STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	C 01/10/2014

RECEIVED
WY Dept of Health
FEB 27 2014
Health Licensing and Surveys

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

OV 3/5/14

(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: ADL - Activities of Daily Living ADON - Assistant Director of Nursing CAA - Care Area Assessment CDM - Certified Dietary Manager CNA - Certified Nurse Aide DON - Director of Nursing IDT - Interdisciplinary Team LPN - Licensed Practical Nurse MAR - Medication Administration Record MDS - Minimum Data Set PRN - Pro re nata (as needed) RD - Registered Dietitian RN - Registered Nurse TAR - Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157	F 157 1. Resident # 53's physician & family were notified of the resident's change of condition on 12/7/13 as illustrated in the medical record 2. Residents with a change of condition related to stroke-like symptoms were identified from the 24 hr report form/rounds by the Director of Nursing or his/her designee to ensure timely physician & family notification had occurred 3. On or before 1/28/14 licensed nursing staff was in-serviced by the Director of Nursing or his/her designee regarding the importance of timely notification of physician & family	2/6/14

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

Executive Director | 2/26/14

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.

3/6/14 - Plan of correction accepted 3/6/14 per conversation with Jennifer Crouse. Alleged date of compliance = 2/6/2014. Julie VanDyke, RN

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F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and physician interview, the facility failed to immediately contact a resident's physician when a significant change in a resident's physical status occurred for 1 of 21 sample residents (#53). The findings were: Review of the medical record for resident #53 revealed s/he was admitted to the facility on 1/30/13 with diagnoses that included cerebrovascular accident. The following concerns were identified: a. Nursing notes dated 12/8/13, timed at 10:45 PM, showed "charting related resident report not feeling well, "think I am having another stroke" slow to follow commands, tongue midline, crushed evening medications for safety related to c/o [complaints of] difficulty swallowing." There was no evidence the resident's physician or family were notified of these symptoms.	F 157	when a resident exhibits a change in condition related to stroke-like symptoms 4. The Director of Nursing or his/her designee will conduct random audits of residents experiencing a change in condition related to stroke-like symptoms to ensure timely notification of physician & family occurred 5. The Director of Nursing or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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F 157	Continued From page 2 b. Nursing notes dated 12/7/13, timed at 3:58 AM showed "continues to have intermittent periods of difficulty speech." There was no evidence the resident's physician or family were notified of these continued symptoms. c. Nursing notes dated 12/7/13, timed at 9:10 AM (10 hours and 25 minutes after initial symptoms were documented), showed "at approximately 9 am {sic} cna's notified this nurse as they were doing cares that resident was unable to verbally respond to them but could shake [his/her] head slightly for yes or no, resident was able to take pill prior at 7 am {sic}, stating [s/he] felt weird, was very slow at getting pills down but was able to do so, resident able to mumble the word no as I asked [him/her] questions at 9 am {sic}, phoned MD and [spouse] will notify everyone of change in condition and monitor for more changes." d. Interview with the resident's physician on 1/10/14 at 9:55 AM, confirmed he was not notified of the resident's symptoms until 12/7/13 at approximately 9 AM, and although he did not believe the outcome for the resident would have been different, he said he would have initiated treatment when the symptoms started if he had been notified at that time. He further confirmed that facility policy was to notify the resident's physician of any change in condition.	F 157		
F 167 SS=D	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for	F 167		

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F 167	Continued From page 3 examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the most recent survey results were accessible to residents and the public during 2 of 2 random observations. The findings were: Interview with the human resources coordinator on 1/9/14 at 9:35 AM revealed the facility's state survey binder containing survey results was located in the main lobby of the facility. Observation on 1/9/14 at 9:35 AM showed the binder was located in a magazine rack on the floor obscured by an end table and loveseat. Confidential group interview with 11 residents on 1/7/14 at 9:30 AM revealed the residents were unaware of where survey results were kept. Observation of the state survey binder on 1/10/14 at 3:50 PM revealed the binder was in the same location as the previous day. Interview with the interim director at that same time confirmed the state survey needed to be placed in an easily accessible area.	F 167	F 167 1. The most recent survey results were placed in a wall mounted device for ease of accessibility to residents & the general public in the entrance lobby 2. Residents were notified during the Resident Council meeting on 2/06/14 of the location of the most recent survey results 3. Staff was in-serviced by the Executive Director or his/her designee on or before 2/03/14 of the importance of state survey results being readily accessible to residents & the public 4. The Executive Director or his/ her designee will conduct random audits to ensure the survey book is updated and accessible. 5. The Executive or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	2/6/14
F 240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's	F 240		

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F 240	Continued From page 4 quality of life. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interview, and medical record review the facility failed to create and sustain an environment that promoted or enhanced the quality of life for 1 of 21 sample residents (#83). The findings were: 1. Review of the 3/1/13 annual, and the 5/24/13, 8/20/13, and 11/12/13 MDS assessments for resident #83 showed s/he required extensive assistance with bed mobility, dressing, eating, and personal hygiene. In addition, review of the 8/20/13 and 11/12/13 quarterly MDS assessments showed the resident declined in toileting from needing extensive assistance to being totally dependent upon staff for his/her toileting needs. The following concerns with individualizing this resident's care and service to maintain his/her quality of life were identified: a. Observations of resident #83 showed on 1/7/14 the resident yelled out, "nurse help" a total of 45 times during 2 blocks of continuous observations totaling 4 hours and 35 minutes. Observation showed no staff responded to the resident 32 of the 45 times s/he yelled for help. b. There were 2 occasions when the resident required assistance with eating that was not provided. See F312 for details regarding resident #83. c. On one occasion the resident was incontinent of stool and was left in that manner for 35 minutes. See F312 for details regarding resident #83. d. Review of the resident behavior tracking	F 240	F 240 1. On or before 2/5/14, the Social Service Director or his/her designee assessed resident #83 for psychosocial well-being. Resident #83 care plan was revised to address his psychosocial and physical needs. 2. On or before 1/24/14 a 100% audit of all resident behavior monitoring sheets was completed to ensure that behavioral un-met needs had been identified and interventions to address these un –met needs was completed by 1/24/14. 3. Facility staff was educated on or before 1/28/14 regarding the importance of addressing residents' requests for assistance for psychosocial or physical needs.	2/6/14

