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

PRINTED: 11/08/2013
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
	53A049	A. BUILDING _____ B. WING _____	C 10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

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WY Dept of Health
NOV 19 2013
Healthcare Licensing and Surveys

(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 CNA: Certified Nurse Aide IDON: Interim Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set CAA: Care Area Assessment BIMS: Brief interview for mental status RN: Registered Nurse MAR: Medication Administration Record Less commonly used abbreviations will be annotated in each deficiency.	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.	F 241	The facility must promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This will be accomplished by: A.1) Facility will implement a hygiene schedule for resident #86 to trim or tweeze facial hair twice a week during baths and/or as needed. A.2) On October 24th, the Nursing Facility implemented hourly rounding to ensure the supervision, dignity and safety of residents #4, #19, #37, #53 and #86. B.1) All residents have the potential to be affected by this deficiency. A Facility wide audit will be conducted on residents in order to identify any issues	
	This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to promote dignity and respect for 4 of 21 sample residents (#4, #19, #37, #86) and 1 non-sample resident (#53). The findings were: 1. Review of the medical record showed resident #19 was admitted to the facility on 9/10/13 with diagnoses including confusion and dementia. Review of the MDS admission assessment dated 9/20/13 showed the resident was severely			

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

_____ — IDON — 11/19/13

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. Case to Michael Speidel, NHA on 11/25/13 @ 3:29pm.

Janeece Collins, ODNC

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F 241	Continued From page 1 cognitively impaired and required extensive assistance with ADLs. a. Observation on 10/22/13 at 7:50 PM revealed CNA #10 exited a resident's room and approached resident #19, who was attempting to stand up. The CNA assisted the resident to transfer to his/her wheelchair and stated, "How would you like to visit [resident name]?" The CNA wheeled the resident down the hall into another resident's room where LPN #12 was performing a medication pass. At 7:52 PM an alarm began sounding across the hall. CNA #10 exited the room to respond to the alarm. LPN #12 also exited the room, leaving resident #19 unattended in another resident's room. The resident was observed attempting to stand up and was redirected by the other resident, "[resident name] you need to sit back down, you are going to fall." CNA #10 reentered the resident's room at 7:56 PM with a nursing aide student and proceeded to apply lotion to the other resident's legs and assist the other resident with toileting in the presence of resident #19. 2. Review of the medical record showed resident #4 was admitted to the facility on 7/31/13 with diagnoses including non-Alzheimer's dementia. Review of the admission MDS assessment dated 8/7/13 showed the resident was cognitively impaired, confused, and required assistance with ADLs. Review of the care plan updated 8/15/13 showed the resident had a self-care deficit and staff were supposed to assist with ADLs. Observation on 10/24/13 at 6 PM showed the resident was seated in the main dining room at the evening meal. The resident was observed to have 2 glasses of fluids located in front of him/her. However, the resident was observed taking a glass of fluids from the resident seated to	F 241	associated with excessive facial hair or other potential violations to resident's dignity. Any issues identified will require immediate correction and in-servicing. C) The DON or designee will provide education to facility nursing staff on: 1. The proper supervision of residents in reference to their dignity, respect and safety. 2. Personal hygiene expectations on facial hair and grooming. 3. Appropriate redirection of residents with cognitive deficits. 4. Supervision and assistance given to residents during meals. DON or designee will conduct 3 audits per week in order to assess facility compliance with expectations regarding resident dignity and supervision. D) The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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F 241	Continued From page 2 his/her left and drinking from the glass. No staff were observed in this part of the dining room. At 6:07 PM, the resident was observed to have dropped his/her meal onto the floor. S/he spent 5 minutes attempting to pick it up by stretching his/her hand down and trying to spear the hamburger on a fork. The resident was not observed or provided any assistance by facility personnel, and eventually was aided by another resident's visiting family member. This same visiting family member was observed assisting other residents in the dining room by moving their plates closer to them. 3. Review of the medical record showed resident #66 was admitted to the facility on 1/4/05 with diagnoses including non-Alzheimer's dementia. Review of the MDS annual assessment dated 10/15/13 showed the resident was moderately cognitively impaired and required extensive assistance with ADLs including bathing. Review of the care plan dated 10/31/13 identified a problem with "visual function related vision impairment" and the resident required extensive assistance with bathing. Observation on 10/24/13 at 4:30 PM revealed the resident had a substantial amount of thick white facial and chin hair that was approximately 1/4 to 1/2 inch in length. An interview conducted with the resident at the time of the observation revealed the resident had previously removed the facial and chin hair independently but was, "unable to see to remove it now." The interview further revealed, "It bothers me because I can feel it, but what can I do? I can't see to pluck it anymore." The resident revealed facility staff had removed the facial and chin hair in the past during bathing, but not in the last several months.	F 241	This page left blank intentionally	

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F 241	Continued From page 3 4. Review of the medical record showed resident #58 was admitted to the secured unit on 9/13/13 with diagnoses including Alzheimer's disease. Review of the MDS admission assessment dated 9/20/13 showed the resident was severely cognitively impaired. Review of the CAA dated 9/25/13 showed the resident should have a care plan developed for cognitive loss and had disorientation and forgetfulness. Review of the care plan dated 9/25/13 identified a problem of cognitive loss related to Alzheimer's dementia. Approaches/interventions directed staff to provide reassurance. The following concern was noted: Observation on 10/22/13 at 7:15 PM revealed the resident walking down the secured unit hallway away from the main dining room, stopping and looking into rooms and at plaques on walls beside doors. The resident walked into the alcove at the end of the hall and approached LPN #10 who was standing by a medication cart and asked, "Do you know where my room is?" LPN #10 told the resident a room number, then proceeded into another resident's room with medications. The resident continued to go into rooms on the alcove and look at the plaques by the door. The resident went back into the hallway and stopped turned around and looked up and down the hallway, then continued back down the hallway toward the main dining area. The resident continued to look into each room, walking in and coming back out. During the observation LPN #10 pushed the medication cart past the resident toward the main dining area, and CNA #2 came out of another resident's room and walked past the resident. At 7:30 PM the resident reached the main dining room and asked another resident, "Can you help me find my room?" The other resident responded, "It is right beside mine, come on I'll show you."	F 241	This page left blank intentionally	

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F 241	Continued From page 4 The resident was shown to a room and stated, "Oh yes, there are my pictures." 5. Resident #37 was admitted to the facility on 12/31/08 with diagnoses that included Alzheimer's disease and non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 9/15/13 revealed that the resident required extensive assistance with eating. Observation of the evening meal on 10/24/13 showed the resident was seated at a table with two other residents who also required assistance with eating. The resident's meal was set before him/her at 5:40 PM, and the other two residents seated at the table received their meals at 5:45 PM. The other two resident's at the table received prompt assistance with their meals, however, resident #37 waited 21 minutes before s/he received any assistance with his/her food. Resident #37 was noted during this time to be watching the other residents at his/her table eat their meals, and displaying a distressed expression. Interview with the IDON on 10/25/13 at 9 AM revealed shift change occurs at 5 to 5:30 PM, which coincides with the evening meal. The IDON further acknowledged the secure unit had "more people that need to be fed than we have staff for."	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	F 248	The Facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. This will be accomplished by:	

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F 248	Continued From page 5 by; Based on observation, staff and resident interview, and medical record review, the facility failed to provide an activities program to meet the individualized needs for 7 of 13 sample residents (#4, #6, #39, #51, #58, #84, #88) who resided on the secure dementia unit. The findings were: 1. Observation on 10/21/13 at 10:30 AM revealed 10 residents were seated in the main dining room area on the secured dementia unit. Four of the 10 residents were asleep in reclining chairs. An interview with the social worker at the time of the observation revealed she was also the activities director and had 3 certified activity assistants; however, only 1 activity assistant was currently working at the facility. 2. Observation on 10/21/13 at 3:43 PM showed 10 residents in the dementia unit were awake and seated in the main living area. Non-certified nurse aide #1 was observed seated with the residents, but she did not engage any of the residents in activities or social interaction. Interview with the nurse aide at that time revealed that activity staff only visited the secure unit occasionally in the mornings. She stated a movie was generally turned on for the residents at that time of day. 3. Continued observation of the main common area of the secure unit on 10/21/13 revealed 2 additional residents had joined the group in the area at 3:55 PM. All were awake and alert. Non-certified nurse aide #1 continued to be seated in the common area, but was not observed to engage with the residents beyond telling them to sit down. A movie was playing on the television with the sound turned very low, and the closed captions was engaged. At 4:05 PM,	F 248	A. The facility will implement resident specific activities for residents #4, #6, #39, #51, #58, #84, #88 that meet their individual needs. B. All residents on the "secure unit" have to the potential to be affected by this deficiency. The facility activity associates will complete the "About Me" form for each resident who resides on the secure unit. Based on the findings of the "About Me" forms, the facility will update resident activities care plans to include individualized/stimulating daily activities. These activities will be offered daily and documented in the residents' activities record. C. Facility's Patient Services Senior Manager or designee will provide education to all activities staff on the delivery of engaging and specific resident activities programming for cognitively impaired residents. The Patient Services Senior Manager or designee will conduct activities audits four times/week on the secured unit to ensure that activities staff are providing individualized/engaging activities to the residents.	

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F 248	Continued From page 6 resident #51 was observed to get up from his/her chair and wander down the hall. No one engaged the resident or redirected him/her. At 4:16 PM, resident #4 was observed to get up from his/her chair in the common area and wander away, entering two rooms that were not his/her own. 4. Observation on 10/22/13 at 6:55 PM revealed non-certified nurse aide #3 was seated directly in front of the television in the main common area of the secure unit, watching the movie that was playing. Eight residents, including 4 sample residents (#6, #58, #84 and #88) were in the area. Of the 8 residents observed in the common area, 3 were seated and asleep, 2 were seated but unable to see the TV, and 3 were up walking around. Further observation at that same time showed non-certified nurse aides #1 and #2 were playing cards at a table in the dining half of the common area with a single resident. Interview with non-certified nurse aides #1 and #2 at that time revealed they were scheduled to work that evening as "activity aides." The aides remained at this table with the resident until 8:33 PM; they were not observed to engage any other residents. At 7:25 PM, resident #6 was observed to wheel him/herself over to the kitchen area gate in his/her wheelchair. S/he then proceeded to unlatch the gate, and wheel him/herself into the kitchen area. At this time, the resident was noted to be in the direct line-of-sight of all three non-certified nurse aides in the area. The resident, whose fall risk assessment dated 10/13/13 revealed s/he was a fall risk, was observed to spend 10 minutes propelling him/herself around the kitchen, and pulling him/herself up out of his/her wheelchair to rummage in containers on the counter. At 7:35 PM the resident left the kitchen area without once	F 248	D. The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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F 248	Continued From page 7 being engaged by any of the staff present in the area. 5. Resident #68 was admitted to the facility on 7/12/11 with diagnoses that included Alzheimer's disease and depression. Review of the resident's annual MDS assessments dated 6/21/12 and 6/14/13 revealed the resident was consistently assessed as placing importance on going outside when the weather allowed. Review of the activities care plan, last updated on 9/16/13 revealed the resident "likes...going outside in warm weather." Review of the behavior care plan, last updated on 9/16/13 revealed the resident had behaviors manifested by verbal outbursts, swearing, irritability, agitation, and attempts to leave the facility. Recommended interventions included "take a walk with [him/her]" and noted the resident "reports [s/he] enjoys listening to music and going outside." The following concerns were identified: a. Review of October activity attendance logs revealed the resident had been on outside walks only 3 times between 10/1/13 and 10/22/13. b. Review of nursing notes revealed between 10/1/13 and 10/25/13 behaviors were charted for this resident on 10 days. Of those 10 times, only twice did the nursing notes indicate the resident was taken outside for a walk. c. An interview with the resident on 10/22/13 at 7:20 PM revealed s/he would like to go outside, adding, "They don't like to let us go outside. Sometimes they let us all go out in a group, but it's so short and we all have to stay huddled together." d. Interview with the IDON on 10/25/13 at 9 AM revealed taking residents of the secure unit outside didn't "happen as often as it should."	F 248	This page left blank intentionally	

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F 248	Continued From page 8 6. Review of the care plan for resident #51, dated 7/3/13, listed the resident's strengths as being "... kind, and watchful of other residents spending a majority of his/her time walking around checking on others." The resident was also noted to enjoy "holding and caring for the real life feeling baby dolls." An approach dated 2/11/13 showed "include in pet visits [and] provide time outdoors." The following concerns were identified: a. Observation on 10/21/13 at 3:25 PM showed the resident was wandering in the hallway and into other residents' rooms. There were no group activities going on in the unit at that time, and the activity calendar showed two activities for the day, "Music with John and Basketball" The resident ambulated without staff assistance, without any assistive devices; and the resident did not have a baby doll. During this time there were no staff in the hallway, and the hallway was not visible from the main dining and television area where staff were located. At 3:43 PM the resident was noticed by the surveyor to be missing from the hallway and the main areas of the unit. When asked at 4 PM, non-certified nurse aide #1 stated she had not seen the resident and did not know where s/he was. This aide inquired of another CNA, who also did not know the resident's whereabouts. At 4:30 PM (47 minutes after noticed missing) RN #11 went room to room down the hallway looking for the resident. The resident was found in another resident's room asleep in an armchair. b. Interview with the MDS coordinator on 10/22/13 at 2 PM revealed the baby doll may have been moved from the secure unit to be held by another resident in another part of the facility. 7. Review of the 9/7/13 care plan for resident #88 showed the resident enjoyed group activities and	F 248	This page left blank intentionally	

