STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 03/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

(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: ADLs - Activities of Daily Living CAAs - Care Area Assessments CNA - Certified Nursing Assistant DON - Director of Nursing IP - Infection Preventionist LPN - Licensed Practical Nurse MAR - Medication Administration Record MDS - Minimum Data Set mg - milligrams RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
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 and staff interview, the facility failed to maintain a dignified setting for residents during 3 of 3 meal observations in the South Fork dining room that included 2 sample residents (#13, #25) and 3 non-sample residents (#10, #23, #75). The findings were: 1. Observation of the evening meal on 3/11/13 from 5:25 PM through 6:07 PM identified the following concerns:	F 241	**F241** **1. Residents #10, #23, #13, #75 and #25 continue to be served meals in the South Fork Dining Room with no evidence of psychosocial trauma as a result of a) the inappropriate staff to resident interaction b)inappropriate assistance with feeding, c) being left alone in the dining room.** **2. All residents who are served meals in the south fork dining room are at risk for inappropriate staff to resident interaction, inappropriate feeding techniques and being left alone in the dining room.**	

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

Tonya M — Executive Director — 5-3-13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that feguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days g 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

OVER

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F 241	Continued From page 1 a. Observation showed there were two residents (#10, #23) in the South Fork dining room who required total assistance with eating. A third resident, #25, was seated at the same table and required extensive assistance with the meal. Observation showed resident #25 was scooping his/her food from the plate onto a napkin whereupon CNA #2 said "stop putting food on your napkin" in a cross tone of voice. In addition, RN #1 said to the CNA "Yeah [resident's name] sometimes eats and sometimes [s/he] plays with it." The RN then said to the CNA "I'm sure glad you came down because I wasn't sure how I was going to feed these two (#10, #23) and [him/her] too", nodding her head towards resident #25. Both staff members were talking to each other as though the residents were not present throughout the meal. b. Observation of the evening meal on 3/11/13 from 5:25 PM through 6:07 PM showed RN #1 was providing total assistance with the meal for residents #10 and #23 at the same time. The RN would feed one bite to resident #10 with her right hand and then one bite to resident #23 with her left hand, back and forth in a robotic manner without engaging either resident. During the entire observation the RN visited with the CNA assisting the third resident (#25) at the table and did not attempt to interact with either resident (#10, #23) she was assisting. Further observation showed as the RN was feeding resident #23, she was spilling food down the resident's chin and onto his/her clothing protector. The RN continued to feed the resident for six minutes before she wiped the food off the resident's chin and mouth and did so then because the resident coughed some food out of his/her mouth and onto the RN's hand. The RN said "eww" and then wiped	F 241	**3. All staff were in serviced by SSD and DON in-serviced nursing staff regarding the following; a). Appropriateness of staff to resident interactions during meal service, b). Appropriateness related to feeding techniques during meal service, c). regarding the need to assist residents out of the dining room to engage in activities or to lie down. The South Fork dining room a.m. and evening meals will be monitored daily 5x/week for one week and weekly x3/weeks and monthly x2/months to ensure the following; the appropriate staff to resident interactions are taking place during the entire meal service, appropriate feeding techniques are being used through the entire meal service, and residents are assisted out of the dining room and offered to engage in activities or to lie down.** **4. Results of the audit will be reported to the PI committee for the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13

5/3/13 This POC accepted by/per Tonya Murner - Administrator and Tony Madden, Surveyor.

5/3/13

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F 241	Continued From page 2 the food off of her hand with a napkin. She then wiped the resident's mouth and chin with a different napkin. c. During this same meal observation the RN and CNA were calculating meal intake and the CNA said "I think s/he (referring to resident #25) ate 50%" to which the RN responded "No I think by the time [s/he] is done [his/her] intake will be 75%". The CNA then said "No I mean [him/her]" nodding his head towards resident #25. The RN replied "Oh I thought you meant [called resident #23 by only his/her last name]". Again, both staff members were talking to each other as though the residents were not present. d. Observation showed the two staff members visited with each other during the entire meal observation referring to the residents in an impersonal manner and did not attempt to include any of the residents in their conversation. 2. Observation on 3/12/13 during the latter part of the breakfast meal from 9:35 AM through 11 AM showed five residents, #25, #23, #10, #13, and #75 remained in the south fork dining room with no staff present. Observation revealed residents #23, #75, #25, and resident #10 were asleep in their chairs at the table. Resident #25 laid his/her head on the table. Resident #13 was propelling his/herself about the dining room in the wheelchair. At 10:17 AM, observation showed CNA #3 said "HI" to resident #25. Resident #25 responded by saying, "I can't walk" and the CNA laughed then walked away. The resident put his/her head back down on the table and slept. No staff member offered to assist the resident to bed to get some rest or assist him/her to a more comfortable setting.	F 241		