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F 240	Continued From page 5 form documentation dated 1/13/13 through 12/20/13 showed the following entries and staff response to the resident's call for help: i. 1/13/13 description of behavior "yelling help", staff documented response "shut the door told [him/her] [s/he] needs to stop yelling." ii. 2/17/13 description of behavior "yelling nurses help" staff indicated this occurred 22 times between 10 PM and 4:30 AM", staff documented response "asked [him/her] not to yell and use call light." iii. 2/18/13 at 1 PM description of behavior "yelling help wants to get up and use toilet", staff documented response "explained [s/he] doesn't use toilet anymore to much in pain, told [him/her] to relax and go [in his/her incontinence brief] because using the toilet hurts [him/her]." iv. 10/9/13 "eve shift" description of behavior "yelling nurse for things [s/he] does no longer do or hurts [him/her] to much like getting up saying all we do is talk instead of take [care] of [him/her], cleaned [his/her]behind still kept yelling for that walked away." 2. Interview with the resident on 1/7/14 at 9:30 AM and again between 2:07 PM and 2:20 PM revealed the resident had been in the facility since 2008. The resident stated, "I hurt every damn day, mostly my leg [points to left leg], sometimes my back, and sometimes just all over." The resident stated, "I quit using my call light and started yelling because nobody answers the call light but if I yell long enough and loud enough eventually somebody will come." The resident also revealed staff, "tell me nothing will help the pain in my leg." The resident further revealed, "I just lie here, can't get up anymore." Refer to F309 regarding inadequate pain	F 240	4. Random audits of residents who are identified as having un-met psychosocial/physical needs will be conducted by the Director of Social Services or his/her designee to ensure that identified needs are addressed and care for the residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. Random audits of resident's behavior monitoring sheets as well as random resident interviews will be conducted to ensure resident's needs are addressed in a proper & timely manner 5. The Director of Social Services or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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F 240	Continued From page 6 management for resident #83. 3. Interview with CNA #5 on 1/7/14 at 7:35 PM revealed the resident yells out constantly and staff did not always check on the resident when s/he yelled because most of the time the resident just yelled without really needing anything. The CNA also said staff did not always document the resident's behaviors because that's just the way the resident was.	F 240	F 241 1. Resident # 56 as well other residents received their meals timely and the dining room will have 3 dietary staff members taking meal orders and assisting with delivery of resident trays' to ensure no resident is required to wait to be served. Tables are cleared and cleaned after residents have completed their meal. New clothing protectors were ordered on 1/29/14 and the old clothing protectors have been discarded. 2. All residents have the opportunity of being affected by the deficient practice, as all residents residing in the facility participate in the dining process.	2/6/14
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and medical record review, the facility failed to ensure residents were treated in a respectful and dignified manner during 2 of 2 random dining observations. The findings were: 1. Observation on 1/6/14 at 4:53 PM showed resident #29 had already received his/her meal and was eating. Two additional residents were sitting at the same table. The second resident received his/her meal at 4:53 PM. Resident #56 continued to wait, watching the other residents at his/her table eating. Resident #56 received his/her meal at 5:15 PM, 22 minutes later. A confidential meeting with 11 residents on 1/7/14 at 9:30 AM revealed the residents were often served at different times when sitting at the same	F 241		

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F 241	Continued From page 7 table; having arrived at the same time. They expressed they did not like waiting for their meal while others at the table were eating. 2. A confidential meeting with 11 residents on 1/7/14 at 9:30 AM revealed the dining room tables were not cleared after a resident completed their meal until everyone in the dining room had eaten. The residents expressed they did not like coming to the dining room and sitting at a table where the dishes had not been cleared. They expressed that having to look at dirty plates and food left on the table was unappetizing. An observation on 1/7/14 at 12:25 PM revealed when some of the residents had finished eating the meal, the dirty dishes and food that had been spilled on the tables remained. There were 8 residents noted to be sitting at the un-cleared tables. 3. Interviews with the dietitian and the activities director on 1/9/14 at 10:45 AM concerning the observations and resident comments, revealed dining room tables were not cleared until after everyone had finished eating because the staff needed to write down how much each resident consumed. Further, the dietitian did not realize residents at the same table, arriving at the same time, were not served at the same time. Further, the activities director agreed sitting at a table with dirty dishes and/or having to wait for your meal while others were eating would not be a pleasant eating experience. 4. Observation on 1/6/14 at 4:45 PM showed residents in the dining room wearing clothing protectors that were frayed. and unfastened because the Velcro was old and could not be secured. Staff were observed tying the protectors	F 241	3. On or before 2/5/14 the appropriate staff were educated on the importance of serving the importance of the residents in a timely manner and the new serving process, clearing dishes after each resident has completed eating and the importance of having clothing protectors in good repair. 4. Random monitoring audits will be completed by the Dietary Manager or his/her designee to ensure that residents are served meals in a timely manner that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality and that the dishes are cleared once a resident completes his/her meal. Random monitoring audits will be completed by the Director of Environmental Services to ensure that the residents' clothing protectors are in good condition. 5. The Dietary Manager or his/her designee will report results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved.	