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F 248	Continued From page 9 social involvement. The care plan showed the resident "particularly likes art, bingo and sports...going outside in the nice sunshine and taking bus rides..." Review of the activity attendance log showed the resident actively participated in 15 group activities, not including passive events like movies and television from 10/1/13 to 10/24/13. These activities included bingo 3 times, two games of toss, one parachute activity, Art/crafts/baking 3 times, music twice, one manicure, and 3 religious activities. Review of the printed activity schedule showed there were no outdoor activities or pet visits offered or scheduled during the month of October 2013, nor was there evidence to show the resident's individual preferences were considered when planning the month's activities. 8. Review of the activities care plan updated on 10/5/13 showed resident #39 enjoyed strolls outside in the courtyard, musical activities, and manicures. Review of the activity log for this resident for 10/1/13 to 10/24/13 showed the resident participated in 5 activities. The resident participated in 2 musical activities, 1 manicure, 1 special event, and one movie. Interview with the resident on 10/24/13 at 3:55 PM revealed s/he "doesn't have anything to do." S/he stated "there is nothing going on" and s/he "usually naps." Review of the activity schedule showed there were no outdoor activities offered or scheduled during the month of October 2013.	F 248		
F 279 SS=E	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.	F 279	Tag 279 begins on the next page	

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F 279	Continued From page 10 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 a comprehensive care plan was developed for 1 of 1 sample resident (#19) who was identified as being underweight. The facility also failed to individualize care plans to meet the needs of residents who had sustained falls or who were at risk for falling for 9 of 18 sample residents (#4, #6, #19, #37, #39, #59, #64, #84, #88). The findings were: 1. Review of the medical record for resident #6 showed s/he was admitted to the facility on 11/25/08 with diagnoses that included non-Alzheimer's dementia, arthropathy (joint disease) and a history of TIA (transient ischemic attack). Review of the resident's annual MDS assessment dated 8/15/13 revealed the resident	F 279	The facility will ensure that the comprehensive care plan, using the results of the assessment, which includes measureable objectives, timetables and description of services furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-being is maintained, reviewed and revised for each resident. This will be accomplished by: A.1) A nutritional care plan for resident #19 which addresses weight and BMI with approaches/interventions was implemented on 10/25/2013. A.2) Residents #4, #6, #19, #37, #39, #59, #64, #84 and #88 will have a care plan in place which will address Fall Risk with resident specific approaches/interventions and ongoing evaluations for effectiveness. B.1) All residents who have been identified as being underweight have the potential to be affected by this deficiency. Facility RD or designee will audit all facility residents identified as being underweight and any discovered issues will be addressed specifically in the resident's care plan with appropriate interventions put into place. B.2) All residents who have been identified as being a high fall risk have the potential to be affected by this deficiency. New fall risk assessments were completed by Facility Nursing Administration Team on 10/23/2013 for	

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

PRINTED: 11/08/2013
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
	53A049	A. BUILDING _____ B. WING _____	C 10/26/2013

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F 279	Continued From page 11 had a BIMS score of 3, indicating severe cognitive impairment. Review of the resident's fall assessment dated 8/19/13 revealed s/he was at risk for falling with a score of 18 due to poor recall, judgment, and safety awareness as well as problems with balance and poor vision. Review of the facility's incident logs revealed the resident had falls in the facility on 10/6/13 and 10/21/13. The following concerns were identified: a. Review of the fall care plan revealed the care plan was updated on 10/6/13 with the intervention "Transfer with assistance" and "Instruct to call for help." On 10/21/13 the care plan was updated with the same interventions. b. Review of fall documentation dated 10/6/13 revealed that subsequent to the fall on that date; the resident was instructed on "safe use of assistive device." Further review of fall documentation revealed that subsequent to the fall on 10/21/13, the resident was instructed on "safe transfer techniques" and "asking for assistance with transfers." c. The goal initiated for the falls care plan, dated 5/21/13 was that the resident would have "minimal injury from falls" rather than preventing falls. This goal was then deemed met on 8/21/13, even though the resident had suffered 2 falls in the intervening time. 2. Medical record review showed resident #64 was admitted to the facility on 3/29/12 with diagnoses that included non-Alzheimer's dementia, arthritis and depression. Review of the quarterly MDS assessment dated 9/16/13 revealed the resident had a BIMS score of 3, indicating severe cognitive impairment. Review of the facility's fall assessment dated 9/23/13 revealed the resident was at a risk for falling with a score of 17 due to decreased safety	F 279	all facility residents. All residents identified as a high fall risk will have their care plan reviewed by DON or designee for effectiveness of approaches/interventions and updated as needed. C.1) Facility RD or designee will conduct weekly audits of 5 or more residents to ensure a nutritional care plan with resident specific approaches/interventions is in place. C.2) DON or designee will provide education for facility clinical staff on the identification and assessment of residents with high fall risks, interventions associated with fall risks, and the care planning of fall risks. Facility DON or designee will audit 8 resident charts per week to ensure: 1. Completion of fall risk assessment. 2. Resident Care plan contains resident specific interventions for those identified as having a high fall risk. 3. Post fall updates to care plans if needed. 4. Facility compliance to care plans. D) The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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F 279	Continued From page 12 awareness, a need for assistance with toileting, balance problems with walking, poor vision and a history of falls. Review of the facility's incident logs revealed the resident had a fall in the facility on 10/4/13. Additionally, the resident's care plan dated 9/23/13 noted the resident suffered 6 falls in the previous quarter. The following concerns were identified: a. Review of the fall care plan revealed the care plan was updated on 10/4/13 with the interventions "Transfer with assistance" and "Instruct to call for help." b. The goal initiated for the falls care plan, dated 6/21/13 was that the resident would have "minimal injury from falls" rather than preventing falls. This goal was then deemed met on 9/26/13, even though the resident had suffered 6 falls in the intervening time. 3. Medical record review showed resident #59 was admitted to the facility on 9/17/12 with diagnoses that included Alzheimer's disease, non-Alzheimer's dementia, obesity and back pain. Review of the significant change MDS assessment dated 8/15/13 revealed the resident had a BIMS score of 1, indicating severe cognitive impairment. Review of the fall assessment dated 8/16/13 revealed the resident was at a risk for falling with a score of 14 due to poor recall, judgment and safety awareness, incontinence, and history of falls. Review of the facility's incident logs revealed the resident had falls in the facility on 8/19/13, 8/20/13, 8/21/13, 8/22/13, 8/28/13, 9/9/13 and 9/26/13. The following concerns were identified: a. Review of the resident's falls care plan, last updated on 9/26/13, revealed no change to the care plan or new interventions added after the resident's falls in August 2013.	F 279	This page left blank intentionally	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 13 b. Interventions added to the care plan on 9/9/13 and 9/25/13 were identical. Both read "Transfer with assistance" and "Instruct to call for help." c. The goal initiated for the falls care plan, dated 4/25/13 was "Reduce the likelihood of serious injury from falls" rather than preventing falls. This goal was then deemed met on 8/29/13, even though the resident had suffered "several minor injury falls" in the intervening time. 4. Review of the medical record for resident #37 showed s/he was admitted to the facility on 12/31/08 and had diagnoses that included Alzheimer's disease and non-Alzheimer's dementia. Review of the significant change MDS assessment dated 6/18/13 revealed the resident had a BIMS score of "0", indicating severe cognitive impairment. Review of the fall assessment dated 9/17/13 revealed the resident was at a risk for falling due to poor recall, judgment and safety awareness, diuretic medication, and a history of falls. Review of the facility's incident logs revealed the resident had a fall in the facility on 9/2/13. Additionally, the resident's care plan noted s/he had 3 falls in the quarter that ended 9/24/13. The following concerns were identified: a. Interventions added to the care plan on 9/2/13 included "Transfer with assistance" and "Instruct to call for help." b. The goal initiated for the falls care plan, dated 6/28/13 was that the resident would have "minimal injury from falls" rather than preventing falls. This goal was then deemed met on 9/24/13, even though the resident had suffered 3 falls in the intervening time. 6. Review of the medical record face sheet	F 279	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 14 showed resident #88 was admitted to the facility on 4/12/12. The resident's diagnoses included Parkinson's disease and Alzheimer's disease. The resident lived on the secured unit of the facility and review of incidents for September and October 2013 showed this resident had 6 falls, one of which occurred on 9/19/13 at 4:39 PM resulting in significant injury to the resident's left hip. Review of the ADLs care plan showed it was updated on 9/12/13 to include extensive assistance required for toileting. Then on 9/12/13 the care plan was updated to include extensive assistance for grooming, dressing, bed mobility, and ambulation. In addition, this care plan showed the resident used a walker and a wheelchair and had a "personal alarm." The following concerns were identified: a. The care plan failed to address any toileting schedule or plan. b. Review of the 9/26/13 updated care plan related to falls showed original interventions dated 11/16/12 and 11/20/12 were to remind the resident to call for help, keep personal items in reach, provide non-skid footwear, and remind the resident to take big steps if s/he was shuffling. As of 10/22/13 these approaches remained the same with the addition of "transfer with assistance instructs to call for help" this approach was added on 9/19/13 and repeated on 9/20/13, and 9/26/13. There were no individualized interventions added to the resident's care plan to identify factors contributing to his/her falls or to prevent further falls; neither was any information added to the resident's care plan related to pain and injury to the left hip. 6. Medical record review showed resident #39 was admitted in April 2013 with a history of falls prior to admission. The medical record further	F 279	This page left blank intentionally	

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F 279	Continued From page 15 showed the resident required extensive assistance for bed mobility, toileting, transferring, locomotion, grooming and dressing. Review of the medical record incident notes revealed the resident had an unwitnessed fall on 5/14/13 at 10:50 AM resulting in a fractured left femur. The resident also had an unwitnessed fall on 9/17/13. The following concerns were identified: Review of the 4/15/13 care plan showed the resident was at risk for falls based on a history of falls, unsteady gait/balance, and medications. There were no approaches for fall prevention shown prior to 7/18/13, and this approach showed staff were to promote comfort, provide transfer with assistance, "instruct the resident to call for help (reinforce the use of the call light rather than screaming at staff)", assure good hygiene, assure adequate pain management, place the bed in the lower, locked position, keep personal items in reach, and to anticipate needs. The care plan failed to reflect the resident had sustained a fracture, and updated approaches/interventions for falls dated 9/17/13 failed to include any new preventative approaches/interventions.	F 279	This page left blank intentionally	
	7. Review of the medical record face sheet showed resident #84 was admitted on 4/26/13. The resident lived on the secure unit of the facility and had diagnoses that included dementia. Review of the 4/26/13 fall risk assessment showed the resident was at risk of falling due to decreased safety awareness, poor recall and judgment, impaired mobility, balance problems when standing, decreased muscular coordination, and needing assistance with toileting. The risk assessment further showed the resident had a history of falls and had a fall with a fracture prior to admission. Review of the facility fall log			

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F 279	Continued From page 16 documentation showed the resident had fallen 6 times on 5/1/13. The data showed two of those falls were unwitnessed and the other falls did not have times recorded. The resident fell twice on 9/12/13, one fall was witnessed and one was not. The resident also had an observed fall with no injuries on 9/19/13, and an unwitnessed fall on 10/21/13 at 11 AM which resulted in a fractured wrist. Review of the care plan related to falls showed the problem was initiated on 5/15/13 after the resident had a fall. However, there were no approaches dated prior to 8/12/13. This 8/12/13 approach showed the nurses were responsible to "proactively promote comfort use assistive devices: wheelchair for locomotion...transfer with assistance...low bed with wheels locked, keep personal items in reach, provide brighter lighting...corrective eyewear..." There were also approaches dated 9/12/13 and 9/19/13 which both showed the nurse aide would "anticipate needs locate near staff when out of bed." 8. Review of the medical record showed resident #4 was admitted to facility on 7/31/13 with diagnoses including non-Alzheimer's dementia. Review of the admission MDS assessment dated 8/7/13, revealed the resident had wandering behaviors, was moderately cognitively impaired, and required supervision from staff when ambulating with a walker. Review of the CAA dated 8/1/13 showed the resident was at risk for falling and had fallen on 8/1/13 and the resident's, "gait is choppy and [s/he] slides feet at times". Review of the care plan updated 8/15/13 showed the resident had potential for trauma-falls related to impaired balance, unsteady gait, and use of devices for walking and fall in recent past. The care plan approaches were updated on 10/24/13	F 279	This page left blank intentionally	