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F 241	Continued From page 3 3. Interview with the unit manager and DON on 3/13/13 at 4:20 PM revealed all staff had been educated on treating residents with dignity. Both the DON and unit manager agreed the above behaviors were not respectful towards the residents and did not maintain their dignity.	F 241		
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 by: Based on observation, resident interview, staff interview, and medical record review, the facility failed to ensure individualized care plans were developed and activities were provided to facilitate a meaningful rhythm of life for 4 (#13, #25, #47, #52) of 13 sample residents. The findings were: 1. Review of the 2/5/13 annual MDS assessment for resident #25 showed s/he was sometimes able to understand and be understood. Further review of this MDS assessment in regard to daily/activity preferences showed reading and religious activities were very important to him/her. Review of the 3/5/12 CAA showed the resident had short and long term memory loss and often spoke in nonsensical sentences. Further the review showed the resident occasionally attended an activity program but needed lots of encouragement and reminders to do so. Finally	F 248	**F248.** **1. Resident #25, care plan was updated to reflect specific individual activity interventions. Activity calendars were updated to reflect South Fork groups being offered 7 days a week. Resident # 25 was offered the opportunity to participate in activities after meals. Resident # 25 is offered 1:1 program. Resident #13, #47 are offered 1:1 program 2-3 times a week as indicated on the care plan. Activity personnel continue to explore and offer interventions to calm resident #13. Resident #52 activity preferences were reevaluated.** **2. All residents are at risk for their activity care plan not being followed related to the above mentioned issues.** **3. All Activity staff will be in serviced related to issues mentioned above. A Performance Improvement audit will be conducted to ensure all residents activity care plans and activity preferences are being followed. Following a 100% audit, a random audit of 10% of activity care plans will be conducted monthly x3/months to ensure activity compliance.**	

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F 248	Continued From page 4 the assessment showed the resident benefited from task segmentation. The following concerns were identified: a. Review of the care plan for activities showed no specific interventions; only to invite and encourage the resident to participate in South Fork groups and to offer task segmentation, cues and prompting. b. Review of the activity calendars for February 2013 and March 2013 revealed only one South Fork group was offered Monday through Friday with nothing on the weekends. c. Periodic observations on 3/11/13, 3/12/13, and 3/13/13 at various times of the day and evening showed the resident was seated at the table in the dining room with his/her head on the table or seated in a recliner in the dining room. Only one attempt at an activity was observed during the three days of observation. That observation occurred on 3/12/13 and was a music activity held from 10:30 AM to 11 AM. The resident slept during most of the activity. d. Interview with the activity director on 3/14/13 at 10:20 AM revealed she thought the resident would probably benefit from a 1:1 program, but said she currently did not have enough staff to work with the resident 1:1. 2. Review of the 2/28/13 annual MDS assessment for resident #13 showed s/he was rarely or never understood and rarely or never able to understand. Additionally, review of this MDS assessment showed music, spending time outdoors, and religious activities were very important to him/her. Review of the 2/25/13 care plan for activities showed one approach was to offer the resident 1:1 visits 2 to 3 times per week for sensory interventions such as lotions, tactile,	F 248	**4. Results of the audits will be presented at the Performance meeting for at least the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13

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F 248	Continued From page 5 strolls, music, and stuffed animals. The following concerns were identified: a. Review of the record of 1:1 activities form showed the resident was offered 1:1 visits only once during the first two weeks of February 2013. Review of the March 2013 record of 1:1 activities form showed the resident was offered 1:1 activities only once during the first and second weeks. Interview with the activities director on 3/14/13 at 10:20 AM verified the care plan was not followed as written in regard to offering the resident 1:1 sensory visits 2 to 3 times per week on a consistent basis. b. Periodic observations on 3/11/13, 3/12/13, and 3/13/13 showed the resident cried out and moaned while in his/her room when his/her spouse was not visiting. Specifically, the resident cried and screamed out from 1:40 PM to 3:30 PM on 3/12/13. It was noted the resident calmed when the activity therapist spent time rubbing his/her shoulders for a few minutes at 1:55 PM then began screaming again when the therapist left the room. The activities director stated in interview on 3/14/13 at 10:20 AM that an ongoing staff shortage prevented her from keeping up with the needs of each resident. 3. Review of the 11/26/12 annual MDS assessment for resident #47 showed s/he had short term memory loss, dementia and moderate independent decision making skills. This review also showed the resident was able to eat with supervision but required extensive assistance with all other ADLs. Further review revealed his/her most important activity preferences were "reading materials, news, and favorite activities." Review of the individual resident daily participation record showed the primary activities	F 248		