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F 241	Continued From page 8 to keep them in place or laying them over a resident's upper body. An interview with the environmental services director on 1/9/14 at 11 AM revealed new clothing protectors were received in July but the facility did not get enough. The director acknowledged the facility had an inadequate system of tracking and monitoring linens and clothing protectors.	F 241	F244 1. Additional linen, including bed linen, bath towels, wash clothes and clothing protectors were ordered on 1/29/14 by the facility's Housekeeping Supervisor. Specific, identifiable residents who had expressed concerns with the linen and/or the lack of attentiveness of CNAs to resident's needs (whether expressed in Resident Council or individually) were polled on or by 02/05/14 by the facility's Executive Director or his/her designee. The announcement of changes (ie. linen order and staff training Re: call light response, changing O2 tanks, talking down) were met with affirmation(s) of resident satisfaction. The facility purchased bath towels and washcloths during the survey. This new linen was washed and put into service on 01/10/14. In addition, clothing protectors were inspected for wear on 1/28/14 by the facility's Housekeeping Supervisor. Protectors deemed to be in poor condition were removed from service on this date	2/6/14
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, review of resident council meeting minutes, and review of the facility's policies and procedures, the facility failed to address various grievances in a timely manner during 6 of the past 12 months. The findings were: 1. Review of the resident council meeting minutes and written individual grievances showed for the months of July 2013 through December 2013, the residents had the following grievances: a. Residents consistently complained there was a shortage of bed linens, towels and wash cloths, also the wash cloths and towels were tattered. In addition, the residents informed the facility the clothing protectors were tattered and the Velcro no longer held the clothing protectors	F 244		

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F 244	Continued From page 9 in place. A resident commented the washcloths in the restrooms were not fit to be cleaning rags and it was "embarrassing to have guests come and see them." b. Residents complained they had to wait for extended periods of time for assistance with toileting, transfers, and oxygen tank refills; at times up to 30 to 60 minutes. The residents also informed the facility they felt the CNAs were not attentive to their needs and portrayed a negative attitude while providing care. Comments included: CNAs came in and turned off the call light and if the request or need was for incontinence care or assistance to the bathroom, they rolled their eyes and mumbled and complained. CNAs are reported to have told residents "to drink old water before new water is put into cups and often ice is just added to old water." A resident reported when s/he asked a CNA for assistance, the CNA replied, "what do you want." The meeting minutes showed the staff requested the residents keep a journal to document their specific concerns/complaints; the residents informed the facility they were fearful of retaliation from the staff. 2. A confidential meeting with 11 residents on 1/7/14 at 9:30 AM revealed their grievances remained unresolved. The clothing protectors remained frayed and the Velcro was still ineffective in holding the protectors in place. Towels and wash cloths were frayed and tattered. The residents continued to voice their concerns about the nursing staff. They felt the staff was short with them and the residents felt they were ignored during their care; for example a resident reported 2 CNAs came in to assist the resident and they talked to each other and not to him/her. Random observations in the dining room on	F 244	2. The facility's Executive Director or his/her designee reviewed the past six months (July-December 2013) of Resident Council minutes on or before 2/05/14 and met with the resident(s) that had any unaddressed concerns from these minutes. In addition, the facility's Recreation Director, in conjunction with the facility's Executive Director and Director of Social Services, convened a Special Resident Council meeting on 2/6/14 for the expressed purpose of informing the council of the action(s) taken to resolve the here-to-fore unresolved concerns and to solicit any new business concerns 3. Systemically, the facility has implemented a Concern and Comment Card program. The program is designed to capture residents' concerns in writing whether initiated via a resident, family, staff member on behalf of a resident or the Resident Council.	

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F 244	Continued From page 10 1/6/14 at 4:45 PM showed residents had frayed clothing protectors. In addition, the staff were observed tying the protectors to keep them in place or laying them over a resident's upper body because the Velcro would not keep them fastened. Observations of resident bathrooms on 1/7/14 from 8:30 AM to 9:23 AM showed towels that were frayed and discolored were provided for resident use. An interview with the environmental services director on 1/9/14 at 11 AM revealed clothing protectors were received in July but the facility did not get enough. Further, towels and wash cloths had been ordered but the items disappeared shortly after they were received. The director acknowledged the facility had an inadequate system of tracking and monitoring linens and clothing protectors. 3. An interview with the interim administrator on 1/10/14 at 1:25 PM revealed she had been with the facility since November 2013. She stated she was aware of some of the grievances of the residents. Further, she had only reviewed December 2013 resident council meeting minutes. The administrator stated the activities director was responsible for following up on resident grievances until resolution. 4. Review of the facility's policy and procedure for grievance procedures dated 6/17/08 showed: The social services staff were responsible for maintaining a system to keep records of all complaints reported. This record should include the date of the report, circumstances, specifics of the investigation, actions taken and follow-up with the complainant. In addition the social services staff were responsible for following up with the family and/or resident to ensure the issue was handled to their satisfaction. Interview with the	F 244	All staff was in-serviced with respect to the Concern and Comment Card program by the facility's Executive Director on or before 02/03/14. The written cards are delivered to the Executive Director for logging and assignment/distribution. The log is used to track timeliness as well as a depicter of possible trends. Residents will be advised of the new Concern and Comment Card Program at the next Resident council meeting. 4. The Concern and Comment Card log will be reviewed weekly by the Executive Director or his/her for appropriate follow through and completion. 5. The Executive Director or his/her designee will report on a summary of the concern and comment card log at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved.	

