventions. The results of this review will be shared with the QAPI Committee monthly. QAPI committee will evaluate the effectiveness of this plan and will imple ment additional interventions, as needed, to ensure continued compliance. Date of Compliance:	03/12/13
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 resident and staff interviews, the facility failed to offer snacks to all residents prior to bedtime. The resident census was 90 at the time of the survey. The findings were: During a confidential interview on 1/29/13 at 2:30 PM, nine residents stated they were not offered a snack at bedtime. Interview with CNA #2 on	F 368		

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F 368	Continued From page 19 1/30/13 at 3:55 PM and CNA #3 on 1/30/13 at 4:06 PM verified that residents were not offered a bedtime snack. Interview with the kitchen manager on 1/30/13 at 4:06 PM also verified that bedtime snacks were not offered to all residents. Interview with resident #26 on 1/30/13 at 4:15 PM and with resident #25 at 4:20 PM revealed the facility did not offer them snacks at bedtime.	F 368	Tag 371- It is the intention of the facility to store, prepare, distribute, and serve food under sanitary conditions. Corrective Action: Stand Mixer was cleaned on 1/28/13. The electric slicer was cleaned and counter underneath was cleaned on 1/28/13. ID of Others: Kitchen Sanitation Check list was conducted on or before date of compliance by regional RD for proper cleanliness of kitchen. System Measure: RD/ designee will provide Education to all dietary staff on proper cleaning technique .	
F 371 SS=E	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 observation and staff interview, the facility failed to ensure food equipment in the kitchen was in a sanitary condition. The findings were: Observation on 1/28/13 at 9:30 AM and later that day at 5:25 PM showed the stand mixer had dried food splatters on and under the mixing arm. The mixer was not in use at those times. In addition, the electric slicer which was stored under a plastic covering was noted to have dried-on food in many of the crevices of the equipment, and on the slicer blade. Also, the area of the counter underneath the slicer was not clean having	F 371	Dietary Manager/designee will do random checks 3 x a week to ensure cleaning schedules are followed. RD/designee will do a weekly Sanitation checklist x4 weeks and than random monthly audits x2 months. Monitoring : The Dining Manager/Designee will track and trend sanitation audits and determine patterns based on a review , and determine the effectiveness of interventions. The results of this review will be shared with the QAPI Committee monthly. QAPI committee will evaluate the effectiveness of this plan and will implement additional interventions, as	

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F 371	Continued From page 20 evidence of dried food particles. Interview with the acting manager on 1/28/13 at 5:25 PM verified the equipment needed to be cleaned more thoroughly. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371	Tag 425 It is the intention of the facility to provide routine and emergency drugs and biological to its residents. Corrective Action: On 1/28/13 Pharmacist recommendation of a decrease in #90 Zyprexia from 5mg to 2.5mg ID of Others: An audit of facility requests for medication evaluation for the last 30 days was completed on or before date of compliance. System Measures: Division Director of Pharmacy services/designees will educate the consulting Pharmacist on completing the medication reviews on identified frequent fallers timely. IDT team will contact Division Director of Pharmacy Services if no response from consulting Pharmacist with in 3 business days of requesting a medication evaluation.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		
	This REQUIREMENT is not met as evidenced			

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F 425	Continued From page 21 by: Based on staff interview and medical record review, the facility failed to ensure timely pharmacy services were provided for 1 of 18 sample residents (#90). The findings were: Review of the medical record showed resident #90 was admitted on 8/12/12 with diagnoses including mental retardation, senile dementia, arthritis, and depression. Review of the medical record showed the resident had 14 falls between 10/3/12 and 1/14/13. Review of the 1/15/13 post-fall evaluation showed the fall team recommended a pharmacy consultation to determine if medications were a contributing factor in the resident's multiple falls. Review of the medical record showed no documentation of the pharmacy evaluation, however on 1/30/13, the DON provided e-mail communication between the facility and the pharmacy showing on 1/15/13 at 12:18 PM, an e-mail was sent to the pharmacy representative requesting a medication evaluation for the resident related to his/her frequent falls. Due to a lack of response by the pharmacist, the same request was made again on 1/28/13 at 9:04 AM. The pharmacist replied by e-mail on 1/28/13 at 2:41 PM, 13 days after requested. Interview with the DON on 1/31/13 at 11:15 AM revealed the resident's Zyprexia was reduced from 5 milligrams (mg) to 2.5 mg on 1/29/13.	F 425	Monitoring: The DON/Designee will track and trend the requests for the timeliness of medication evaluations,to determine patterns based on the timeliness of interventions. The results of this review will be shared with the QAPI Committee monthly. QAPI committee will evaluate the effectiveness of this plan and will implement additional interventions, as needed, to ensure continued compliance. Date of Compliance: Tag 441-It is the intention of the facility to 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. Corrective Action: Antibiotics was start on resident #32 on 1/16/13. Antibiotic was started on resident #90 on 1/15/13. ID of Others: SDC/designee will review the last two weeks starting February 1, 2013 . Of identified infections to ensure that follow up and investigation was completed in a timely manner.	03/12/13
F 441	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	F 441		