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F 248	Continued From page 6 provided for the resident during January 2013, February 2013, and two weeks in March 2013 were television, walking in his/her room, puzzles, and staff visits. During the interview on 3/14/13 at 9:45 AM, the activities director verified the primary activities were provided as documented. At that time she acknowledged the inconsistency in the resident's activity preferences and the activities that had been provided. Periodic observations on 3/11/13, 3/12/13, and 3/13/13, revealed the resident remained in his/her room during scheduled group activities. Only one attempt to encourage activity participation was observed during the three days observation. That observation occurred on 3/12/13 at 9:40 AM, and the resident refused. Interview with the resident on 3/12/13 at 10:40 AM revealed s/he was not interested in the morning music activity. 4. Review of the 12/5/12 significant change MDS assessment for resident #52 showed s/he had moderate cognitive impairment and required extensive assistance with all ADLs. Review of the CAAs showed the resident returned to the facility after a short stay hospital admission and had not been as active as prior to the hospitalization. Review of the 12/5/12 care plan showed staff were to invite and encourage the resident to attend activities of interest such as parties, music, games, outings, and special events. The following concerns were identified: a. Review of the individual resident daily participation records for January 2013, February 2013 and March 2013 revealed s/he participated in games 2 times and refused 18 times during the three months. This review also showed participation in 9 parties with 4 refusals and no participation in outing or special events.	F 248		

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F 248	Continued From page 7 b. Interview with the activities director on 3/14/13 at 9:45 AM revealed the primary activities provided for the resident was television, staff visits and walking in his/her room. She further stated she knew the resident was not as active after returning from the hospital, but the resident's activities had not been re-evaluated accordingly due to staff shortages.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided 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 ensure staff developed an individualized activity care plan for	F 279	**F279** **Resident #25, care plan was developed/updated to reflect specific individual activity interventions.** **2. All residents are at risk for their activity care plan not being followed related to individual activities.** **3. All Activity staff will be in serviced related to developing/updating individualized care plans. A Performance Improvement audit will be conducted to ensure all residents have individualized activity care plans. Following a 100% audit a random audit of 10% of activity care plans will be conducted monthly x3/months to ensure presence of an individualized activity care plan.** **4. Results of the audits will be presented at the Performance meeting for at least the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13

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F 279	Continued From page 8 1 of 13 sample residents (#25). The findings were: Review of the 2/5/13 annual MDS assessment for resident #25 showed s/he was sometimes able to understand and be understood. Further review of this MDS assessment in regard to daily/activity preferences showed reading and religious activities were very important to him/her. Finally the assessment showed the resident benefited from task segmentation. Review of the 3/5/12 activities assessment showed the resident enjoyed pets, walking, music, radio, and family visits. Review of the 2/7/13 activity progress notes showed the resident's family lived out of the area so were unable to visit regularly. Review of the 3/5/12 activities CAA showed the resident had short and long term memory loss and often spoke in nonsensical sentences. Further, the review showed the resident occasionally attended an activity program but needed lots of encouragement and reminders to do so. The following concerns were identified: a. Review of the care plan for activities showed no specific interventions were developed; only to invite and encourage the resident to participate in South Fork groups and to offer task segmentation, cues and prompting. b. The activities director verified in interview on 3/14/13 at 10:20 AM this resident's care plan had no specific interventions established for staff to follow.	F 279		
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	F 282	**F282** **1. All residents' activity care plans are at risk for not being followed including resident #13.**	

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F 282	Continued From page 9 care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed the activity care plan for 1 of 13 sample residents (#13). The findings were: 1. Review of the 2/28/13 annual MDS assessment for resident #13 showed s/he was rarely or never understood and rarely or never able to understand. Additionally, review of this MDS assessment showed music, spending time outdoors, and religious activities were very important to him/her. Review of the 2/25/13 care plan for activities showed one approach was to offer the resident 1:1 visits 2 to 3 times per week for sensory interventions such as lotions, tactile, strolls, music, and stuffed animals. However, review of the record of 1:1 activities form showed the resident was offered 1:1 visits only once during the second and fourth weeks of February 2013. Review of the March 2013 record of 1:1 activities form showed the resident was offered 1:1 activities only once during the first and second weeks. Interview with the activities director on 3/14/13 at 10:20 AM verified the care plan was not followed as written in regard to offering the resident 1:1 sensory visits 2 to 3 times per week on a consistent basis. The director also said she had been short one staff member for awhile and it was hard to keep up with the needs of residents.	F 282	**2. Activity staff will be in-serviced by regarding the importance of following residents' activity care plans. A random audit of 10% of residents' activity care plans will be conducted monthly x3/months to ensure they are being followed.** **3. Results of the audits will be presented at the Performance meeting for at least the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314	**F314** **1. Resident # 40 skin breakdown is being assessed, monitored and appropriate interventions are in place.**	