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	535049	A. BUILDING _____ B. WING _____	C 01/10/2014

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F 244	Continued From page 11 interim administrator and regional vice president of operations on 1/10/14 at 1:25 PM revealed the social services director and social services assistant position were recently vacated.	F 244	F 250 1. The facility has hired a qualified Director of Social Services and a Social Services Assistant to ensure that the facility provides medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. On or before 02/6/14 residents #83, #17 and #97 were assessed by the new facility Social Services Director and a PHQ9 assessment was utilized. The physician was notified of the assessment results to determine treatment plan for these residents if necessary. Additionally, a behavioral interactional guideline was developed to educate the nursing staff on resident #83's, #17 and #97's psychosocial, behavioral and mood needs. 2. A 100% audit was completed by the Director of Social Services to determine if any of these residents had a change in their PHQ9 scores comparing the most recent PHQ9 score to the previous PHQ9 score. Any areas of concern noted were addressed at the time of discovery.	2/6/14
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure social services were effective to meet the individualized needs for 3 of 4 sample residents (#17,#83, #97) assessed as having increased signs and symptoms of depression. The findings were: 1. Review of the medical record showed resident #83 was admitted to the facility on 5/27/08 with diagnoses including depression. Review of the annual MDS assessment dated 3/1/13 showed the PHQ-9 (a resident mood assessment tool used to assess the signs and symptoms associated with depression based on the resident's response the higher the score the more severe the depression at the time of assessment) score was, "5" on a scale of 0-27. Review of the most current modified quarterly MDS assessment dated 11/12/13 showed the PHQ-9 score was, "17" indicating an increase in the resident's signs and symptoms of depression. The following	F 250		

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F 250	Continued From page 12 concerns were identified: a. Review of the medical record showed a physician's order dated 9/9/13 to discontinue Remeron (a medication used to treat depression). Review of the medical record further revealed the resident had received no other medications to treat depression from 9/9/13 to date. Review of the medical record additionally showed no documentation the physician was notified of the resident's reported increase in the signs and symptoms of depression after the discontinuation of the Remeron. Review of the care plan conference record dated 11/14/13 showed under the conference summary the social services assessment was, "still in progress." No additional social services notes were available. b. Interview with the resident on 1/7/14 at 9:30 AM revealed the resident stated, "I just lie here I can't get up anymore". The resident further stated, "I stopped using my call light and started yelling because nobody answers the call lights, but if I yell long enough and loud enough eventually somebody will come". c. Observation on 1/7/14 at 10:16 AM revealed the resident was calling out, "nurse help". The ADON entered the resident's room and the resident stated, "I just want to die, I've lived too long". Observation of the resident at 1:40 PM that same day revealed CNAs #2 and #4 performed incontinence care and the resident informed them, "I have just lived too long, I want to die". d. Interview with the resident's physician on 1/10/14 at 10 AM revealed the physician had discontinued the Remeron on 9/9/13 because the resident's appetite had improved and the resident's signs and symptoms of depression had improved. The physician revealed he had not been made aware of the increased signs and symptoms of depression.	F 250	3. On or before 2/4/14, the Division Director of Clinical Services educated both the Director of Social Services regarding the importance of completing mood assessments, specifically the PHQ9 tool on every resident upon admission, quarterly and with a change in condition. If the PHQ9 score is greater than the previous score, the physician and responsible party must be informed, to determine further evaluation/treatment for the resident 4. Random audits will be conducted by the Director of Social Services or his/her designee to determine if any resident has had a change in his/her PHQ9 depression score and to ensure that if they have, that the physician was notified and that a treatment plan was initiated 5. The Director of Social Services or his/her designee will report results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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

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F 250	Continued From page 13 2. Review of the medical record revealed resident #17 was admitted to the facility on 4/1/10 with diagnoses that included Alzheimer's disease and depression. Review of the annual MDS assessment dated 6/10/13 and quarterly MDS assessment dated 12/4/13 revealed the resident's score on the PHQ-9-OV (Staff Assessment of Resident Mood) had doubled from a score of 6 to a score of 12, indicating an increase from mild depression to moderate depression (review of the quarterly MDS assessment dated 9/5/13 revealed a PHQ-9-OV score of 7). There was no evidence in the medical record this increase in symptoms of depression was referred to the resident's physician for treatment evaluation. 3. Review of the medical record revealed resident #97 was admitted to the facility on 12/5/11 with diagnoses that included non-Alzheimer's dementia and depression. Review of the resident's annual MDS assessment dated 8/12/13 and quarterly MDS assessment dated 11/7/13 revealed the resident's score on the PHQ-9-OV increased from a score of 6 to a score of 14, indicating an increase from mild depression to moderate depression. There was no evidence in the medical record this increase in symptoms of depression was referred to the resident's physician for treatment evaluation. Interview with the MDS Coordinator on 1/10/14 at 3:30 PM revealed the responsibility for performing resident mood assessments had fallen to the MDS coordinators following the recent vacancies for the social service director and social services assistant positions. She confirmed that MDS coordinators were not notifying physicians of increased symptoms of depression.	F 250		

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F 253 F 253 SS=D	Continued From page 14 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to ensure 5 resident rooms (#112, #114, #115, #118, #216) observed during random observation were maintained in good repair. The findings were: Observations on 1/9/14 from 2:20 PM through 3:15 PM revealed the following concerns: a. Room #118 had a 6 inch damaged area on the baseboard by the left side of the television. The bathroom door had a 2 inch circular hole on the outside of the door and 4 circular holes 3 inches in diameter on the inside of the door. The left wall outside of the bathroom door had a 12 inch scrape through the wall that exposed the metal beneath. In the same area there was a separate 8 inch by 4 inch area with the paint scraped off. Interview with the resident who resided in the room on 1/9/14 at 2:35 PM revealed s/he was "embarrassed" by the condition of his/her room. b. Room #112 had 3 patched areas on the wall to the left of the bathroom door that were not painted; these areas stood out and measured 6 inches by 3 inches. In the bathroom there were 2 areas on the linoleum floor where the linoleum was missing. The missing areas measured 8 inches and 7 inches in diameter respectively. c. Room #114 had an 18 inch scrape on the	F 253 F 253	F 253 1. The chipped paint on the walls of cited resident rooms (room numbers 112, 114, 115, 118 and 216) was repaired and repainted with fresh paint on or before 02/06/14 by the Director of Maintenance. In addition, the bathroom door in room number 118 was repaired on or before 02/06/14 and the bathroom flooring was replaced in room number 112 by a local flooring company. 2. The Director of Maintenance or his/her designee inspected 100% of all patient rooms on 1/31/14. Rooms determined to be in need of touching up were corrected on or before 02/06/14. 3. The Director of Maintenance has implemented a new Maintenance Work Order request form. The forms will be maintained in a binder at each nurse's station. All staff was in-serviced by the Director of Maintenance on the existence of the forms and how to use them on or before 01/28/14.	2/6/14