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

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F 279	Continued From page 17 with interventions including, proactively promote comfort, instruct to rise slowly, increase assistance and surveillance. Review of fall documentation showed the resident sustained unwitnessed falls on 8/1/13, 8/31/13, 9/16/13, 9/21/13, and 9/23/13. The resident's care plan was not updated to reflect falls until 10/24/13 after the resident had sustained 4 additional falls. In addition, the care plan approaches/interventions were not individualized to meet the specific needs of the resident related to his/her dementia. 9. Medical record review showed resident #19 was admitted to the facility on 9/10/13 with diagnoses including confusion, dementia, and a history of malnutrition. Review of the MDS admission assessment dated 9/20/13 revealed the resident was cognitively impaired. Review of the CAA dated 9/20/13 showed the resident should have a care plan developed for nutrition. The nutritional assessment dated 9/20/13 showed the resident had a pattern of food left uneaten and required supervision to stay on task. The assessment further showed the resident was 5 foot tall and weighed 76 pounds. The resident's assessment also revealed the body mass index (BMI) was 14.8 which was low and may lead to worsening of chronic conditions, and a care plan should be developed. Review of the care plan dated 9/20/13 showed there was no care plan for nutrition. The following concerns were identified: a. Review of the medical record showed no additional weights had been documented for the resident. b. Interview with the registered dietitian (RD) on 10/24/13 at 4:20 PM confirmed the resident did not have a nutritional care plan but should have had one developed. The interview further revealed the resident was supposed to be	F 279	This page left blank intentionally	

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

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F 279	Continued From page 18 weighed once a month. The surveyor requested the resident be weighed. The RD reported on 10/25/13 at 11:10 AM the resident's weight was 73 pounds and the BMI was 14.2. c. Review of the preadmission screening for nursing facility admission (PASSR) level II dated 8/27/13 showed, "Recommendations regarding services that may be needed at the nursing facility include: Close supervision to prevent further falls". The medical record further revealed prior to admission the resident sustained a fall on 7/24/13 resulting in a right hip fracture and underwent surgical repair with hardware placement. The admission MDS assessment dated 9/20/13 showed the resident was severely cognitively impaired, required extensive assistance with ADLs, used a wheelchair for ambulation, and had fallen prior to admission. Review of the CAA dated 9/20/13 showed the resident was at risk for falling. Review of the care plan dated 9/20/13 showed the resident had the potential for trauma/falls related to gait/balance, history of falls, medications and mental status (poor safety awareness). Approaches/interventions included sensor alarm, pull tab alarm in bed and chair, and to instruct the resident to call for help. The care plan was updated on 9/21/13 to include the approach, "transfer with assistance and instruct to call for help". Care plans were not updated to reflect the falls the resident sustained on 9/21/13, 10/4/13 and 10/6/13. In addition, the listed approaches/interventions were not evaluated for effectiveness. 10. Interview with the MDS coordinator on 10/23/13 at 2:20 PM confirmed interventions based on instructing, teaching, and cognitive association would not be effective for a resident	F 279	This page left blank intentionally	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 19 with severe cognitive impairment. 11. Review of facility policy and procedure entitled, "Routine Care" review date 9/2011 showed, "IV. Procedure/Interventions: 9. A total care plan is to be written on each resident".	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to provide complete nursing assessments for 1 random non-sample resident (#8) who was displaying disruptive behaviors, and for 1 of 11 sample residents (#59) who had falls. The findings were: 1. Review of the 11/2/12 care plan showed resident #8 was dependant on staff for all ADLs. Additional care plan review showed on 10/31/12 the resident was increasingly disruptive, making verbal outbursts. The care plan revealed the resident had been screaming, hollering, and making disruptive sounds during cares and when s/he was moved. According to the approach dated 2/14/13 staff were to report indicators of pain, offer conversation, assess or report pain indicators, and "if [resident's name] pain is	F 309	The facility will provide complete nursing assessments and comprehensive care plans for all residents to provide the necessary care and services needed to attain the highest practicable physical, mental and psychosocial well-being. This will be accomplished by: A.1) Resident #8 will have appropriate nursing assessments completed when exhibiting signs of disruptive behaviors. Assessments will include pain level, hunger/thirst, repositioning need, toileting need. Current resident care plan will be reviewed and via frequent assessments, appropriate interventions to decrease/prevent episodes of disruptive behavior will be implemented and added to the resident's plan of care. A.2) Resident #59 had a fall risk assessment completed on 10/23/2013. Resident will have a full body assessment completed to assess for residual effects related to previous falls and a full review of the comprehensive care plan will be completed. B.1) All residents who show signs of disruptive behaviors have the potential to be affected by this deficiency. All residents identified with disruptive behaviors will have a nursing assessment	

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

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F 309	Continued From page 20 addressed [his/her] behaviors decrease." Review of the 11/2/12 care plan related to communication showed the resident was unable to communicate verbally to make needs known. The approach dated 2/2/13 showed "assess for unmet needs such as pain, toileting, hunger, [and] thirst." The following concerns were identified related to assessment of this resident's behavior and communication: a. Observation on 10/22/13 at 7:10 PM showed the door to the room was shut; a resident in the room was crying and grunting loudly. At that time, the surveyor observed the resident (#8) who was laying in bed with his/her knees up. Further observation showed the resident continued to yell, moan and cry out. The resident was quiet from 7:15 PM to 7:20 PM, then resumed crying loud enough to be heard into the hallway through the closed door. At 7:35 PM CNAs #2 and #13 were observed assisting the resident in the adjacent room. Interview with CNA #2 at that time revealed the resident's crying was his/her "normal behavior." Neither aide checked on resident #8 or offered any assistance to him/her. At 8:05 PM, LPN #10 stated in interview that she had not assessed the resident that evening, the resident was laid down by the aides, and the resident gets "irritated." She further stated the resident usually cries out for about 30 minutes and then stops. She stated if the crying lasts longer than 30 minutes, she would then assess him/her for pain. The LPN then acknowledged the cries were the resident's way to communicate because s/he was non-verbal. The LPN stated "[s/he] will also do this when [s/he] is hungry." b. Review of the October 2013 MAR from 10/1/13 to 10/23/13 showed the resident received routine Tylenol 500 mg 2 capsules twice a day at	F 309	completed to ascertain potential cause of behaviors. Appropriate approaches and interventions will be promptly evaluated for effectiveness. B.2) All residents who require a comprehensive assessment for falls have the potential to be affected by this deficiency. Every fall, whether witnessed or unwitnessed, will be investigated and audited for post-fall neurological checks and appropriate documentation. DON or designee will conduct post fall comprehensive care plan reviews to ensure that appropriate interventions are in place to prevent or decrease additional occurrence of falls. C.1) DON or designee will provide education on targeted behaviors assessment and documentation. These are to include pain level, hunger/thirst, repositioning need, and toileting need. DON or designee will audit five random resident charts per week for appropriate nursing assessments and evidence of effective interventions in result of these assessments. C.2) DON or designee will provide education on post fall assessments and neurological checks. DON or designee will audit five random resident charts per week for appropriate nursing assessments and evidence of effective interventions in result of these assessments.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	C 10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

(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 309	Continued From page 21 8 AM and at 4 PM. On 10/22/13 the MAR showed the resident received the 4 PM dose. The MAR did not show any PRN (as needed) pain medication administered for that day. c. Continued review of the MAR showed the resident had orders for Xanax 0.25 mg three times a day PRN for anxiety. Review of the target behavior (part of the MAR) for the use of Xanax showed it was used for calling out continuously. Staff were to check for the target behavior each shift. There were initials recorded for each shift on 10/22/13; however, it did not indicate if the resident was, or was not, displaying the target behavior. Further review showed the PRN Xanax was not administered on 10/22/13. The last time the PRN was given was on 10/17/13 at 5:58 PM for "yelling and hollering during dinner." 2. Resident #59 was admitted to the facility on 9/17/12 with diagnoses that included Alzheimer's disease, non-Alzheimer's dementia, obesity and back pain. Review of the resident's medical record and facility incident logs revealed the resident suffered falls on 8/19/13, 8/20/13, 8/21/13, 8/22/13, 8/28/13, 9/9/13, and 9/25/13. The following concerns were identified: a. Review of nursing notes dated 8/19/13 and timed at 6:06 PM revealed the resident was found on the floor in the "hallway." Injuries noted at the time included "rug burn type" reddened areas to the right side of the resident's head, and the corner of the right eye. A neurological check done at the time of the fall revealed only that the resident had "firm bilateral hand grasp." No further neurological checks were documented after this fall. b. Review of nursing notes dated 8/20/13 and timed at 12:33 AM revealed the resident was again found on the floor in the hallway, and was	F 309	D) The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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

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F 309	Continued From page 22 complaining of pain in his/her face. A neurological check done at the time of the fall revealed the resident had "pupils equal, round and react to light. Bilateral hand grasp firm (immediately after)." No further neurological checks were documented after this fall. a. Review of nursing notes dated 8/21/13 and timed at 6:18 PM revealed the resident had another fall, this time in the dining room. Injuries noted at this time included "redness to middle forehead at hairline." Neurological check documentation from this date and time includes only "(immediately after)(after 1/2 hour) Pupils equal, round and react to light, as much as resident allowed Bilateral hand grasp firm." No further neurological checks were documented after this fall. d. Review of nursing notes dated 8/22/13 and timed at 6:21 PM revealed the resident was again found on the floor in the hallway. Neurological checks at this time were noted as being "N/A [not applicable]." Interview with the IDON on 10/25/13 at 9 AM revealed the facility expectation that neurological checks will be performed on a routine basis (every 15 minutes for the first hour, then every 30 minutes for the next two hours, etc.) after any unwitnessed fall, or fall with apparent head impact. Request for a facility policy and procedure on neurological assessments resulted in none being provided.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312	Tag 312 will begin on the next page	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 312	Continued From page 23 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff and resident interview, and review of facility policy, the facility failed to ensure personal hygiene needs were met for 2 of 13 sample residents (#4, #19) and 1 non-sample resident (#48) who were dependent upon staff for hygiene/bathing needs. The findings were: 1. Medical record review showed resident #4 was admitted on 7/31/13 with diagnoses including non-Alzheimer's dementia. Review of the admission MDS assessment dated 8/7/13 showed the resident was cognitively impaired, confused, and required assistance with ADL's including bathing. Review of the care plan dated 8/15/13 showed the resident had a self-care deficit and staff were supposed to assist the resident with bathing and hygiene. Bathing schedules indicated the resident received showers 2 times weekly on Mondays and Thursdays. The following concerns were identified: a. Observation on 10/22/13 at 7:05 PM revealed the resident had long, jagged fingernails with brown matter under the nail beds. Observation on 10/24/13 at 5:10 PM showed the resident had long, jagged fingernails with brown matter under the nail beds. Observation on 10/24/13 at 6 PM revealed the resident was eating a hamburger with his/her hands and removed the pickle from the hamburger with his/her fingers. The resident's fingernails continued to be long, jagged and have brown	F 312	The facility will ensure that personal ADL/Hygiene care needs are met for residents who are dependent upon staff. This will be accomplished by: A. Resident #4, #19, #48 will receive personal ADL/Hygiene needs, including nail care, a minimum of 2 times per week with their scheduled bath time. B. All residents who are dependent for personal ADL/hygiene needs have the potential to be affected by this deficiency. A facility wide audit will be conducted by DON or designee for all residents to evaluate Hygiene needs with special emphasis on nail care. Any identified issues will be addressed immediately. C. DON or designee will provide education to facility nursing staff on facility standards for resident ADL/hygiene and nail care. DON or designee will observe and assess 8 residents weekly for hygiene needs and nail care. D. The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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F 312	Continued From page 24 matter under the nail beds. Observation on 10/25/13 at 9:07 AM revealed the resident's fingernails continued to be long and jagged, and the brown matter remained under his/her nail beds. Interview with RN #9 at the time of the observation confirmed the resident received baths 2 times a week and routine nail care was supposed to be performed during bathing. b. Review of the CNA notes revealed the resident received baths 2 times weekly during the evening shift. The resident received baths on 10/21/13 and 10/24/13. 2. Medical record review showed resident #19 was admitted to the facility on 9/10/13 with diagnoses including confusion and dementia. Review of the MDS admission assessment dated 9/20/13 showed the resident was severely cognitively impaired and required extensive assistance with ADLs including bathing and hygiene. Review of the care plan dated 9/20/13 showed the resident had a self-care deficit related to dementia and manifested by incomplete ADLs. Approaches/interventions included staff providing extensive assistance with bathing and grooming. Review of the bath schedule for the resident showed the resident was supposed to receive showers 2 times weekly in the AM on Tuesdays and Fridays. The following concerns were identified: a. Observation on 10/21/13 at 4 PM revealed the resident was seated on the 400 hall at the CNA desk, the resident's fingernails were long, jagged and had thick dark brown matter under the nail beds. Observation on 10/22/13 at 7:35 PM revealed the resident had long, jagged fingernails with thick dark brown matter under the nail beds. Observation on 10/24/13 at 4:37 PM revealed the resident had long, jagged fingernails	F 312	This page left blank intentionally	