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F 314	Continued From page 10 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, review of facility policies and procedures, and medical record review, the facility failed to ensure staff assessed, monitored, and implemented measures to prevent and treat skin breakdown for 1 (#40) of 1 sample resident who had skin breakdown. The facility's failure to provide timely assessments, interventions, and monitoring resulted in harm for resident #40. The findings were: Review of the medical record for resident #40 showed s/he was re-admitted on 7/2/12 with diagnoses including late effects of CVA (cerebral vascular accident), muscle weakness, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. Review of the 12/8/12 significant change MDS assessment showed the resident had no pressure ulcers at this time but was at risk according to the Braden risk skin assessments performed on 10/5/12 (score of 18) and 12/27/12 (score of 17). Review of the Braden risk skin assessment scores for 1/11/13, 1/23/13 and 1/30/13 showed scores of 14. Braden risk assessment scores of 14 indicate the resident's risk of developing a pressure ulcer was higher	F 314	**2. Following a 100% audit all residents identified with skin breakdown have been assessed, monitored and appropriate interventions are in place.** **3. Nursing staff will be in-serviced regarding the importance of timely assessments, interventions and monitoring of skin breakdown. All residents with skin breakdown will be monitored to ensure assessments; interventions and monitoring of skin breakdown are being conducted through re-education of nursing staff, daily audits by unit managers of weekly skin assessments to ensure compliance per policy and proper interventions and treatments are in place. Audits will take place 5x/week x1/week and weekly x3/weeks and monthly thereafter x2/months.** **4. Results of the audits will be presented at the Performance meeting for at least the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13

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than in December 2012 when the previous Braden risk assessment was performed on 12/27/12. The following concerns with pressure ulcer assessment, notification, and management were identified:

a. Review of the March 2013 physician's recapitulation of orders showed an order dated 7/2/12 for weekly skin checks. However, review of the weekly skin integrity data collection flow sheet showed the skin checks were performed on 12/18/12 then not again until 1/1/13, 14 days later instead of the ordered every 7 days. Further review of the weekly skin integrity data collection flow sheets showed the check was performed on 1/15/13 and then not again for another 13 days on 1/28/13. The resident developed a pressure ulcer on the right heel on 1/11/13 and one on the left heel on 1/24/13. Interview with the DON and unit manager on 3/13/13 at 4:20 PM revealed the weekly skin checks should have been performed weekly not every other week.

b. Review of the 1/8/13 weekly skin integrity data collection flow sheet showed the resident's skin was intact. Review of the pressure ulcer status record dated 1/11/13, three days later, showed a pressure ulcer was first observed on the right heel on 1/11/13 which was unstageable. Further review of this document showed the physician was not notified until 1/15/13. Review of the 1/15/13 computerized nursing notes timed at 3:19 PM showed a late entry for 1/13/13 indicating the nurse documented her concern about "a spot of skin" on the outside of the resident's right heel that appeared to be an area of concern. Further review of these computerized nursing notes showed the physician, family, DON and wound nurse manager were notified of the pressure ulcer on 1/13/13. However, review of the

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F 314	Continued From page 12 handwritten wound nursing notes showed no documentation in regard to pressure ulcers prior to the 1/15/13 nursing notes timed at 9:30 AM. Based on inconsistencies in the documentation it was unknown whether the pressure ulcer was identified on 1/11/13 or 1/13/13. It was also unclear whether the physician was notified on 1/13/13 or 1/15/13. In addition, review of the 2/5/13 nutrition assessment, performed after the development of two pressure ulcers in January 2013, showed the resident's skin was intact which was incorrect. c. Based on review of the 1/24/13 pressure ulcer status record and the 1/24/13 timed at 7:56 AM nursing notes, the resident had developed a pressure ulcer on the left heel, also unstageable, in addition to the one on the right heel. Review of the medical record showed the first physician's orders for wound treatment was on 1/23/13, making it 12 days from when the first pressure ulcer was identified on 1/11/13 or 10 days if the pressure ulcer was identified on 1/13/13. A second pressure ulcer developed between when the physician was first notified and when the first physician orders were written. d. Review of the pressure ulcer status records for the right heel entries on 1/11/13, 1/17/13, 1/24/13, 2/15/13, 2/21/13, 2/28/13, 3/8/13 and 3/15/13 showed the right heel caused the resident pain. Interview with the resident on 3/12/13 at 10 AM revealed the right heel was painful, especially during dressing changes and when anything touched the area. e. The inconsistencies in various clinical records made it impossible to determine the timeliness of identification and physician notification in regard to the pressure ulcers. Review of the accumulated information did show,	F 314		

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F 314	Continued From page 13 however, the physician did not order any specific, individualized treatment until after the second pressure ulcer developed on 1/23/13. f. Review of the facility's policies and procedures regarding pressure ulcers, dated 10/7/10, showed instructions to do skin integrity assessment/checks weekly and to follow the residents' care plans and update them as necessary. Further review showed the "...facility's procedures are such that all disciplines are alerted immediately if the resident either has skin breakdown or is at risk for the development of skin breakdown. The Nursing department coordinates the response to resident needs (in the area of skin integrity) by the following means....With an array of preventative measures practices on the resident's behalf when the resident has been identified as being at risk...."	F 314		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain a medication error rate under 5 percent (%). Out of 46 opportunities for errors, 4 errors were committed, resulting in an error rate of 8.6%. The residents affected by the errors were sample resident #52 and non-sample resident #59. The findings were: 1. On 3/12/13 at 9:25 AM, LPN #1 was observed	F 332	**F332** **1. All residents with inhalation related medications are at risk for not receiving proper instruction or assistance after use including resident #52 and #59.** **2. All nurses were in-serviced on March 25, 2013 regarding properly instructing and assisting residents following use of inhalation related medication. Random audits will be conducted by the DON or her designee with nurses daily 5x/week x1/week, weekly x3/weeks and monthly x2/months to ensure the proper instruction and assistance is provided to residents following inhalation medication administration.**	