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F 441	Continued From page 22 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 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 review of the infection control program documentation, staff interview, medical record review, and review of the 24-hour nursing shift	F 441	System/Measure: SDC/designee will provide education to licensed nursing on or before date of compliance on infection control protocol once an infection is Identify the nurse will notify primary care physician if no response with in 24 hours will notify Medical Director. Unit managers/designee will review 24 hour report for any newly identified infections daily Monday thru Friday to ensure timely interventions are in place Monitoring: The SDC/Designee will track and trend and audits, determine patterns based on a review infection log to determine the timeliness of interventions. The results of this review will be shared with the QAPI Committee monthly. QAPI committee will evaluate the effectiveness of this plan and will implement additional interventions, as needed, to ensure continued compliance. Date of Compliance: TAG 465 Corrective Action: Residents #70 bath room was cleaned on 1/31/13. Residents #83 floor was cleaned on 1/31/13. ID of Others : An audit to be completed on or before date of compliance of residents rooms for dried urine on floor.	03/12/13

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F 441	Continued From page 23 reports, the facility failed to ensure an effective infection surveillance and treatment program was in place. The program failed to address identified infections with timely treatment interventions for 2 of 15 sample residents (#32, #90). The findings were: 1. Review of the 1/7/13 nursing notes timed at 10:50 PM for resident #32 showed his/her left eye was red and had yellow drainage. Review of the 24-hour nursing report dated 1/8/13 showed the potential eye infection for this resident was noted. However, continued review of the medical record showed the physician was not notified of the potential eye infection until 1/13/13, six days after it was identified. The physician ordered eye drops on 1/14/13 to treat the infection; however, the eye drops did not arrive from the pharmacy until 1/16/13. Nine days lapsed from the time the infection was identified on 1/7/13, until treatment began on 1/16/13. Interview with the infection control coordinator on 1/31/13 at 10:45 AM revealed he was aware of the eye infection but had not yet performed any investigation or follow-up. He said a nine day delay in treatment was too long and staff should have notified the physician sooner. 2. Review of the medical record showed resident #90 had a urine culture and sensitivity ordered by the physician on 1/7/13. The test results were received by the facility on 1/11/13. The results were faxed to the physician on 1/11/13 at 1:15 PM. Because they received no orders or response from the physician by 9:30 PM that same evening, the test results were faxed again. The order for the antibiotic to treat the urinary tract infection was not received from the	F 441	Systems Measures: SDC/designee will provide education to facility staff on providing a safe, functional, sanitary and comfortable environment for residents, staff and the public. In addition remind that all staff has access to housekeeping supplies including mops and disinfectants. Maintenance/ designee will do daily rounds of facility x3 for urine odors. Housekeeping Staff/ designee will track the times of cleaning residents #70 bathroom and resident #83 floor daily. Monitoring: The Maintenance/Designee will track and trend audits to determine patterns based on a review of daily facility rounds, and determine the effectiveness of interventions. The results of this review will be shared with the QAPI Committee monthly. QAPI committee will evaluate the effectiveness of this plan and will implement additional interventions, as needed, to ensure continued compliance Date of Compliance:	03/12/13

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F 441	Continued From page 24 physician until 1/14/13, resulting in a three day delay in starting treatment. Interview on 1/31/13 at 10:45 AM with the infection control nurse revealed that the nursing staff was responsible for communicating with the physician and should have followed up to obtain an order for antibiotics sooner than the three days.	F 441		
F 465 SS=D	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 by: Based on observation and staff interview the facility failed to maintain a sanitary, odor free environment for 2 of 2 non-sample residents (#70, #83). The findings were: 1. During an observation on 1/28/13 at 11:20 AM and 1:50 PM, a strong urine odor was detected in the north-west hallway. During an interview with the maintenance director on 1/30/13 between 11 AM and 11:30 AM, he said residents #70 and #80 were known to urinate on the floor in their rooms. The following concerns with maintaining a sanitary environment were identified: a. During an interview on 1/30/12 at 2:15 PM, the unit manager #2 stated resident #70 misses both the urinal and the toilet when urinating. Unit manager #2 also said resident #83 purposefully urinated on the floor. b. Observation on 1/31/13 at 8:35 AM showed dried urine in front of the toilet (1 square foot) in	F 465		

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F 465	Continued From page 25 the room of resident #70. Additionally, a large area (4 square feet) of dried urine was observed next to the bed in the room of resident #83. Both rooms and the hallway had a strong odor of urine. Observation on 1/31/13 at 9:30 AM with unit manager #2 verified the strong odor of urine, fresh and dried, was still present in those rooms and in the adjacent hallway. c. Interview with the infection control coordinator on 1/31/13 at 10:45 AM revealed that housekeeping supplies including mops and disinfectants were available to staff 24 hours per day and confirmed that using paper towels to clean the urine on the floors was not adequate.	F 465		