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F 312	Continued From page 25 with thick dark brown matter under the nail beds. Observation of the evening meal on 10/24/13 at 5:37 PM revealed the resident used his/her fingers to pick-up and eat hamburger and pieces of fruit. Observation on 10/25/13 at 9 AM with RN #12 verified the resident's fingernails remained long and jagged with thick brown matter caked under the nail beds. Interview with CNA #22 at the time of the observation verified the resident had received a shower earlier that morning and nail care had been performed. During the observation CNA #35 stated, "she's lucky she got her shower, the way she pinches and grabs." b. Review of CNA bathing documentation revealed there was no documentation whether showers were given as scheduled for the following dates: 9/17/13, 9/20/13, 9/27/13, 10/11/13, and 10/18/13. c. Interview with the MDS coordinator on 10/24/13 at 3:50 PM verified showers and hygiene were supposed to be documented by the CNA on the computerized record under AM and PM bathing and hygiene tabs. 3. Medical record review showed resident #48 was admitted to the secured-dementia unit on 6/17/11 with diagnoses including Alzheimer's disease and schizoaffective disorder. Review of the MDS quarterly assessment dated 9/5/13 showed the resident was cognitively impaired and required extensive assistance with ADLs including hygiene and bathing. Review of the care plan updated on 12/13/12 identified that the resident required extensive assistance with ADLs. Approaches/interventions included nail care was performed by CNAs with bathing. Review of the bath schedule for the resident showed the resident was supposed to receive showers 2 times weekly during the evening shift on	F 312	This page left blank intentionally	

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F 312	Continued From page 26 Saturdays and Wednesdays. The following concern was identified: a. Observation on 10/24/13 at 4:45 PM revealed the resident's fingernails were long and polished and upon turning over his/her hands a thick dark brown matter was observed caked under the nail beds. The resident revealed that staff provided nail care because s/he had tremors in both hands. The resident also stated s/he, "had a shower last night". Observation on 10/24/13 at 6 PM revealed the resident used his/her hands to eat a hamburger and pieces of cubed melon during the evening meal. Observation on 10/25/13 at 9:15 AM with RN #9 confirmed the resident's nail beds were caked with thick dark brown matter and should have been cleaned during his/her shower the previous evening. Review of the facility's policy and procedure entitled, "Routine Care", last review date 9/2011 listed under, "IV. Procedure/Interventions: 4. Daily body care will be given as resident condition necessitates".	F 312		
F 323 SS=K	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,	F 323	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 will be accomplished by: A) On 10/23/2013, the Facility staff initiated an action plan that: a. Provided supervisors on the floor to augment current staffing levels to assist with supervision, care delivery	

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F 323	Continued From page 27 staff and resident interview, review of incident documentation, and resident and family interview, the facility failed to ensure effective supervision and interventions were implemented to prevent falls for 11 of 18 sample residents (#4, #6, #15, #19, #23, #32, #39, #51, #84, #86, #88) identified at risk for falls. In addition, serious injuries related to falls occurred to sample residents #88, #89, #84, and #32. The facility's failure to promote an environment of safety for fall-prone residents resulted in a determination of immediate jeopardy. The findings were: 1. Review of the medical record face sheet showed resident #88 was admitted to the facility on 4/12/12. The resident's diagnoses included Parkinson's disease and Alzheimer's disease. The resident's medical history included surgical repair of the left hip and placement of orthopedic hardware. The resident lived on the secure dementia unit. Review of incident reports for September and October 2013 showed this resident had 6 falls, one of which occurred on 9/18/13 at 4:39 PM resulting in significant injury to the resident's left hip. The following concerns were identified: a. Review of incident records showed the resident fell in his/her room on 9/1/13 at 6:40 AM and this fall was unwitnessed by staff. The resident fell a second time the same day, this time in the dining room at 2:50 PM, again unwitnessed by staff. Interventions developed after each of these falls instructed staff to "continue to observe." b. Review of incident notes showed the resident fell twice on 9/18/13; the first fall was in the dining room at 4:39 PM and was unwitnessed by staff. This fall resulted in complaints of pain to the left hip, ecchymosis to the left elbow, and	F 323	and overall operations. b. Created an interim staffing schedule detailing how care delivery would be maintained until a more permanent solution could be discovered. c. Initiated a newly devised hourly rounding procedure to ensure proper care delivery for all residents. d. Conducted education/training on resident safety and supervision with 100% of scheduled staff at the beginning of each employee's shift. e. Residents #4, #6, #15, #19, #32, #39, #51, #84, #86 and #88 were given a new falls risk assessment. Care plans of these residents were reviewed and all new and existing falls prevention interventions were implemented immediately. This was initiated in order to ensure effective supervision and interventions to prevent falls for residents #4, #6, #15, #19, #32, #39, #51, #84, #86, #88. B) All residents who are identified as a high fall risk have the potential to be affected by this deficiency. On 10/23/2013, all facility residents were given new fall risk assessments by the facility IDT. The care plans of the identified residents were reviewed for needed changes and all new and existing	

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F 323	Continued From page 28 erythema noted to the left shoulder. The incident report noted the resident had a tabs alarm placed on his/her wheelchair and staff were instructed to provide "frequent checks to promote safety." At 9:10 PM that evening (9/18/13) the resident had another fall, this was in the activity room. The incident note showed the resident was self-transferring from the wheelchair to the couch and a staff member witnessed the fall. The resident complained to staff of pain in the left hip following this fall. The physician was notified and the resident was examined that evening; an x-ray was scheduled for the following day. Review of the x-ray report, dated 9/19/13, showed two views revealed damage to the hip and the existing orthopedic hardware; "...there is more collapse of the superior femoral head. The screw now is broken through the collapsing cortex." c. Continued review of incidents in the residents record showed an unwitnessed fall on 9/20/13 at 1 AM which resulted in complaints of pain to the left knee. Resulting documentation instructed staff to educate the resident on "staying in bed and using the call light." d. Incident logs showed the resident continued to fall; on 9/20/13 the resident had an unwitnessed fall at 4:10 AM. The resident was found in his/her room on his/her knees leaning against the bed with his/her incontinence brief off, calling out for help. The note further documented the resident's continued complaint of pain in the left hip. e. Observation on 10/22/13 at 9:40 AM showed the resident wheeled him/herself away from the dining room table without staff assistance. The resident wheeled down the hallway and into another individual's room. The resident opened the closet and looked around the room. The hallway was not in view of the dining	F 323	interventions were implemented immediately. C) DON or designee will provide education to facility nursing staff on the following topics: a. Falls prevention and proper resident supervision. b. Urgency towards fall alarms c. The Falling Stars Program d. Documented Hourly Rounds e. Safety Interventions, monitoring and compliance f. Post Fall Huddles g. Communication of updated resident interventions via pre shift report The facility DON or designee will conduct an audit on all falls to ensure that facility fall prevention systems are in place and that appropriate assessments and/or interventions have been implemented. The facility DON or designee will also conduct daily audits of staff supervision and compliance towards resident fall prevention interventions. D) The results of the daily and fall audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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F 323	Continued From page 29 area, and there were no staff in the area until 9:51 AM, when non-certified nurse aide (NA) #2 noticed the resident and asked him/her what s/he was doing. The resident stated s/he was looking for the bathroom. The NA wheeled the resident out of the room and called to a CNA for assistance. At 10:06 AM CNA #11 and the training aide transferred the resident from the wheelchair to the bed using a full Hoyer mechanical lift. Prior to the transfer the resident repeatedly stated s/he needed the bathroom and to "hurry." The aides transferred the resident into bed where his/her incontinence briefs were changed. As the resident was being laid down, s/he was crying out and ringing his/her hands. The aides stated that movement caused pain to resident's left hip. f. Review of a nurse's note dated 10/22/13 timed at 2:59 PM showed the resident had another fall on 10/22/13 at "approx" 1 PM. The fall was unwitnessed and happened in the dining room. The note showed the resident did not have any injuries, denied pain, and staff were instructed to "continue to monitor." g. Review of the ADLs care plan showed it was updated on 3/12/13 to add extensive assistance required for toileting. A subsequent care plan update on 9/12/13 further added extensive assistance for grooming, dressing, bed mobility, and ambulation. This later care plan showed the resident used a walker and a wheelchair for mobility and had a "personal alarm." The care plan did not address any toileting schedule or plan. Review of a 9/26/13 updated care plan showed fall related interventions dated 11/16/12 and 11/20/12 instructed staff to remind the resident to call for help, keep personal items in reach, provide non-skid footwear, and remind the resident to take big steps if s/he was observed with a	F 323	This page left blank intentionally	

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F 323	Continued From page 30 shuffling gait. As of 10/22/13 these approaches were essentially unchanged, supplemented with staff instructions dated 9/19/13 to "transfer with assistance, instruct to call for help." The 9/19/13 instructions were reiterated on care plan reviews dated 9/20/13, and 9/26/13. There were no interventions on the resident's care plan to identify factors contributing to his/her falls or to actively prevent further falls; neither was any information added to the resident's care plan related to pain and injury to the left hip. h. Interview with the unit manager, RN #11 on 10/22/13 at 3:33 PM, verified the resident was at risk for falls and stated the resident should be supervised in the main area of the unit and not left in the wheelchair in his/her room alone. 2. Review of the care plan for resident #39 showed s/he was admitted in April 2013. Review of the ADL portion of the care plan showed it was initiated on 4/16/13 and there were new approaches developed on 7/18/13 and 10/8/13. These approaches showed the resident was increasingly unsteady and required assistance to ambulate. The resident was also noted to require extensive assistance for bed mobility, toileting, transferring, locomotion, grooming and dressing. Review of the 4/16/13 care plan showed the resident was at risk for falls based on a history of falls, unsteady gait/balance, and medications that could contribute to loss of balance. There were no approaches for fall prevention shown prior to 7/18/13, even though the resident had a fall and a fall-related fracture in May 2013. The care plan instructed staff to promote comfort, provide transfer with assistance, "instruct the resident to call for help (reinforce the use of the call light rather than screaming at staff)", assure good hygiene, assure adequate pain management,	F 323	This page left blank intentionally	

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F 323	Continued From page 31 place the bed in the lower, locked position, keep personal items in reach, and to anticipate needs. The following concerns were identified: a. Review of the medical record and incident reports showed the resident had an unwitnessed fall on 5/14/13 at 10:50 AM. The fall occurred in the resident's room and was attributed to the resident being "impatient with staff and attempted to transfer self from recliner to bed." The post-fall investigation failed to note if the resident's call light was in reach or had been activated. Accompanying documentation showed the resident had a skin tear to the right elbow. No further injuries or pain were identified at that time. Staff were instructed to "continue to observe" and teach the resident "safe transfer techniques [and] use of call light." b. Review of a radiology report dated 5/15/13 showed the resident was evaluated for complaints of pain to the left hip after the 5/14/13 fall. Diagnostic imaging revealed "...transverse subcapital fracture of the left femur with 50% cranial displacement of the shaft in relation to the head." c. Review of an incident dated 9/13/13 showed the resident was "very argumentative" when found kneeling in front of his/her wheelchair. The incident report alleged the resident to state, "[s/he] needs in [his/her] wheelchair right now, what the f--- is taking so long" and "[s/he] has to go to the bathroom, and no one ever responds to the call bell." There were no complaints of pain or injury attributed to this fall episode. d. Review of a 9/17/13 incident report showed the resident had an unwitnessed fall at 5:30 PM in the his/her room. The report stated the resident was "trying to get into [his/her] chair from the bed." As a result of this fall, staff were required to	F 323	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	C 10/25/2013

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F 323	Continued From page 32 educate the resident to "use of call light, instructed resident on being patient on staff when it comes to [his/her] needs." e. Review of the care plan related to falls revealed updated approaches dated 9/17/13. The documented approach instructed staff to anticipate the resident's needs, locate the resident near staff when out of bed, transfer with assistance, and instruct resident to call for help. The care plan failed to reflect the resident's fractured left hip. f. Observation on the evening of 10/22/13 at 6:10 PM showed the resident's call light was on and the resident was yelling loudly for "help." The resident's room was located at the far end of the hallway and was not visible from the main areas of the unit. The call light had an audible tone, but it was low in volume and only audible in the immediate vicinity of the nurses' station. There were no staff readily available in either the nurses' station or the area around the resident's room. Observation and interview with the resident at that time revealed s/he was sitting up in bed with his/her feet on the floor. The resident stated s/he needed help to go to the bathroom, needed his/her incontinence brief changed, needed the bed rearranged, and was cold. The surveyor asked the resident to wait while a staff member was located. The resident expressed concern that help took a "long time." After leaving the resident's room, the surveyor searched for a staff member to assist the resident. The call tone was still sounding from the nurses' station, but there were no staff within hearing distance of the alarm. At 8:15 PM, three staff were on the secure unit; CNA #2 was in the main area assisting another resident, another aide was assisting a resident with a shower, and LPN #10 was passing medications. Interview with the LPN at 8:20 PM	F 323	This page left blank intentionally	