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F 332	Continued From page 14 administering medications to resident #52 during the medication pass. The LPN administered 2 puffs of Dulera (a long-acting beta-agonist inhaled medication used for treatment of asthma symptoms and chronic obstructive lung disease (COPD)) 200 mcg/5mcg. During the observation, 16 seconds elapsed between the two puffs of Dulera. Eight seconds later, the LPN administered Spiriva (an inhaled anticholinergic bronchodilator used for treatment of asthma symptoms and COPD) 18 micrograms. The LPN completed the administration of the inhalers and departed without providing assistance or instructions for the resident to perform an oral rinse. 2. On 3/13/13 at 9:30 AM, RN #2 was observed administering medications to resident #59. The RN administered 2 puffs of Symbicort (a long-acting beta2-agonist inhaled bronchodilator medication used for treatment of COPD and asthma) followed by Spiriva 18 micrograms. During the observation, 20 seconds elapsed between the two puffs of Symbicort. The RN did not assist or provide the resident with an oral rinse after the first inhaler, and the resident drank the water the RN gave him/her after the second inhaler was administered. 3. According to the following acceptable standards of practice, the oral rinses that were not done, and administration of long-acting beta-agonist inhalers with shorten time intervals between puffs were the 4 medication errors observed during the medication pass: a. Review of the Expert Panel Report 3 (EPR3: Guidelines for Diagnosis and Management of Asthma from the National Heart	F 332	**3. Results of the audits will be presented at the Performance meeting for at least the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13

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F 332	Continued From page 15 Lung and Blood Institute (a division of National Institutes of Health) updated April 2007 page 151 at http//www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf, revealed there should be a waiting time of approximately one minute between puffs for metered dose inhalers. The exception is for short-acting beta-agonists, where a shorter wait time of 15 - 30 seconds is acceptable. This information was accessed on 3/22/13. b. Review of the manufacturer's recommendations revealed an oral rinse should be performed after receiving Symbicort and Dulera inhalers to prevent oral candidiasis (thrush). 3. Interview on 3/14/13 at 9 AM with the DON and administrator revealed all of the nurses were expected to ensure residents performed an oral rinse after using inhalers.	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356	**F356** **1. Nurse staffing is being posted and audited each shift. No permanent copy of each shifts staffing posting can be retrieved for the last 18 months.** **2. Permanent copies of the nurse staff postings are currently being kept daily.** **3. The Staff Development Coordinator was in-serviced regarding updating and retaining permanent copies of the nurse staffing posting according to regulation. DON will audit the daily postings and retention of copies 5x/week x1/week, weekly x3/weeks and monthly x2/months.**	

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F 356	Continued From page 16 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to complete the nurse staff posting at the beginning of each shift during 4 of 4 days of the survey. In addition, the facility failed to maintain permanent copies of the nurse staff posting for the required 18 months. The findings were: Upon entrance into the facility on 3/11/13 at 3:20 PM, observation revealed the nurse staff posting dated 3/11/13 had all three shifts posted at the same time. Periodic observations on 3/12/13, 3/13/13, and 3/14/13 revealed all three shifts were again posted at the same time. During an interview with the business office staff on 3/14/13 at 10:35 AM, she stated she posted the nurse staffing for the entire day (all three shifts) each day. In addition, the interview revealed business office staff did not maintain a permanent copy of each day's postings for the required 18 months.	F 356	**4. Results of the audits will be presented at the Performance meeting for at least the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13

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F 356	Continued From page 17 The business office staff member said she was unaware a permanent copy was to be maintained and the facility had never retained copies. Interview with the DON on 3/13/13 at 4:20 PM revealed she too was unaware of the requirement to maintain a permanent copy of the nurse staff posting for 18 months.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a proper plumbing system as evidenced by the presence of sewage gas in the kitchen dishwashing area. The findings were: 1. During observations on 3/11/13 at 4:48 PM and then again on 3/13/13 at 12:48 PM a sewage odor emanating from the kitchen dishwashing room was noted. Interview with the dishwasher on 3/11/13 at 4:48 PM revealed the odor came from the floor drains and had been noticed once or twice a week for approximately 2 months. Interview with the maintainance manager on 3/13/13 at 1:03 PM revealed the odor came up through either one of the two floor drains or	F 371	**F371** **1. The sewer smell from the floor drains in the dishwashing area of the kitchen were addressed by placing odor eliminators in the drain. A Plus Plumbers performed a test on 4/26/13 to determine if any pipes or traps in the kitchen/dish room areas have been cracked or are leaking.** **2. Odor eliminators were also placed in all 2 inch and 3 inch drains throughout the kitchen. No pipes or traps were found to be cracked or leaking.** **3. Kitchen staff were in-serviced regarding reporting sewer drain smells to Maintenance Director and E.D. Weekly audits will be conducted by ED for kitchen sewer drain smells for 3 months.** **4. Results of the audits will be presented at the Performance meeting for at least the next three months or until the committee determines substantial compliance has been met.**	4-28-13