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F 253	Continued From page 15 wall to the right of the bathroom door that exposed the metal beneath. d. Room #115 had a 12 inch scrape on the wall to the left of the bathroom door that exposed the metal beneath. e. Room #216 had a 28 inch scrape across the wall by the first bed. The wall by the bathroom door had an 11 inch scrape on the right that exposed the metal beneath. Interview with the maintenance director on 1/9/14 at 3:20 PM verified the issues found on the tour were accurate. He also confirmed the facility failed to have a plan with a specific timeframe to address these issues.	F 253	4. Random audits will be completed by the Director of Maintenance which will assess the condition of a resident's room. The Director of Maintenance or his/her designee will complete the noted repairs after each random audit. 5. The Director of Maintenance or his/her designee will report results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	
F 254 SS=E	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and review of resident council meeting minutes, the facility failed to provide a sufficient quantity of linens to meet resident need. In addition, the facility failed to ensure linens available for resident use were in good condition throughout the facility. The findings were: 1. Review of the resident council meeting minutes and written individual grievances showed for the months of July 2013 through December 2013, the residents had the following complaints: a. Residents consistently complained there was a shortage of bed linens, towels and	F 254	**F254** 1. The facility purchased bath towels and washcloths during the survey. This new linen was washed and put into service on 01/10/14. In addition, clothing protectors were inspected for wear on 1/28/14 by the Housekeeping Supervisor. Protectors deemed to be in poor condition were removed from service on this date.	2/6/14

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F 254	Continued From page 16 washcloths, also the washcloths and towels were tattered. b. In addition, the residents informed the facility the clothing protectors were tattered and the Velcro no longer held the clothing protectors in place. A resident commented the washcloths in the restrooms were not fit to be cleaning rags and it was "embarrassing to have guests come and see them." Observation of resident bathrooms on 1/7/14 from 8:30 AM to 9:23 AM showed towels and washcloths that were frayed and discolored. Interview on 1/10/14 at 12:20 PM with CNA#1 revealed the facility was always short of towels and washcloths for resident use. 2. An interview with the environmental services director on 1/9/14 at 11 AM revealed clothing protectors were received in July but the facility didn't get enough. Further, towels and wash cloths had been ordered but the items disappeared shortly after they were received. The director acknowledged the facility had an inadequate system of tracking and monitoring linens and clothing protectors.	F 254	2. The Housekeeping Supervisor conducted a complete linen inventory, count and condition, by or on 1/17/14 to identify shortages to par levels. A linen order was placed on 1/29/14 to raise the inventory, where necessary, to par levels. 3. The Housekeeping Supervisor conducted an in-service regarding the importance linen condition and appropriate par levels. 4. The Housekeeping Supervisor or his/her designee will commence a weekly audit of all linen to ensure linen is 1). In good condition and 2). Plentiful enough to par levels. The results of the audits will be turned into the facility Executive Director and subsequent orders placed as necessary. Residents will be advised at the next resident council of this new ordering program.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	5. The Housekeeping Supervisor or his/her designee will report results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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F 280	Continued From page 17 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to update the care plan with effective interventions to prevent wound progression for 1 of 3 residents (#77) identified as being at high risk for pressure ulcers. The findings were: Review of the medical record for resident #77 revealed s/he was admitted to the facility on 1/18/13 with diagnoses that included heart failure, chronic pulmonary disease, diabetes mellitus, chronic pain and morbid obesity. Review of the quarterly MDS assessment dated 10/17/13 revealed the resident required extensive to total assistance with ADLs and was always incontinent of bowel and bladder. The following concerns were identified: 1. Nursing notes dated 12/16/13 revealed "Resident has an open area on her sacrum that is moisture acquired at this time. Has good blood flow on the borders. Resident already has a draw sheet in place on [his/her] bed. Needs excellent pericare and keep area dry. Will leave open to air and apply blue top remedy cream with barrier protection to heal. Will continue to monitor weekly and as needed." Review of the resident's care	F 280	F 280 1. Resident # 77 is no longer in the facility 2. Residents with wounds were identified. Their care plans were reviewed to determine that a wound care plan and effective interventions to prevent wound progress were present 3. Staff were in-serviced by the Director of Nursing or his/her designee on or before 01/28/14 of the importance of creating a care plan when new wounds occur and that interventions to prevent wound progression were added to the care plan. Staff were also in-serviced on the current policy and procedure related to non-pressure wounds. 4. Random audits will be conducted by the Director of Nursing or his/her designee to ensure residents with wounds have a wound care plan developed and interventions to prevent wound progression were added to the care plan 5. The Director of Nursing or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	2/6/14