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

PRINTED: 11/08/2013
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
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F 323	Continued From page 33 verified there were two CNAs assigned to the hall where resident #39 was located, and both were helping other residents; the LPN continued passing medications. At 8:20 PM interview with the resident revealed s/he often waited "...a very long time, they don't care about you here. Around here they don't come for a very long time." At 8:30 PM, 20 minutes after the call light had been activated, LPN #10 responded to the resident when she was made aware by the surveyor of the resident's continued need. 3. Review of the medical record face sheet showed resident #84 was admitted on 4/26/13. The resident lived on the secure unit of the facility and had diagnoses that included dementia. Review of the 4/26/13 fall risk assessment revealed the resident's fall risk was influenced by decreased safety awareness, poor recall and judgment, impaired mobility, balance problems when standing, decreased muscular coordination, and a need for assistance with toileting. The risk assessment further showed the resident had a history of falls and had a fall with a fracture prior to admission. Review of the resident's care plan showed fall risks were included on a 5/15/13 update after the resident had a fall. However, there were no interventions dated prior to 8/12/13, when staff were instructed to "proactively promote comfort use assistive devices: wheelchair for locomotion...transfer with assistance...low bed with wheels locked, keep personal items in reach, provide brighter lighting...corrective eyewear..." Supplemental approaches dated 9/12/13 and 9/19/13 required nurse aides to "anticipate needs, locate near staff when out of bed." The following concerns were identified: a. Review of the facility fall log documentation showed the resident fell 6 times on 5/1/13. The	F 323	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 34 log showed two of those falls were unwitnessed, the remaining 4 falls were incompletely documented and failed to include details about the time and location of the falls. There were no injuries attributed related to these falls. The resident fell twice on 9/12/13, one fall was witnessed by staff and one was not. There were no injuries documented for these falls. The resident also had another observed fall without injury reported on 9/19/13. b. Review of fall documentation showed the resident had an unwitnessed fall on 10/21/13 at 11 AM. The resident subsequently complained of pain in the right forearm and right thigh. Staff were required to "continue to observe" and the resident was instructed on use of the call light and not to self-ambulate. c. Observation on 10/21/13 at 3:22 PM showed the resident was wheeling him/herself in the hallway closest to the main entrance to the secure unit. The resident was observed to go into room 526 and stand partially up from his/her wheelchair. At that time the resident's tabs alarm monitor was activated. There were no staff in the area at that time and the alarm sound was unnoticed by staff. Continued observation showed the resident sat back down, wheeled around the room, and eventually returned to the hallway. The surveyor asked the resident if s/he heard the sound of the alarm and the resident denied hearing anything. The surveyor observed the resident with the alarm sounding until 3:33 PM (11 minutes), at which time LPN #1 came down the hall and reattached the alarm so it stopped. d. Review of a nursing note dated 10/22/13 at 9:35 AM showed the resident was assessed and medicated for "severe" pain in the right wrist. A 5:29 PM nurse's note that day showed the physician was contacted regarding the wrist pain	F 323	This page left blank intentionally	

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F 323	Continued From page 35 following the most recent fall and an x-ray order was obtained. Review a nurse's note from 10/23/13 at 8:37 AM revealed x-ray findings showed "an impacted distal radial fracture with a transverse and vertical component." The note showed the physician would be in "ASAP" (as soon as possible) to assess the resident and place a splint. 4. Review of the medical record for resident #32 showed the resident was admitted to the facility on 10/2/13 with diagnoses including non-Alzheimer's dementia. Review of the MDS admission assessment dated 10/10/13 showed the resident was cognitively impaired and required extensive assistance with ADL's including ambulation. Review of the CAA dated 10/3/13 showed the resident was getting up frequently unassisted, was unsteady on his/her feet, and was at risk for falls and significant risk for physical illness or injury. Care plans dated 10/14/13 showed the resident required extensive assistance with ADL's, was at risk for falls, and had poor safety awareness related to dementia. Approaches/interventions updated 10/19/13 included instructing the resident to call for help, sensor alarms in the bed and chair, tab alarms and bed in lower, locked position. The following concerns were identified: a. Review of fall documentation showed the resident sustained unwitnessed falls on 10/18/13, and 10/19/13. The resident was observed on the floor in the 400 hallway on 10/18/13 at 10:30 AM and complained of pain in the right buttock. Actions taken included continuing to observe and teaching safe transfer techniques. On 10/19/13 at 1 PM the resident was, "found down" in his/her room and complained of pain in right hip. Actions included "continue to observe." There was no	F 323	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 36 documentation indicating whether alarms were in place and/or functioning or if the bed was in a low, locked position. A fall risk assessment was conducted on 10/19/13 at 2:01 PM, after the second fall, and indicated the resident was at risk of falling related to decreased safety awareness and dementia. b. Review of an x-ray dated 10/21/13 showed the reason for the exam was due to 2 falls and severe pain. The MD radiology impression was an "acute fracture new from September 2013 of the superior and inferior pubic rami on the right." c. Observation on 10/21/13 at 3:25 PM revealed the resident was seated in a recliner in his/her room. The sensor alarm was observed lying under the resident's bed, the tab alarm was lying on the resident's dresser in the off position and not attached to the resident's clothing. CNA #22 entered the resident's room stating, "I forgot to put your alarm back on." The CNA placed the tab alarm clip on the resident's clothing, but did not check the alarm and was not aware the alarm was turned off until informed by the surveyor. The sensor alarm remained under the resident's bed. The CNA indicated at the time of the observation that the resident was supposed to have the tab alarm on while sitting up. Observation on 10/22/13 at 7:50 PM revealed the resident's sensor alarm was alarming. LPN #12 was observed in the hallway at the medication cart beside the resident's open door. The LPN walked away from the medication cart into another resident's room and shut the door. CNA #10 responded to the alarm at 7:55 PM. At 7:57 PM the resident's sensor alarm began alarming again and CNA #10 responded to the alarm at 8:01 PM and offered to take the resident to the bathroom, the resident declined. The CNA instructed the resident to use the call light for assistance.	F 323	This page left blank intentionally	

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F 323	Continued From page 37 Observation on 10/23/13 at 2:10 PM revealed the resident was seated in a recliner in his/her room. The resident's tab alarm was lying on the bedside table turned off and the sensor alarm was lying under the resident's bed, turned off. At 2:18 PM an unidentified staff member walked into the resident's room stating, "I didn't think she hooked you up". The tab alarm was turned on and the clip was attached to the resident's clothing. The sensor alarm was left lying under the resident's bed. An interview with RN #5 at 2:18 PM revealed staff were preparing to move the resident to a room closer to the nursing station. d. Interview with CNA #10 on 10/22/13 at 8:05 PM revealed CNAs and nurses were supposed to check resident alarms prior to the end of their shift to ensure alarms were in place and functioning. Interview with CNA #2 on 10/22/13 at 8:35 PM revealed all staff were responsible for checking to see if alarms were in place and maintenance was responsible for ensuring alarms were functioning properly. Interview with the IDON on 10/25/13 at 9:55 AM revealed he expected all staff to respond to alarms. 5. Review of the medical record for resident #19 showed the resident was admitted to the facility on 9/10/13 with diagnoses including dementia and confusion. Review of the preadmission screening and resident review for nursing facility admission (PASSR) level II dated 8/27/13 showed, "Recommendations regarding services that may be needed at the nursing facility include: Close supervision to prevent further falls." The medical record further revealed that prior to admission the resident sustained a fall on 7/24/13 resulting in a right hip fracture and underwent surgical repair with hardware placement. The admission MDS assessment dated 9/20/13	F 323	This page left blank intentionally	

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F 323	Continued From page 38 showed the resident was severely cognitively impaired, required extensive assistance with ADL's, used a wheelchair for ambulation, and had fallen prior to admission. Review of the CAA dated 9/20/13 showed the resident was at risk for falling. Review of the care plan dated 9/20/13 showed the resident had the potential for trauma/falls related to gait/balance, history of falls, medications and mental status (poor safety awareness). Approaches/interventions included sensor alarm, pull tab alarm in bed and chair, and to instruct the resident to call for help. The care plan was updated on 9/21/13 to include the approach, "transfer with assistance and instruct to call for help." The following concerns were identified: a. Review of fall documentation showed the resident sustained falls on 9/21/13, 10/4/13 and 10/6/13. Review further showed none of the falls were observed by staff. Review of the fall documentation for 10/6/13 showed the resident had sustained a, "large hematoma [bruise] on the right side of forehead". Actions included continue to observe, instruct resident on needing assistance with transfers, anticipate needs and locate near staff when out of bed. The fall on 10/6/13 showed actions which included continue to observe, ice pack applied, vital signs and neurological checks every 15 minutes for 1 hour, then every 30 minutes for 2 hours then every hour for 4 hours, and the resident was instructed on safe transfer techniques. b. Observation on 10/21/13 at 10:20 AM revealed the resident had a yellow, purple tinged bruise on the right side of his/her face surrounding the peri-orbital (eye) area. Continuous observation on 10/22/13 from 7:35 PM until 8:07 PM revealed at 7:35 PM the resident was observed on the 400 hall at the CNA	F 323	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 39 desk seated in a locked recliner that was pushed up to the desk. The resident's wheelchair was observed to the left of the resident with the tab alarm attached to the back of the wheelchair near the right handle. The alarm was turned off and the clip that attaches to the clothing was wrapped around the right handle of the wheelchair. No staff was present. The resident was observed standing up and sitting down repeatedly, there were no alarms in the recliner or attached to the resident's clothing. At 7:40 PM the resident was observed getting up out of the recliner and attempting to turn around between the desk and the recliner. The resident sat back down in the recliner and put his/her feet upon the side of the desk, and pushed the desk with both feet. At 7:50 PM CNA #10 exited a resident's room and approached the resident who was attempting to stand up. The CNA assisted the resident to transfer to his/her wheelchair and stated, "How would you like to visit [resident name]?" The tab alarm was not turned on or attached to the resident's clothing. The CNA wheeled the resident down the hall into another resident's room where LPN #12 was performing a medication pass. At 7:52 PM an alarm began alarming across the hall, CNA #10 exited the room to respond to the alarm. LPN #12 exited the room leaving the resident unattended in another resident's room. The resident was observed attempting to stand up and was redirected by the other resident, "[resident name] you need to sit back down, you are going to fall." CNA #10 reentered the resident's room at 7:55 PM with a nursing aide student and proceeded to apply lotion to the other resident's legs and assist the other resident with toileting in the presence of resident #19. An interview was conducted with CNA #10 at the time of the observation and s/he was made aware	F 323	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 40 the resident's tab alarm was turned off and not attached to the resident's clothing. The CNA was unaware the resident was supposed to have a sensor alarm in the seat of the wheelchair. Interview further revealed CNAs and nurses were supposed to check resident alarms prior to the end of their shift to ensure alarms were in place and functioning. c. Subsequent observation made on 10/23/13 at 8:50 AM revealed the resident was in a recliner at the 400 hall CNA desk. There was no tab alarm attached to the resident's clothing or on the recliner, and there was no sensor alarm in the seat of the recliner. 6. Review of the medical record for resident #86 showed the resident was admitted to the facility on 1/4/05 with diagnoses including non-Alzheimer's dementia. Review of the annual MDS assessment dated 10/15/13 showed the resident was moderately cognitively impaired and had a history of falls. Review of the care plan updated 10/23/13 showed approaches/interventions including instruct to rise slowly, instruct to call for help, encourage asking for assistance, anticipate needs and locate near staff when out of bed. Review of the fall documentation revealed the resident sustained unwitnessed falls on 8/23/13, 9/2/13, 10/14/13, 10/15/13, and 10/23/13. The following concern was identified: Interview with the resident on 10/24/13 at 4:30 PM revealed s/he was able to recall falling in the AM of 10/23/13. The resident stated, "it was early in morning before breakfast and I had to go to the bathroom so I put my call light on and after nobody came, I got up to go to the bathroom, lost my balance and fell." The interview further revealed the resident had to wait, "at least 15	F 323	This page left blank intentionally	