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F 371	Continued From page 18 through the washing machine waste water discharge drain. He stated the sewage system drainage pipes occasionally dried out, and he poured water and a bacterial enzyme product into the drain to eliminate the odor. According to Food Code 2009 U.S. Public Health Service 5-205.15 A plumbing system shall be (A) Repaired according to Law; and (B) Maintained in good repair.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	**F441** **1.The facility is at risk of negative outcomes from poor infection control practices, poor monitoring and assessments related to infection control including residents #13, #4, #15, #18, #41, #65, #25, and #67** **2. Facility staff will be in-serviced on the importance of proper hand hygiene practices in regards to providing resident care, meal assistance, medication administration, exiting soiled utility rooms, and importance of offering hand hygiene for residents prior to and after meals and toileting. Also in-serviced staff on reporting any broken or cracked wall mounted hand hygiene dispensers to Maintenance Director. Housekeeping staff was in-serviced regarding maintaining clean red and yellow containers including lids. IP person was in-serviced regarding having mechanisms in place to monitor hand hygiene compliance among all staff and residents. A performance improvement audit tool will be used by the SDC or designee to**	

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F 441	Continued From page 19 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 observation, staff interview, and review of infection surveillance activities, the facility failed to promote a safe and sanitary setting for residents and staff. The facility failed to ensure staff used appropriate hand hygiene practices during 1 of 3 observations of perineal care, 1 of 3 licensed staff observed during medication administration, 2 of 3 housekeepers observed cleaning resident rooms, and 3 of 3 meal observations. The facility further failed to minimize the potential for spreading infection among staff using 2 of 2 soiled utility rooms and 3 of 12 wall-mounted hand hygiene product dispensers. In addition, the facility failed to implement a systematic process to monitor infection prevention practices among staff. The findings were: 1. Observation on 3/12/13 at 11 AM showed CNA #1 provided perineal care to resident #13. Continued observation showed the CNA removed the soiled gloves used during perineal care; however, she did not perform hand hygiene prior to assisting the resident from the toilet to a Hoyer lift and into his/her wheelchair. Continued observation showed the CNA repeatedly touched	F 441	**conduct random audits weekly x4/weeks and monthly x2/months of hand hygiene practices among all staff and residents. Housekeeping Supervisor will conduct weekly audits x4/weeks and monthly x2/months to ensure yellow and red containers and lids are cleaned. Housekeeping Supervisor will conduct random audits weekly x4/weeks and monthly x2/months of wall mounted hand hygiene dispensers to ensure proper functioning. DON will conduct monthly audits x3/months to ensure IP person has mechanisms in place to monitor, investigate and assess compliance rates of hand hygiene among all staff and residents.** **3. Results of the audits will be presented at the Performance meeting for at least the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13

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F 441	Continued From page 20 the resident's intact skin, hair, clothing, wheelchair, and other high-contact surfaces in the room. Observation showed the CNA applied lip balm to the resident's lips, again without having performed hand hygiene since assisting with perineal care. Perineal care involves cleaning body areas soiled with excrement. Review of the facility policy on using gloves, showed under section II E. "Wash hands after removing gloves. Gloves do not replace handwashing." Interview with the DON on 3/18/13 at 1:25 PM confirmed her expectation that the CNA wash her hands following perineal care, between glove changes, and before assisting with personal cares such as combing hair and applying lip balm. 2. Observation of medication administration on 3/12/13 at 11:15 AM showed RN #3 cleansed her hands with an alcohol-based hand rub (ABHR) prior to the start of the medication administration and at the completion of the medication administration. The RN administered medications to 1 sample resident (#4) and 5 non-sample residents #15, #18, #41, and #65 and failed to perform hand hygiene between each resident contact. During an interview on 3/13/13 at 11:20 AM with RN #3, she acknowledged her awareness of facility policies that required staff to perform hand hygiene between resident contact and, further, confirmed that she failed to do so. 3. Observation of the evening meal on 3/11/13 from 5:25 PM through 6:07 PM and the lunch meal on 3/13/13 from 12:07 PM through 1:05 PM revealed that none of the staff present in the dining area washed their hands when assisting	F 441		

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residents with their meals. During the breakfast meal on 3/12/13 CNA #3 was observed to repeatedly run her hands through her hair and wiped her nose with her hands while assisting resident #25 with his/her meal. The CNA was not observed to cleanse her hands at any time during the meal.