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F 280	Continued From page 18 plan for skin, with a most recent onset date of 7/23/13, revealed the 12/16/13 wound was not noted on the care plan, and none of the stated interventions such as excellent pericare, applying blue top remedy cream, and monitoring weekly were added to the care plan. 2. Nursing notes dated 1/5/14, timed at 1:44 PM revealed "Resident has 2 unstageable pressure areas - 1) to coccyx measures 4.5 cm in length by 1.5 cm in width by 1.5 cm in depth covered entirely in slough at 100% - 2) to right hip area measures 1 cm in length by 5 cm in width with 10% slough noted to distal end - will request physical therapy screen for closed pulse irrigation 5 X per week - will implement medi-honey to both areas after cleansing with sterile normal saline and apply mepilex dressing to both areas twice daily - MD notified and family notified. Will continue to monitor." Interview with the facility wound care nurse on 1/10/14 at 3:10 PM revealed that he was the nurse that assessed the initial open area on 12/16/13, and confirmed the pressure ulcer discovered on 1/5/14 was in the same location as the open area documented on 12/16/13. He further confirmed the resident's care plan was not updated when the wound was initially discovered on 12/16/13, was unable to provide a reason for the lack of update, and expressed concern the facility had no written policy and procedure for non-pressure wounds.	F 280		
F 309 SS=G	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	F 309		

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F 309	Continued From page 19 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to provide effective pain management for 1 of 9 sample residents (#83) identified as having moderate to severe pain. The lack of effective pain management likely compromised the resident's ability to attain the highest practicable level of physical, mental, and psychosocial well-being. The findings were: Review of the medical record for resident #83 showed the resident was admitted to the facility with diagnoses including hemiparesis and chronic pain. Review of the quarterly MDS assessment dated 11/12/13 showed the resident was mildly cognitively impaired, required extensive to total assistance with ADLs and had pain that s/he was unable to rate. Review of the CAA dated 2/21/13 showed the resident had pain that "adversely affects mood, disturbs sleep", and included behaviors such as, "screaming, kicking, babbling, cursing, and repetitive questions." The care plan updated on 11/9/13 showed the resident had chronic daily pain associated with back, shoulder, hip and leg discomfort. Interventions included administering PRN pain medication, observing for non-verbal and behavioral signs of pain such as facial grimacing, aggression, agitation, vocalizations, complaints of pain, and crying. Interventions also included providing ice packs, massage, exercise, repositioning, touch, and music and to notify the physician for changes in pain or if pain was not reduced after one hour of	F 309	F 309 1. On 2/4/14 a pain assessment was completed by the unit manager for resident #83 to determine the acceptable level of pain and to determine what factors exacerbated the pain. Based on the pain assessment completed on this date, resident #83's acceptable level of pain was a 3. As of 2/2/14 resident #83's pain level has been at or below his acceptable level of pain. Non-pharmacological pain reduction interventions were also determined and documented on the care plan for the resident 2. On or before 2/5/14 All residents had a pain assessment completed by the nursing department to determine if any residents had un-met pain needs. 3. Nursing staff were educated on or before 1/28/14 by Director of Nursing or his/her designee on the importance of unitizing non-pharmacological pain intervention as well as addressing resident's pain concerns and requests associated to pain	2/6/14

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F 309	Continued From page 20 receiving the first intervention. Review of the recapitulation of physician's orders signed and dated 1/2/14 showed the resident had an order for Hydrocodone/acetaminophen 7.5 mg/325 mg (a narcotic pain medication) every 4 to 6 hours as needed for chronic pain, gabapentin 300mg (a drug labeled to treat seizures that had analgesic effects and is often prescribed to treat chronic pain) three times daily for chronic pain, and Fentanyl 50 micrograms/hour (a narcotic pain patch that is applied to the skin) every 72 hours for chronic pain. In addition, there were physician orders dated since 12/29/11 to perform leg massage to left lower extremity or bilateral lower extremities PRN for cramping pain. Review of the MAR for the resident from 11/1/13 through 1/6/14 showed the resident received Hydrocodone/acetaminophen 7.5/325 mg on 11/2/13, 11/3/13, and 12/25/13. Review of the TAR 11/1/13 through 1/6/14 showed the resident had not received any non-pharmacological interventions including applying warm packs to the left leg as needed for cramping pain or massaging the left lower extremity or bilateral lower extremities as needed for cramping pain. The following concerns with pain management were identified: a. Continuous observation on 1/7/14 from 8:40 AM until 11:10 AM revealed the resident was lying in bed with his/her door open. At 8:50 AM the resident yelled out "nurse." At 9 AM when the resident called out, "nurse," again, CNA #2 entered the resident's room and the resident complained of his/her "leg hurting and burning." The CNA informed the resident she would notify the nurse. CNA #2 then exited the resident's room and entered another resident's room to answer a call light without informing the nurse about the resident's pain as she said she would.	F 309	4. Random audits of resident's pain management needs will be conducted by the Director of Nursing or his/her designee to ensure that residents have an effective pain management regime in place to attain the highest practicable level of well being. Random audits of resident's with a pain management regime will be conducted to ensure effectiveness 5. The Director of Nursing or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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	535049	A. BUILDING _____ B. WING _____	C 01/10/2014

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F 309	Continued From page 21 At 9:15 AM CNA #3 entered the resident's room and delivered the resident's breakfast tray. The resident informed this CNA that his/her leg was hurting. CNA #3 exited the resident's room and continued to deliver trays; again without telling the nurse the resident was in pain. Observation at 10:16 AM showed an unidentified staff member entered the resident's room and the resident again said, "my legs are hurting and burning." That staff member replied she would inform the nurse. Between 10:16 AM and 10:30 AM the resident yelled out, "nurse please help", 3 more times. LPN #1 entered the resident's room at 10:30 AM (1 hour and 50 minutes after the first observation of the resident yelling out for nurse help) and informed the resident s/he had brought a "pain pill," which the resident took whole with water. Review of the January 2014 MAR showed the resident received his/her regularly scheduled gabapentin 300mg at 10:30 AM. However, there was no evidence this resident's pain was assessed as to severity or intensity. In addition, there was no evidence PRN pain medication or non-pharmalogical interventions for pain were documented as being administered the morning of 1/7/14. Finally, there was no evidence the resident's pain was re-assessed within the 1 hour required after receiving the regularly scheduled gabopentin for pain to determine its effectiveness in relieving his/her pain. b. Continuous observation on 1/7/14 from 12:40 PM until 2:45 PM revealed the resident continued to yell out, "nurse help" and/or, "help" a total of 19 times. At 12:40 PM the resident was yelling, "nurse" and continually bouncing his/her left leg. The DON went into the resident's room and the resident complained of "hurts from my catheter to my [genitals] and my legs are hurting and burning." The DON assessed the resident's	F 309		