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F 323	Continued From page 41 minutes, sometimes longer, before someone comes to answer the call light." The resident was able to recall falling several times in the last month but was unable to recall specific dates, and complained of, "I hurt my right hand, but it is better now." 7. Review of the medical record for resident #4 showed the resident was admitted to the facility on 7/31/13 with diagnoses including non-Alzheimer's dementia. Review of the admission MDS assessment dated 8/7/13 showed the resident had wandering behaviors, was moderately cognitively impaired, and required supervision from staff when ambulating with a walker. Review of the CAA dated 8/1/13 showed the resident was at risk for falling and had a fall on 8/1/13 and the resident's, "gait is choppy and [s/he] slides feet at times". Review of the care plan updated 8/15/13 showed the resident had potential for trauma-falls related to impaired balance, unsteady gait, and use of devices for walking and fall in recent past. The care plan approaches were updated on 10/24/13 with interventions including, proactively promote comfort, instruct to rise slowly, increase assistance and surveillance. Review of fall documentation showed the resident sustained unwitnessed falls on 8/1/13, 8/31/13, 9/16/13, 9/21/13, and 9/23/13. The following concerns were identified: a. Further review of fall documentation revealed the resident complained of pain in the left ribs from the fall on 8/31/13, and continued on 9/1/13 to have, "left side pain with a protruding area on left lower ribs." An x-ray of the ribs was done on 9/3/13 and the impression showed no evidence of a displaced rib fracture. The fall on 9/16/13 showed the resident was disoriented and,	F 323	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 42 "found down from sitting in another resident's wheelchair." The resident sustained a hematoma to the back of his/her head. The fall on 9/21/13 showed the resident sustained an abrasion to the right knee. The fall on 9/23/13 showed the resident already had abrasions on both knees and the right knee was bleeding and required a dressing. Actions after falls included continue to observe, monitor vital signs and perform neurological assessments, and the resident was instructed on safe use of assistive devices and using the call light. b. Observation on 10/22/13 at 7:05 PM revealed the resident ambulating with the assistance of a rolling walker on the secured unit. The resident was walking in the main dining area behind seated staff and into the hall to the left of the main dining area out of the line of sight of staff. The resident was unsteady with turning the walker and at times picked the walker up and carried it. Observation on 10/25/13 at 9:07 AM revealed the resident was in the main dining area on the secured unit. The resident was standing by a reclining chair, picked up his/her walker and turned it upside down examining the wheels. The resident then turned and sat in the recliner, picked up the walker and placed it in his/her lap. At 9:10 AM the resident was redirected by RN #9. c. Review of the medical record showed there was no assessment of the resident's ability to safely ambulate with the rolling walker. 8. Review of the care plan for resident #51 showed s/he had diagnoses of Alzheimer's disease and was at risk for falls due to impaired balance. Care planning for falls was initiated on 9/2/12 and included approaches dated 7/1/13, 9/7/13, and 10/1/13; these approaches required staff to provide assistance with transfers, instruct	F 323	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 43 the resident to call for help, anticipate the resident's needs, and locate near staff when out of bed. The care plan also addressed the resident's wandering behavior in a note dated 10/3/12. The 10/3/12 approach required staff to record behaviors and maintain the safety of the resident and others around the resident. There were no details explaining how this maintenance of safety would be provided. The 10/1/13 approach further showed when the resident was "acting out" staff were directed to visit with him/her. Observation on 10/21/13 identified the following concern related to fall risks and supervision: a. At 3:25 PM the resident was wandering in the hallway and into other residents' rooms. The resident ambulated without staff assistance and without any assistive devices. During this time there were no staff in the hallway and the hallway was not visible from the main dining and television areas where staff were located. b. At 3:33 PM the tub/shower room door was observed ajar. The room lights were off and the door was noted to have a key pad lock. Two spray bottles of chemical cleaner labeled "Virex" were seen on a counter inside the room. Continued observation showed the tub/shower room remained open and unoccupied until 3:50 PM, when the IDON came into the unit and the surveyor asked about the door being opened. The IDON stated that the door should be closed and, when closed, required a key pad code to unlock and open. c. At 3:43 PM the resident was noticed by the surveyor to be missing from the hallway and the main areas of the unit. When asked at 4 PM nurse aide #1 stated she had not seen the resident and did not know where s/he was. This aide inquired of another CNA who did not know	F 323	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 44 the resident's whereabouts. At 4:30 PM (47 minutes after noticed missing) unit manager, RN #11 went room to room down the hallway looking for the resident. The resident was found in another resident's room asleep in an armchair. 9. Review of fall documentation for resident #23 showed the resident experienced falls on 5/23/13, 6/10/13, 9/18/13 and 10/18/13. Review of the care plan showed the resident was at risk for falls based on impaired balance, an unsteady gait, and falls in the recent past. The care plan was initiated on 10/25/12 and was updated on 7/19/13, 9/18/13 and 10/18/13 after additional falls. The approaches were for staff to ensure the call button was within reach, to assist the resident with ambulation, toileting and transferring, to anticipate needs, and to locate the resident near staff when out of bed. These approaches remained the same after each fall. Beginning 10/22/13, resident medical records and facility falls records were reviewed in detail. From these data it was discovered that resident #23 fell 3 times between 8/26/13 and 10/18/13 (8/26/13, 8/27/13, 10/18/13; all without injury); s/he also had 2 falls in April 2013 (noted in Care Plan note dated 5/8/13). From the resident's care plan it was further documented that s/he had poor safety awareness, was not inclined to use her call light or ask for assistance, and continued to show declined cognition and increased confusion. For each of the falls noted, facility staff listed interventions to " ...instruct to use call light...teach resident to request assistance...place call button in reach...anticipate needs." Interview with LPN #11 on 10/23/13 at 9:20 AM confirmed the resident's declining mental status and falls history. The LPN acknowledged the resident was not a good candidate for	F 323	This page left blank intentionally	

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F 323	Continued From page 45 teaching and might not associate the call button with the need to transfer or reposition. Further interview with the MDS/Care Plan coordinator on 10/23/12 at 2:20 PM confirmed the resident had short-term and long-term memory problems and was not always able to retain new information. She acknowledged interventions based on instructing, teaching, and cognitive association would not be consistently effective for this resident. She did not know why fall prevention interventions were not individualized for this resident. 10. Based on facility falls data and medical record review, it was discovered resident #16 had 13 falls since admission on 10/9/13 (4 falls on 10/9/13, 2 falls each on 10/10/13, 10/12/13, 10/15/13, and a single fall on 10/20/13; all without injury). In each case, post-fall assessment and interventions stated "transfer with assistance, instruct to call for help" and "anticipate needs, locate near staff when out of bed." Observations on 10/23/13 and 10/24/13 revealed the resident was seated in the 200 unit hallway in the vicinity of the nurses' station, but staff were not consistently in the area; 4 observations ranging from 35 to 71 minutes showed staff were not near, nor in line-of-sight, should the resident need assistance or attempt to self-transfer or stand. The resident's care plan further stated s/he exhibited cognitive decline, memory loss, and dementia. There was nothing in the care plan to address the resident's recent admission to the facility or his/her adjustment to the new living environment. Interview with the MDS/Care Plan coordinator on 10/23/13 at 4:05 PM confirmed the resident was a high risk for falls since his/her admission two weeks ago. She acknowledged the planned interventions were unsuccessful and an	F 323	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 46 individualized approach might be helpful in reducing further falls. 11. Review of the medical record for resident #6 showed s/he had diagnoses of dementia and a history of transient ischemic attack. Review of a fall risk assessment dated 10/13/13 revealed s/he was at risk for falls due to poor recall, judgement, and safety awareness, poor vision, balance problems and decreased muscular coordination. Review of the resident's care plan revealed a plan for falls last reviewed on 8/21/13. Interventions included providing assistance with transfers, to instruct the resident to call for help, to assist the resident with ambulating, transferring and toileting (if s/he would allow), to anticipate needs, and locate near staff when out of bed. The following concerns were identified for the resident related to fall risks and supervision: a. The goal initiated for the falls care plan, dated 5/21/13 was "minimal injury from falls" rather than preventing falls. This goal was then deemed met on 8/21/13, even though the resident had suffered 2 falls in the intervening time with one of those fall resulting in "minor injury." b. Review of facility incident logs revealed the resident had suffered falls most recently on 10/6/13 and 10/21/13. The resident's care plan was updated on both of those occasions with "Transfer with assistance" and "Instruct to call for help." c. Review of the resident's 8/15/13 annual MDS assessment revealed the resident had a BIMS score of 3, indicating severe cognitive impairment. Interview with the MDS coordinator on 10/23/13 at 2:20 PM confirmed that interventions based on instruction and teaching would not be effective for a resident with severe	F 323	This page left blank intentionally	

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GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

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F 323	Continued From page 47 cognitive impairment. d. Observation of the secure unit common area on 10/22/13 at 7:25 PM showed the resident wheeled him/herself over to the kitchen-area gate in his/her wheelchair. S/he then proceeded to unlatch the gate, and wheel him/herself into the kitchen area. At this time, the resident was noted to be in the direct line-of-sight of three aides in the area. The resident was observed to spend 10 minutes propelling him/herself around the kitchen, and pulling him/herself up out of his/her wheelchair to rummage in containers on the counter. At 7:35 PM the resident left the kitchen area without once being engaged by any of the staff present in the area. 12. Review of the data provided by the facility covering the interval from May through October (10/23/13) 2013, showed residents experienced 197 falls. Of 48 residents identified as having falls, 24 (50%) were noted to have multiple falls within the 6-month time frame; 22 (46%) experienced multiple falls within the past 90 days. During this same 6-month interval, the facility recorded 14 instances of falls resulting in skin tears or abrasions, 16 with swelling or bruising, 3 with lacerations, and 4 with fractures identified by diagnostic imaging; 2 of the falls with fractures occurred within the past 2 weeks. There were 6 instances of resident falls when facility staff failed to document the presence or absence of injury following the fall. 13. Interview with RN #12 and the MDS coordinator on 10/22/13 at 2 PM revealed the number of resident falls had been identified as a concern back in August 2013. Both stated a new process was needed and part of the problem was not having adequate information about the	F 323	This page left blank intentionally	

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F 323	Continued From page 48 resident falls to complete post fall evaluations. On 10/23/13 at 9:30 AM, the administrator was notified of an immediate jeopardy situation in the area of patient safety related to falls. The facility's action plan included the following immediate changes: a. Provide supervisors on the floor to augment current staffing levels to assist with supervision, care delivery and overall operations. b. The facility will create an interim staffing schedule that detailed how care delivery will be maintained until a more permanent solution can be discovered. c. Nursing administration will complete a newly devised hourly rounding procedure to ensure proper supervision and care delivery of all residents. d. Direct care staff will ensure all safety and fall interventions are fully implemented. Administrator or designee will conduct audits to evaluate the environment is safe for residents with the intent to correct if issues are noticed. e. Administrator or designee will conduct education/training on resident safety with 100% of scheduled staff at the beginning of each employee's shift. The training will include general observation and awareness of all residents, the falling star program, facility wide urgency toward responding to alarms, hourly rounds and monitoring safety intervention compliance, post fall huddles, and communication of updated resident interventions via pre shift report. f. The facility will complete a new falls risk assessment for 100% of residents. g. Identified residents' care plans will be reviewed for needed changes and updated interventions. All new and existing interventions will be implemented immediately.	F 323	This page left blank intentionally	

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F 323	Continued From page 49 h. Ongoing monitoring by the licensing office by the facility submitting nursing schedules and incident data for the previous 7 days each Friday until the revisit survey. The action plan was accepted on 10/24/13 at 2:47 PM, and based on implementation of the plan, the immediate jeopardy was abated on 10/25/13 at 4:13 PM. However, deficient practice remained at a scope and severity of H (actual harm that is not immediate jeopardy).	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This will be accomplished by: A) Resident #19 will have complete medication regimen evaluated by a licensed pharmacist for suggestions that may include changes in medications and/or gradual dose reductions. Resident #19 will also receive a new AIMS assessment by facility nursing staff. Changes in Resident #19's care plan will be initiated if found necessary. B) All residents who receive antipsychotic drug therapy have the potential to be affected by this	