4. Additional observations of meal and snack times on 3/11/13 through 3/13/13 revealed multiple instances where facility staff ignored hand hygiene for residents. These observations highlighted the following concerns:

a. Observations of 3 meal times (evening meal on 3/11/13, breakfast meal on 3/12/13, lunch meal on 3/13/13) showed residents were not given the opportunity to wash their hands or assisted with hand hygiene prior to eating. In all 3 observations, residents were seen to touch high-contact surfaces such as wheelchair arms and wheels, table tops, hand rails, and horizontal and vertical surfaces for support. At none of the meal time observations in the main dining room did staff offer or assist residents with hand hygiene prior to serving the meal. Even though staff used an ABHR for themselves during meal service and feeding assistance, none were seen to offer the same opportunity to residents.

b. Review of the 12/12/12 quarterly MDS assessment and corresponding care plan for resident #67 showed s/he required extensive assistance with all ADLs due to cognitive impairment and decreased mobility. On 3/12/13 at 10:30 AM CNAs #6 and #7 assisted the resident with toileting in the bathroom. During the observation the resident touched the bathroom commode with his/her hands. The CNAs cleansed the resident's perineal area before

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F 441	Continued From page 22 transferring him/her to a wheelchair. Then CNA #6 wheeled the resident to the overbed table in the room and placed cookies on the table. The CNAs performed hand hygiene before departing from the room, but failed to do the same for the resident. The resident ate the cookies with unclean hands. 5. Observation of housekeepers #1 and #2 on 3/12/13 from 8:25 AM to 9:05 AM showed that both individuals wore gloves when cleaning resident rooms. However, neither individual changed their gloves throughout the 40-minute observation; nor did they perform hand hygiene during the observation. Further, housekeeper #2 was observed to repeatedly wipe her face and nose with her gloved hand while cleaning resident rooms and the adjacent corridor. 6. Observation while touring the facility on 3/11/13 at 4 PM and again at 5:30 PM of the north (Saddle Ridge) unit soiled utility room revealed that 2 red containers designated for biohazardous waste were soiled with dried, particulate matter and long, darkly stained lines that appeared to have resulted from material dripped over the containers, lids, and contact areas used to open and reseal the containers. Three additional yellow containers designated for soiled linens were also observed to be soiled with dried material on the lids. Observation in the South Fork unit hallway soiled utility room on 3/11/13 at 5:10 PM revealed 1 red waste container and 2 yellow containers were similarly soiled and dirty. Continued observations and staff interviews on 3/12/13 through 3/14/13 demonstrated the following concerns: a. Observations on multiple occasions	F 441		

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F 441	Continued From page 23 between 3/12/13 and 3/13/13 of the 2 soiled utility rooms revealed staff disposed of red-bagged (regulated medical waste) trash or deposited soiled linen for laundry services. Of 7 episodes when staff entered soiled utility rooms, opened red or yellow containers, and resealed the lids, none of the staff were observed to don gloves, perform hand hygiene after handling the dirty container lids, or clean contact surfaces on the containers or lids. Following each observation of staff exiting a soiled utility room, they were seen to touch high-contact surfaces such as a drinking fountain, medical record binders, handrails, or to engage residents and provide assistance. b. Periodic observations of the soiled utility rooms on 3/12/13 and 3/13/13 showed the red and yellow containers and lids remained soiled. c. Housekeeper #1 stated in interview on 3/12/13 at 8:50 AM that she was not sure how often the red and yellow containers in the soiled utility rooms were cleaned. She acknowledged the containers were soiled, in particular on those surfaces most likely to be touched when opening and closing the lids. d. The housekeeping supervisor stated in interview on 3/13/13 at 7:20 AM that the containers and lids were supposed to be cleaned every day. She further stated she had inspected the rooms earlier that same morning and acknowledged the cans had not been cleaned as she expected. 7. Tour of the facility on 3/12/13 beginning at 9:45 AM revealed that 2 of 12 wall-mounted hand hygiene product dispensers were cracked or broken. The 2 broken dispensers, one in the main dining room and the other in the rehabilitation gym, failed to reliably dispense a sufficient	F 441		

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	535039	A. BUILDING _____ B. WING _____	C 03/14/2013

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F 441	Continued From page 24 amount of ABHR gel for effective hand hygiene without repeatedly pumping the dispensers or pushing the outer cover with one hand while pumping the dispenser with the other. The dispensers were a common design and intended to operate with a single hand utilizing a single pumping action. A wall-mounted soap dispenser in the staff restroom adjacent to the main nurses' station was tested on 3/12/13 and again on 3/13/13. In both instances the dispenser failed to properly dispense a sufficient amount of soap for hand washing. The pump mechanism functioned erratically and caused a delay in dispensing soap; a 4 inch diameter stain on the floor beneath the soap dispenser attested to improper function resulting in soap being dispensed to the floor. The long-term care unit manager stated in interview on 3/13/13 at 2:10 PM that she was aware the soap dispenser functioned erratically. She acknowledged staff had to accommodate the delayed dispensing, but noted that soap often dripped on the floor. 8. Infection surveillance activities were reviewed with the IP and DON on 3/13/13 beginning at 10:15 AM. Review of surveillance data and accompanying interview with the IP revealed the facility targeted selected tasks and individuals when monitoring hand hygiene practices. The IP stated examples in which she focused on individuals performing perineal care and resident transfers to assess staff compliance with hand hygiene practices. She acknowledged she did not have mechanisms in place to monitor hand hygiene compliance among all staff and had not	F 441		