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F 309	Continued From page 22 suprapubic catheter, urinary drainage bag and [genitals], and informed the resident she would tell the nurse s/he needed something for pain. The DON exited the room and walked to the nursing station several feet away and informed LPN #1 the resident had complained of pain. Again, there was no evidence staff assessed the resident's pain or provided pharmacological or non pharmacological interventions to address the resident's pain. The resident continued to yell out, "nurse help" 6 times until an unidentified CNA entered the resident's room at 1:05 PM. The resident informed the CNA, "I need to be cleaned up and my legs still hurt." At 1:12 PM the resident was yelling, "nurse help" and CNA #4 entered the resident's room. At that time the resident complained, "I need to be cleaned up and my Goddamn leg hurts." CNA #4 informed the resident it required 2 people to assist him/her and s/he would get another CNA and come back. CNA #4 did not address the resident's complaint of pain, she then exited the room and walked down the hall and entered another resident's room to answer a call light. At the nursing station at 1:18 PM the resident could easily be heard yelling, "nurse, help" 2 additional times. LPN #1, who was sitting at the nursing station, looked up towards the resident's room and commented, "there's nothing wrong with [his/her] lungs so [s/he] shouldn't get pneumonia." However, the LPN did not assess the resident for pain or offer any pain management interventions. From 1:19 PM until 1:40 PM the resident yelled out "nurse" 3 times, and "help" 2 times and bounced his/her left leg. Staff were observed walking up and down the hall and sitting at the nursing station, however, no staff entered the resident's room until 1:40 PM when CNAs #2 and #4 entered to perform incontinent care. During incontinent care	F 309		

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3/5/14

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F 309	Continued From page 23 from 1:40 PM until 2:07 PM, the resident asked, "please get me something for pain my Goddamn leg is on fire, it hurts so bad." CNA #2 informed the resident s/he had told the nurse earlier but would tell the nurse again. c. Review of the January 2014 MAR showed the resident was administered Hydrocodone/acetaminophen 7.5mg/325mg at 2 PM, 5 hours and 20 minutes after the resident first complained of pain at 8:50 AM. Interview with CNAs #2 and #4 at the time of the observation, on 1/7/14 from 1:40 PM to 2:07 PM, revealed the resident always yelled out whether s/he was in pain or not. d. Interview with the resident on 1/7/14 at 9:30 AM and again between 2:07 PM and 2:20 PM revealed the resident had been in the facility since 2008. The resident stated, "I hurt every damn day, mostly my leg [points to left leg], sometimes my back, and sometimes just all over." The resident further stated, "I quit using my call light and started yelling because nobody answers the call light but if I yell long enough and loud enough eventually somebody will come." The resident also revealed staff, "tell me nothing will help the pain in my leg." The resident further revealed, "I just lie here, can't get up anymore." The resident denied being offered ice packs or massage for leg pain, and stated, "sometimes they prop it up with pillows but that doesn't help for long." e. Interview with the DON on 1/9/14 at 4:40 PM revealed she expected staff to assess and administer pain medication, and notify the physician as needed to manage pain. f. Interview with the resident's physician on 1/10/14 at 10:00 AM revealed the physician was aware the resident had chronic pain. The physician verified he had ordered scheduled	F 309		

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F 309	Continued From page 24 Fentanyl patches and Hydrocodone/acetaminophen as needed every 4 to 6 hours (2 narcotic pain medications) and gabapentin 3 times a day to manage the resident's pain. The physician also revealed he expected staff to administer PRN pain medication when a resident had complaints of pain and to notify him if the medications were not effective or the resident had worsening pain. g. According to the American Geriatrics Society, titled, "Pharmacological Management of Persistent Pain in Older Persons" August 2009-Vol.,57, NO.8 copyright 2009.."Persistent pain or its inadequate treatment is associated with a number of adverse outcomes in older people, including functional impairment, falls, slow rehabilitation, mood changes (depression and anxiety), decreased socialization, sleep and appetite disturbance.."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff and resident interview and review of facility policy and procedures, the facility failed to ensure assistance was provided for 2 of 21 sample residents (#6, #83) and 1 non-sample resident (#25) identified as requiring extensive assistance with ADLs. The findings were:	F 312	F 312 1. Resident # 83 & # 6 have been provided assistance for all meals. Resident # 83's perineal-care has been provided in a timely manner. Resident # 25 no longer resides in the facility	2/6/14