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F 329	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview the facility failed to ensure residents were free from unnecessary drug therapies for 1 of 21 sample residents (#19). The findings were: Review of the medical record for resident #19 showed the resident was admitted to the facility on 9/10/13 with diagnoses including dementia and confusion. Review of the MDS admission assessment dated 9/20/13 showed the resident was cognitively impaired and had hallucinations and delusions. The care plan dated 9/20/13 defined chronic pain and psychotropic medication use as problems. Approaches/interventions included administering pain medications and noting effectiveness and adverse effects and for staff to use a verbal pain assessment tool to assess pain, monitor for impairment of daytime functioning, and evaluate for effectiveness and adverse effects of medication. Review of the medical record also showed documentation the resident recurrently had rigid posturing. The following concerns were identified: a. Review of the medical record showed the resident had physician admission orders for the following pain medications: Acetaminophen 500 mg (1) tablet by mouth every 4 hours as needed for pain, Acetaminophen 500 mg (2) tablets by mouth every 4 hours as needed for pain, Ultram (Tramadol) 50 mg (2) tablets every 6 hours as needed for pain (give first before Percocet as needed for pain), Roxanol (morphine sulfate liquid narcotic pain medication) 20 mg/ml give (0.5ml/10mg) by mouth every hour as needed for	F 329	deficiency. The Facility IDT will conduct a facility wide audit on all residents who are on antipsychotic medications to ensure that their drug regimen is appropriate. The Facility IDT will also conduct a facility wide audit on all residents who require an AIMS assessment to ensure that the assessment has been completed accurately and thoroughly. Any issues identified in these audits will be corrected immediately. C) DON or designee will provide education to Licensed Nurses on antipsychotic medication use and on the AIMS assessment. The Facility DON or designee will conduct weekly chart audits of 5 residents to ensure that appropriate drug regimens are in place and that the AIMS assessment is being completed appropriately. D) The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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F 329	Continued From page 51 pain, Fentanyl (a transdermal narcotic pain patch that is applied and absorbed through the skin) 100mcg (micrograms)/hour apply (1) patch every 3 days for moderate to severe chronic pain, Fentanyl 25 mcg/hr. apply (1) patch every 3 days for moderate to severe chronic pain, and Percocet (a narcotic pain medication containing acetaminophen) 5/325 mg give (1) tab by mouth every 4 hours at midnight, 4 AM, 8 AM, noon, 4 PM, and 8 PM for moderate to severe pain. b. Review of the MAR for September 2013 showed the resident had received 2 doses of Acetaminophen 1000 mg and 1 dose of Acetaminophen 1000 mg, 6 doses of Ultram 100 mg, 57 doses of Percocet 5/325 mg, and both Fentanyl patches totaling 126 mcg/hr were applied 7 times during the month. In October 2013 the resident received 6 doses of Ultram 100 mg, 7 doses of Roxanol 10 mg, 92 doses of Percocet 5/325 mg, and both Fentanyl patches totaling 125 mg/hr were applied 7 times during the month. c. Observation on 10/23/13 revealed the following concerns: At 8:50 AM the resident was asleep seated in a geri chair at the 400 hall CNA desk. Observation from 9:50 to 10:00 AM showed the resident was observed in the same spot in the geri chair asleep and the interim DON was observed trying to rouse resident by sitting the resident up in the chair. The resident was very lethargic and kept nodding off, the resident had his/her arms crossed and had rigid posture of arms and legs. Observation at 11:35 AM revealed the resident was in the main dining room seated at a table asleep. Staff were observed frequently rousing the resident and encouraging him/her to eat. Observation at 6:35 PM revealed the resident was in a wheelchair pushed up to the CNA desk on the 400 hall. The resident was slumped over	F 329	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 52 asleep with his/her chin on chest. At 6:52 PM the resident continued to be slumped over asleep in the wheelchair and his/her head fell forward and bumped the desk. The resident folded her arms under her head and continued to sleep at the desk. Interview with CNA #9 at the time of the observation revealed this was, "normal" for the resident. d. Interview with the registered dietitian on 10/24/13 at 4:20 PM revealed the resident goes through periods of drowsiness every couple of days and doesn't eat well. e. Review of the medical record further showed that in addition to duplicate pain medications the resident also received Seroquel (an antipsychotic medication) 50 mg by mouth twice daily at 7 AM and 7 PM for anxiety, Alprazolam 0.5 mg by mouth twice daily at 1 PM and 1AM for anxiety, Remeron 15 mg by mouth once daily at 8 PM for anxiety and Haldol (an antipsychotic medication) 5 mg intramuscularly every 30 minutes as needed for confusion (the resident received 3 doses in October). Zyprexa (an antipsychotic medication) 2.5 mg by mouth daily as needed for agitation. The resident received the Zyprexa 15 times in September 2013 and 10 times in October 2013 prior to the medication being discontinued on 10/19/13. f. Interview with the MDS coordinator on 10/24/13 at 3:50 PM revealed the resident had not had an abnormal involuntary movement scale (AIMS) assessment performed. The AIMS assessment is used to detect involuntary movements, including rigidity, associated with the use of antipsychotic medications. g. Interview with the IDON on 10/25/13 at 9:55 AM verified the resident had rigid posturing but attributed this to the resident being, "a hard sleeper". Interview further revealed, "staff were	F 329	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 53 probably using pain medication inappropriately at times", related to the resident's multiple behaviors. h. Interview with the pharmacist on 10/25/13 at 12:55 PM revealed staff were not consistently documenting behaviors or side effects of medications and was unaware the resident was displaying rigid posturing. The pharmacist was unaware the AIMS assessment for the resident had not been performed, but did indicate Zyprexa had been discontinued as a result of the pharmacy review performed this month. The pharmacist then verified the resident had duplicate pain medication therapies to manage chronic pain.	F 329		
F 353 SS=K	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353	The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. This will be accomplished by: A) On 10/23/2013, the Facility staff initiated an action plan that: a. Provided supervisors on the floor to augment current staffing levels to assist with supervision, care delivery and overall operations. b. Created an interim staffing schedule detailing how care delivery would be maintained until a more permanent solution could be discovered.	

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F 353	Continued From page 54 duty. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records, nurse staffing schedules and incident documentation related to falls, as well as staff, resident and family interviews, the facility failed to ensure sufficient numbers of qualified nursing staff were available to meet residents' needs and to provide adequate supervision for 11 of 18 sample residents (#4, #6, #15, #19, #23, #32, #39, #51, #84, #86, #88) identified at risk for falls. Serious injuries related to falls occurred to sample residents #88, #39, #84, and #32. In addition, of 48 residents identified as having falls in the last 6 months, 24 (50%) were noted to have multiple falls. At the time of survey, the facility census was 95. This failure to provide adequate numbers of nursing staff to supervise fall-prone residents resulted in a determination of immediate jeopardy. The findings were: 1. Refer to F323 for details regarding the facility's fall data and failure to provide the required nursing supervision and interventions to promote an environment of safety for fall-prone residents including sample residents #4, #6, #15, #19, #23, #32, #39, #51, #84, #86, and #88. Serious injuries related to falls occurred to sample residents #88, #39, #84, and #32. This failure resulted in a determination of immediate jeopardy related to resident safety. 2. Review of the daily nursing staffing schedules for September and October 2013 showed there was not a consistent pattern for staffing. The schedule was divided into 4 units (200, 300, 400	F 353	c. Initiated a newly devised hourly rounding procedure to ensure proper care delivery for all residents, d. Conducted education/training on resident safety and supervision with 100% of scheduled staff at the beginning of each employee's shift. This was initiated in order to ensure effective supervision and interventions to prevent falls for residents #4, #6, #15, #19, #32, #39, #51, #84, #86, #88. B) All facility residents have the potential to be affected by this deficiency. Facility NHA or designee will evaluate current staffing patterns for effectiveness regarding resident supervision and fall prevention. Any identified changes to staffing patterns will be made immediately. C) DON or designee will provide education to nursing staff on expectations regarding appropriate staffing and resident supervision. The education will include: a. The continued utilization of documented hourly care giver rounds. b. Accident prevention and resident supervision. c. Facility specific fall prevention systems. The Facility DON or designee will conduct daily audits of facility staffing levels and supervision to ensure that the facility is meeting the needs of its residents. Results will be reported daily	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

(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 353	Continued From page 55 and 600 halls). The number of staff per unit per shift varied from day to day. There were 53 unfilled CNA shifts from 9/1/13 to 10/23/13. In addition, there were 22 shifts when scheduled CNAs failed to show up for work and were not replaced. There were an additional 5 licensed nurse shifts shown as vacant with no replacements. 3. Interview with the IDON on 10/21/13 at 3:50 PM revealed the facility currently had "staffing problems." He further stated he had worked as a floor nurse the previous Friday and would cover shortages again that evening for 7 hours. 4. Interview with 10 alert and oriented residents on 10/22/13 at 2:30 PM revealed not enough staff was present in the facility to accommodate the residents' needs. Residents that required assistance expressed having to wait in excess of 30 minutes to have call lights answered, this occurred on a daily basis during various shifts. The interview further revealed resident's had taken their concerns to administration about a month ago and had not yet received a response. 5. Interview with training aides #1 and #2 on 10/22/13 at 8:33 PM revealed it was common to have 1 or 2 CNAs working each shift on the secure dementia unit where 26 residents resided. There were usually 1- 2 non-certified aides also working; however, they had to work directly with a CNA to provide care to residents. 6. Interview with a family member on 10/24/13 at 5:30 PM revealed s/he came to the facility a couple of times weekly. The family member stated residents "definitely need more supervision, if you need someone you usually	F 353	to the facility NHA. D) The results of the daily audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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F 353	Continued From page 56 can't find anyone." S/he stated during this survey was the first time s/he had seen so many staff working. Another family member stated in interview on 10/24/13 at 6:50 PM that s/he was dissatisfied with staffing levels. The family member stated that poor staffing and repeated resident falls caused significant concern for resident safety. The family member stated s/he visited daily to provide care and feared their family member would not be cared for adequately by the facility. The family member stated the concerns were discussed with the administrator; however, the promises of increased staffing had not been accomplished. This family member further stated that since the survey team had come into the building, there was more staff working than usual. On 10/23/13 at 9:30 AM, the administrator was notified of an immediate jeopardy situation in the area of inadequate numbers of qualified nursing staff related to resident supervision and falls. The facility's action plan required the following immediate changes: a. Provide supervisors on the floor to augment current staffing levels to assist with supervision, care delivery and overall operations. b. The facility created an interim staffing schedule that detailed how care delivery would be maintained until a more permanent solution could be discovered. c. Nursing administration completed a newly devised hourly rounding procedure to ensure proper supervision and care delivery for all residents. d. Administrator or designee will conduct education/training on resident safety with 100% of scheduled staff at the beginning of each employee's shift. The training will include general	F 353	This page left blank intentionally	

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F 353	Continued From page 57 observation and awareness of all residents, the falling star program, facility wide urgency toward responding to alarms, hourly rounds and monitoring safety intervention compliance, post fall huddles, and communication of updated resident interventions via pre shift report. e. The facility will submit nursing schedules and incident data for the previous 7 days to the licensing office each Friday for ongoing monitoring. The action plan was accepted on 10/24/13 at 2:47 PM, and based on the facility's implementation of the plan; the immediate jeopardy was abated on 10/25/13 at 4:13 PM. However, deficient practice remained at a scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy).	F 353		
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 preparation and service equipment was in a cleanable condition in	F 371	The facility will ensure food preparation and service equipment is in a cleanable condition. This will be accomplished by: A) The plastic cutting board attached to the sandwich preparation table in the kitchen will be replaced. The plastic cutting board attached to the sandwich preparation table in the kitchenette will be replaced. Any plates identified as chipped will be replaced. Plates will be ordered by November 30, 2013. B) No specific residents noted on form CMS 2567. All residents have the potential to be affected by this deficiency.	

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F 371	Continued From page 58 2 of 3 kitchen areas (the production kitchen and main kitchenette). The findings were: Observation on 10/21/13 at 10:45 AM showed a plastic cutting board attached to a sandwich preparation table was discolored and scored. Observation on 10/23/13 at 4:45 PM showed the cutting board on the sandwich preparation table in the main kitchenette was also discolored with brownish stains and was scored from cutting on the surface. Additionally, in the main kitchenette at that time the plates used to serve the residents' meals for the evening were noted to be chipped on the outside edges of the eating surface. There were 11 plates noted to have these chipped edges. Interview with server #1 on 10/23/13 at 5:20 PM verified these were the plates used on a daily basis. Interview with the registered dietitian on 10/23/13 at 5:20 PM verified the chipped plates and the cutting boards should be replaced. According to Food Code 2009, U.S. Public Health Service: 4-202.11: "(A) Multiuse FOOD-CONTACT SURFACES shall be: (1) SMOOTH; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; (3) Free of sharp internal angles, corners, and crevices; (4) Finished to have SMOOTH welds and joints..."	F 371	C) RD or designee will provide education to facility culinary staff on the cleaning of cutting boards and replacement of chipped dishware. The facility RD or designee will conduct audits on the cleanliness of cutting boards and the conditions of plates 2 times per week. D) The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13
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	F 425	Tag 425 to begin on next page	

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F 425	Continued From page 59 §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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the availability of physician ordered medication for 1 of 21 sample residents (#6). The findings were Resident #6 was admitted to the facility on 11/26/18 with diagnoses including non-Alzheimer's dementia and arthropathy. Review of physician's orders revealed an order dated 9/13/13 for Fentanyl (a narcotic pain reliever) 12 mcg/hour patch to be applied every three days. Review of the resident's care plan, last reviewed on 8/21/13, revealed interventions for disruptive behavior problems included "Administer medications as ordered", "Assess/treat pain", and "Report pain indicators." Interventions for falls included "Assure adequate pain management." The following concerns were	F 425	The facility will ensure that physician ordered medications are available to residents. This will be accomplished by: A) Resident #6 will have prescribed pain medication available in the facility. B) All residents who have physician prescribed medications have the potential to be affected by this deficiency. Resident medication supply will be verified by facility Licensed Nurses following medication delivery to validate adequate supply. Any medications that are not available will be re-ordered/obtained per facility policy and any delay in availability will be promptly relayed to facility DON or designee. C) DON or designee will provide education to nursing staff in relation to facility procedures for verifying adequate supply of medications, ordering new or refilling medications, and the obtaining of medications outside of local pharmacy hours. DON or designee will audit the MARs of 8 residents per week to ensure that the prescribed medications were available for resident use. D) The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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F 425	Continued From page 60 Identified: a. Review of the resident's MAR revealed the Fentanyl patch was held on 9/28/13 because the medication was unavailable. There was no documentation to indicate the pharmacy was notified of the omission, or that the medication was provided to the resident on 9/29/13 or 9/30/13. b. Interview with the IDON on 10/25/13 at 9 AM revealed a history of problems with the resident's pharmacy. At that time the IDON further revealed the facility's expectation when medications were unavailable was that staff would contact the pharmacy and make additional attempts to administer the medication, rather than wait until the next time the medication was scheduled to be administered.	F 425		
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	F 441	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. This will be accomplished by: A.1) Personal hygiene products found in the same immediate location as soiled linens and trash were immediately removed on 10/22/2013. A.2) Resident #76 was placed on facility precautions per facility policy. After reviewed by facility Infection Control Nurse, it was determined that the resident was not infectious and no care plan changes were needed. A.3) Through reading equipment	