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F 441	Continued From page 25 investigated the overall hand hygiene compliance rate among facility staff. Neither were there active assessments to determine the compliance rate for hand hygiene among non-care staff, such as housekeeping and dietary, nor did the facility assess hand hygiene opportunities for residents.	F 441		
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure laboratory tests results were received and placed in the record for 2 (#4, #40) of 13 sample residents who had laboratory tests ordered. The findings were: 1. Review of the physician's orders for resident #40 showed an order for a urine culture and sensitivity. Review of the laboratory reports in the medical record showed the results for the culture were present but the sensitivity report was absent. During an interview on 3/14/13 at 8:15 AM the DON stated she had to call the laboratory to obtain the results of the sensitivity report. The DON verified the results were not in the medical record. 2. Review of the 1/5/13 physician's order for resident #4 revealed an order for a magnesium blood level. Review of the medical record revealed the results of the test were not in the	F 507	**F507** **1. The urine culture test result was placed in resident # 40's medical record and the Mg blood test result was placed in resident # 4's medical record.** **2. All residents are at risk of having urine culture results or Mg blood test results not being received or placed in their medical records.** **3. Staff will be in-serviced regarding ensuring urine culture results and Mg blood test results are received and placed in residents' medical records. A lab tracking log has been created for nurse managers to audit 5x/week x1/week, weekly x3/weeks then monthly x2/months to ensure urine culture and Mg blood test results have been received and placed in residents' medical records** **4. Results of the audits will be presented at the Performance meeting for at least the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13

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F 507	Continued From page 26 medical record. Interview with RN #3 on 3/12/13 at 2:48 PM revealed she was unable to find the results in the chart. The RN stated "the lab work was either not done or the results were not received back from the lab."	F 507		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the quality assurance and performance improvement (QAPI)	F 520	**F520** **1. The facility is now utilizing the QAPI process to evaluate and address identified concerns regarding resident activity participation and infection prevention surveillance.** **2. Monthly PI will use the QAPI process for identifying more facility specific concerns.** **3. PI committee will be in-serviced at next meeting on utilizing the QAPI process to identify concerns regarding resident activity participation and infection prevention surveillance throughout the facility. Monthly audits by the ED will be conducted to ensure activity participation and infection prevention surveillance is being completed.** **4. Results of the audits will be presented at the Performance meeting for at least the next 3 months or until the committee determines substantial compliance has been met.**	4-28-13

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F 520	Continued From page 27 activities, the facility failed to utilize the QAPI process to evaluate and address identified concerns regarding resident activities and infection prevention surveillance. The findings were: Interview with the administrator and DON on 3/14/13 at 8:30 AM revealed the QAPI program quality measures included falls, pressure sores, psychoactive drugs, physical restraints, urinary tract infections, and weight loss. They also revealed the QAPI program utilized the corporate established system for identifying quality measures, data collection and analysis, goals, and thresholds. However, further review revealed the QAPI activities did not include concerns specific to this facility regarding resident activities and infection prevention surveillance. 1. Interview with the activities director on 3/14/13 at 9:45 AM revealed the activity program was not meeting the needs of the residents and reassessments were not completed in a timely manner when residents had changes in conditions. She stated she had noted an increase in the number of residents who refused to participate in the activities. The activities director also stated she had identified these problems, but they had not been incorporated into the facility wide QAPI program. 2. Review of the QAPI program showed one of the quality measures included infection prevention. However, this review showed QAPI activities had not been expanded to include additional infection surveillance activities specific to the facility. Infection surveillance activities were reviewed with the IP and DON on 3/13/13	F 520		

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F 520	Continued From page 28 beginning at 10:15 AM. Review of surveillance data and accompanying interview with the IP revealed the facility targeted selected tasks and individuals when monitoring hand hygiene practices. The IP stated examples in which she focused on individuals performing perineal care and resident transfers to assess staff compliance with hand hygiene practices. She acknowledged she did not have mechanisms in place to monitor hand hygiene compliance among all staff and had not investigated the overall hand hygiene compliance rate among facility staff. Neither were there active assessments to determine the compliance rate for hand hygiene among non-care staff, such as housekeeping and dietary; nor did the facility assess hand hygiene opportunities for residents. 3. Interview with the administrator and DON on 3/14/13 at 8:30 AM and review of the QAPI information provided, revealed identified issues regarding resident activities and infection prevention surveillance had not been incorporated into the facility wide QAPI program. 4. Concerns with the activity program were also identified during the survey and cited at F248. In addition, the failure of staff to perform hand hygiene was identified during the survey and cited at F441.	F 520		