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F 441	Continued From page 61 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 observation, staff interview, and review of infection prevention activities, medical records, and manufacturer's instructions, the facility failed to maintain a safe and sanitary environment in 1 of 4 soiled utility rooms and further failed to adopt care plans for 1 of 1 sample residents (#76) for infection precautions. In addition, facility staff failure to properly clean and disinfect 1 of 3 glucose test meters (glucometers). The findings were: 1. Observations in the soiled utility room on the secure unit on 10/22/13 at 2:10 PM revealed personal hygiene products (soap, shampoo, electric razors) were stored in the same immediate location as soiled linens and trash. CNA #19 stated in interview during the observation that personal care products should	F 441	specifications on the cleaning of facility blood glucose monitors, it was discovered that monitors required a 10% bleach "Hype Wipe". Hype Wipes were stocked on each floor. B.1) Residents who have personal hygiene products that are stored outside of their room have the potential to be affected by this deficiency. A facility wide audit of all resident storage areas will be conducted to ensure resident personal hygiene products are not stored in the same location as soiled linens and trash. Any items found in these areas will be immediately removed. B.2) All residents who require precautions based on facility infection control policy will be reviewed for appropriate approaches/interventions on their interim care plan. Any issues noted in the care plans will be corrected by facility Infection Control Nurse or designee and staff will be educated to the resident's specific plan of care. B.3) SureStepFlex Glucometers will be replaced by a Nova biomedical device that requires cleaning with an alcohol OR 10% bleach wipe. C.1) DON or designee will provide education to facility nursing staff on the proper storage of resident personal hygiene products. 3 random audits of storage rooms will be conducted weekly by DON or designee. C.2) DON or designee will provide education to facility nursing staff on the responsibility of initiating an interim	

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F 441	Continued From page 62 not be stored in a "dirty room." 2. Observation while touring the facility on 10/21/13 at 2:40 PM showed room 213 was posted with a "Droplet and Contact Precautions" sign; personal protective equipment was located on a cart outside the resident room. The signage advised staff and visitors to perform appropriate infection prevention practices when entering the room. Further investigation revealed the following: a. On 10/22/13 resident #76's medical record was reviewed. It was discovered that on 10/18/13 the resident experienced nausea, diarrhea, and vomiting; these signs and symptoms prompted posting precautions on 10/19/13. The cause of the resident's illness was unknown and precautions were posted to reduce the risk of transmission to staff and other residents. The precautions restricted resident #76 from leaving his/her room and required staff to don mask, gloves, and disposable gowns when entering room 213 and interacting with the resident. b. Interview with the infection preventionist (IP) on 10/22/13 at 2:20 PM confirmed resident #76 was placed on transmission-based precautions, in particular related to episodes of projectile vomiting and coughing. The IP confirmed the resident's movements about the facility were restricted to protect his/her health and the health of other residents. c. Further review of the resident's medical record failed to uncover evidence that staff developed an interim care plan to outline the resident's restrictions, adapt interventions and goals in light of the infection precautions, teaching or information for the resident to explain the precautionary status, or social interactions to minimize concerns the resident might	F 441	care plan for residents placed on precautions. DON or designee will conduct a weekly audit of all residents placed on precautions to make certain that the interim care plan has been initiated and meets the needs of each specific resident. C.3) DON or designee will provide education to facility nursing staff on the proper cleaning of the new glucometers. DON or designee will conduct audits 3 times per week to ensure that the cleaning of the glucometers meets expectations. D) The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

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F 441	Continued From page 63 experienced as a result of the precautions. d. Observation on 10/22/13 at 11:40 AM showed that precaution signage was removed from room 213. Interview with the IP on 10/24/13 at 8:20 AM confirmed the resident was no longer symptomatic and precautions were removed on 10/22/13. e. The MDS/Care Plan coordinator confirmed in interview on 10/22/13 at 2:50 PM that the resident's care plan had not been updated to reflect infection precautions. She stated care plans should be, and generally were, modified for infection precautions; but acknowledge it had not been done in this instance. 3. Observation on 10/23/13 at 3:30 PM with RN #7 on 300 hall revealed glucometers were cleaned with alcohol between resident uses. Observation further revealed glucometers had a removable test strip holder that, when removed, was found to have a small amount of dried rust-colored matter between the cover and base. RN #7 was unaware the test strip holder needed to be removed and cleaned. Review of the facility's policy entitled, "Cleaning of Glucose Meters" dated June 2012 showed staff was supposed to clean the external surface of the meter after every patient use and this reflected the manufacturer's recommendations, there was no reference to cleaning the test strip holder cover, base or lens. Review of the manufacturer's reference guide located with the glucometer instructed the user to remove the test strip holder and wipe the strip holder cover, base, and lens with a cotton swab dampened with a 10% bleach solution and cautioned the user not to use alcohol (page 15 and 16 of the reference guide).	F 441		
F 498	483.75(f) NURSE AIDE DEMONSTRATE	F 498	Tag 498 will begin on the next page	

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F 498 SS=E	Continued From page 64 COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of employee education files, the facility failed to ensure education and competence of nurse aides on an annual basis. At the time of survey, the facility employed 32 CNAs and 6 level II CNAs. The findings were: Interview with the IDON on 10/25/13 at 9:50 AM verified it was difficult to keep stable CNA staff. He then stated the orientation and education system was "not good." The competency checks for CNAs were expected to be completed by the unit managers. When asked to provide the competency education for CNAs, the IDON was unable to locate the files. On 10/25/13 at 3:30 PM the administrator provided two CNA files, and verified the other files were not able to be located. Review of these files showed CNA #5 had not had competencies checked for providing resident care since 2011. The file for CNA #24 showed it was incomplete. The areas that were not completed included the check list for verification of CNA skills for providing resident care including measuring vital signs, performing personal care, resident rights, assisting residents with safe transfers, performing range of motion exercises, assisting residents with eating, monitoring and reporting behaviors, and expectations to report	F 498	The Facility will ensure that education and competency of skills for CNAs will be completed on an annual basis. This will be accomplished by: A. No specific residents identified in the CMS 2567. B. All residents in the facility have the potential to be affected by this deficiency. Facility DON or designee will conduct an audit of all existing Certified Nursing Assistants to evaluate completion level of annual competencies. Facility DON or designee will conduct Certified Nursing Assistant competencies for those employees found not in compliance. C. DON or designee will provide education to Nursing Administration team on the importance of annual competencies and facility competency systems. The Facility DON or designee will audit the competencies of all newly hired Certified Nursing Assistants at the end of their preceptor lead floor orientation. All existing staff will be required to have completed their annual competencies as part of their yearly evaluation. The Facility DON or designee will conduct a monthly audit on existing Certified Nursing Assistant Staff to evaluate the completion of annual competencies. D. The results of all audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the	

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F 498	Continued From page 65 findings to licensed staff.	F 498		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure clinical records were accurately documented for 3 of 21 sample residents (#19, #32, #39). The findings were: 1. Review of the medical record showed resident #19 was admitted on 9/10/13. The record further showed the resident was supposed to receive showers 2 times weekly on Tuesdays and Fridays. Review of CNA documentation showed showers were not documented as being given on 9/17/13, 9/20/13, 9/27/13, 10/11/13, or 10/18/13. Further review of the resident's medical record showed the resident received scheduled pain medication, Percocet (a narcotic pain medication) 5/325 mg (1) tablet by mouth every 4 hours; however, documentation on the MAR was blank	F 514	Performance Improvement Committee. The facility will ensure that all clinical records are accurately documented. This will be accomplished by: A.1) Resident #19, #32, and #39 will receive showers 2 times weekly. Additional attempts will be made in case of refusal. Showers and refusals will be documented completely and accurately. A.2) Resident #19 was placed on comfort care and all medications except liquid Morphine, Ativan and Atropine drops were discontinued. Medication documentation for residents #19 and #39 will be complete and accurate including documentation for pain medications that identify pain levels, location and effectiveness of intervention. B.1) All facility residents who are scheduled for weekly showers/baths have the potential to be affected by this deficiency. The Facility DON or designee will conduct a facility wide audit on the accuracy and completeness of resident bathing documentation. Any issues discovered in result of this audit will be immediately corrected. B.2) All facility residents who received pain medication have the potential to be affected by this deficiency. The Facility DON or designee will conduct a facility wide audit resident Medication Administration Records for accuracy and completeness. Any issues discovered in result of this audit will be immediately corrected.	12/17/13

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F 514	Continued From page 66 10 times in September 2013 and 9 times in October 2013. In addition, the resident was supposed to receive Alprazolam (an antianxiety medication) 0.5 mg twice daily. Review of the MAR showed blank documentation 3 times in September 2013 and 5 times in October 2013. The resident was also receiving Ergocalciferol 50000 units, (1) capsule every three days for osteoporosis, the MAR showed this was blank 1 time in October 2013. 2. Review of the medical record for resident #32 showed the resident was admitted to the facility on 10/2/13. The record further showed the resident was supposed to receive showers 2 times weekly on Saturdays and Wednesdays. Review of the CNA documentation showed showers were not documented as given on 10/5/13, 10/9/13, 10/19/13, or 10/23/13. Interview with the IDON on 10/25/13 at 9:55 AM revealed he expected staff to document when showers were given or if the resident refused document the reason and attempt to assist with bathing another time. The interview further revealed the IDON expected the MARs to be filled out completely. 3. Review of the care plan showed resident #39 had multiple care areas where pain was addressed. Review of nursing pain assessments for 10/1/13 to 10/23/13 showed the resident was assessed and treated for pain multiple times daily. The assessments failed to document the pain levels, location of the pain, or effectiveness. The resident received Norco 5 mg-325 mg tablet and/or acetaminophen 500 mg tablet multiple times most days. Interview with the IDON on 10/25/13 at 9:50 AM revealed that when pain was assessed, the expectation was to document the	F 514	C.1) DON or designee will provide education to facility Nursing Staff on facility standards for bathing schedule and documentation. The Facility DON or designee will audit bathing documentation 3 times per week to evaluate Nursing Staff compliance to expectations. C.2) DON or designee will provide education to facility Nursing Staff on facility documentation standards for medication administration. The Facility DON or designee will audit the Medication Administration Records 3 times per week to evaluate Nursing Staff compliance to expectations. D) The results of the weekly audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	12/17/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	C 10/25/2013

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F 514	Continued From page 67 pain rating and location to show the medication was needed. The nurse was also expected to document the effectiveness of the medication.	F 514		
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 review of falls documentation and staff interview, the facility failed to ensure an effective quality assurance and performance improvement (QAPI) program was in place. The failure to have	F 520	The 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 staff. This will be accomplished by: A) No specific residents identified in the CMS 2567. B) All residents have the potential to be affected by this deficiency. On 10/23/2013, the facility instituted nursing staff hourly rounds to be conducted on all residents on all units in order to increase resident supervision and prevent resident falls. On 10/24/2013, the facility instituted the "Fall Stars" program which identifies residents on the basis of falls risk and educated facility staff on the fundamentals of the program. C) NHA or designee to provide education to Facility IDT on the importance and fundamentals of the Quality Assessment and Assurance Program. NHA or designee to track and trend falls numbers on the basis of location, time, frequency, observation status, injury and activity. These numbers will be reported and analyzed in the newly established monthly falls committee for evaluation and potential preventative actions.	

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F 620	Continued From page 68 an effective plan impacted resident care and quality of life related to safety and supervision, activities, and the integrity/accuracy of medical record documentation. The findings were: Review of the data provided by the facility covering the interval from May through October (10/23/13) 2013, showed residents experienced 197 falls. Of 48 residents identified as having falls, 24 (50%) were noted to have multiple falls within the 6-month time frame; 22 (46%) experienced multiple falls within the past 90 days. The census at the time of survey was 96 residents. During this same 6-month interval, the facility recorded 14 instances of falls resulting in skin tears or abrasions, 16 with swelling or bruising, 3 with lacerations, and 4 with fractures identified by diagnostic imaging; 2 of the falls with fractures occurred within the past 2 weeks. There were 6 instances of resident falls when facility staff failed to document the presence or absence of injury following the fall. Interview with the administrator on 10/24/13 at 1:43 PM verified the facility had identified a problem with falls beginning in July 2013. He stated the members of the QAPI committee were discussing a program to reduce the incidence of falls. However, at the time of survey, they had not implemented any action plans to reduce the incidence of resident falls. The administrator acknowledged the facility lacked trending analysis to evaluate resident falls or monitoring for post-fall assessments and care plan interventions. In addition, there was currently no data being collected or analyzed related to the residents' quality of life issues or the electronic	F 620	D) The falls committee will report all actions monthly at the Facility's Quality Assessment and Assurance Committee for further monitoring and actions.	12/17/13

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F 520	Continued From page 69 medical records system. The administrator acknowledged there was not a formal written QAPI plan in place. The program was in the process of "being created and defined."	F 520	This page left blank intentionally	