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F 312	Continued From page 25 1. Review of the medical record showed resident #83 was admitted to the facility on 5/27/08 with diagnoses including hemiplegia/hemiparesis. Review of the MDS quarterly assessment dated 11/12/13 showed the resident was moderately cognitively impaired and required extensive assistance with ADLs including eating and toileting. The MDS assessment further showed the resident had limited range of motion in bilateral upper and lower extremities and had frequent bowel incontinence. Review of the CAA dated 3/1/13 indicated the resident's care plan for assistance with ADLs should continue. Review of the care plan updated 11/9/13 showed the resident required extensive to total assistance with all ADLs and refused meals related to limited range of motion, and residual effects from a CVA (cerebrovascular accident or stroke). Interventions included staff providing all ADL care and support to ensure daily needs were met. The following concerns were identified: a. Observations on 1/7/14 at 9:15 AM showed CNA #3 delivered the resident's breakfast meal tray. The CNA placed the tray on the bedside table, uncovered the tray and uncovered the containers, then exited the room. The resident was unable to use his/her left hand and was unable to cut up the biscuit and mix it with gravy. At 9:20 AM the resident began yelling, "nurse help". The surveyor entered the resident's room and the resident asked, "can you cut up my biscuit it's hard on the bottom and I can't cut it up with just my right hand". The surveyor informed the resident s/he would notify facility staff the resident required assistance. The resident then stated, "can't you just do it, they won't come and help me that's why I stopped using my call light and started yelling because nobody answers the	F 312	2. Residents requiring extensive assistance with meals & residents requiring extensive/total assistance with peri-care were identified to ensure extensive assistance is provided during meals & peri-care was provided properly & in a timely manner 3. Nursing staff were in-serviced by the Director of Nursing or his/her designee on or before 02/4/14 regarding providing extensive assistance at meals & of providing peri-care in a proper & timely manner for residents identified with these needs 4. Random audits of residents requiring extensive assistance with meals will be conducted by the Director of Nursing or his/her designee to determine extensive assistance is being provided for meals. Random audits of resident's requiring extensive/total assist with peri-care will be conducted to ensure peri-care is provided in a proper & timely manner	

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F 312	Continued From page 26 call light but if I yell long enough and loud enough eventually somebody will come". The surveyor informed staff the resident requested assistance with cutting up his/her biscuit and mixing it with the gravy, CNA #2 indicated the resident liked toast, not biscuits. At 9:25 AM CNA #2 entered the resident's room and gave him/her 2 pieces of toast but did not offer to assist the resident with the meal. At 9:40 AM the resident continued to attempt to cut the biscuit with a fork and mix it with the gravy when CNA #3 entered the resident's room to take vital signs but offered no assistance with the meal. The resident informed the CNA s/he was done and the CNA removed the breakfast tray. The resident consumed approximately 25% of the meal and half of the liquids. Observation at 12:50 PM showed CNA #3 delivered the lunch meal tray, placed it on the bedside table, removed the cover and container lids and exited the resident's room. The resident attempted to eat a potato dish and vegetables with a fork, then dropped the fork on the tray and began eating with his/her right hand. The resident continued to yell out, "nurse help" intermittently, however, staff did not offer or provide assistance with eating and the tray was removed from the resident's room at 1:40 PM. Approximately 25% of the meal was eaten and half the liquids. b. Observation at 1:05 PM on 1/7/14 revealed the resident continued to yell out, "nurse help" intermittently and an unidentified CNA entered the resident's room. The resident informed the CNA s/he needed to be "cleaned up". The CNA informed the resident s/he would get another CNA to assist, and exited the room. The resident continued yelling, "nurse help". At 1:12 PM CNA #4 entered the resident's room and the resident again said, "I need to be cleaned ..." The CNA	F 312	5. The Director of Nursing or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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F 312	Continued From page 27 informed the resident s/he would go get help because it took 2 CNAs to assist the resident. The resident continued to intermittently call out, "nurse help" until 1:40 PM when CNA's #2 and #4 entered the resident's room and provided incontinence care. The resident had been incontinent of stool and remained in the soiled incontinence brief for 35 minutes while waiting for assistance. c. Interview at 1:40 PM on 1/17/14 CNA #2 said the resident yelled all the time and was able to eat independently. d. Interview with the DON on 1/9/14 at 4:40 PM revealed she expected staff to assist the resident with ADLs as needed. 2. Review of the medical record for resident #6 showed the resident was re-admitted to the facility on 7/25/13 with diagnoses including Alzheimer's disease and malnutrition. Review of the most current MDS assessment dated 11/4/13 showed the resident had impaired vision, was moderately cognitively impaired and required extensive assistance with ADLs including eating. Review of the care plan dated 7/30/13 showed the resident required extensive to total assistance with eating. Interventions included direct care staff anticipating needs and providing all ADL care to ensure daily needs were met. The following concerns were identified: a. Observation on 1/7/14 at 9:17 AM revealed CNA #3 delivered the lunch meal tray, placed it on the bedside table, removed the cover, opened containers and exited room. The resident's spouse, who resides in the same room, assisted the resident with eating. Observation at 12:50 PM showed the resident sitting in his/her room attempting to eat unassisted, however, the resident nodded off until CNA #2 entered the	F 312		

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F 312	Continued From page 28 resident's room and removed the tray. The resident consumed approximately 20% of the meal and 1 glass of liquid. No staff were observed to assist, cue, or encourage the resident to eat as indicated on the care plan. 3. Observation on 1/7/14 at 1 PM showed CNA #6 performed perineum care for resident #25. The CNA removed the resident's wet incontinence pad and cleansed the resident's posterior perineum. The CNA did not cleanse the anterior perineum, lower abdomen or upper thighs where urine may have come in contact with the skin. Review of the 10/27/13 annual MDS assessment showed the resident required extensive assistance with toileting and personal hygiene. Review of the policy and procedure for personal hygiene care, undated showed: "always proceed from the least contaminated area to the most contaminated area. Start with the anterior perineum then cleanse the anal area of the resident."	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 314	F 314 1. Resident #77 no longer resides in the facility. Resident #105's pressure ulcers are measured weekly & all pressure areas have been reported per facility policy for follow-up. 2. All residents with pressure ulcers have had their areas measured.	2/6/14

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F 314	Continued From page 29 and staff interview the facility failed to monitor and treat skin breakdown for 2 of 3 sample residents (#77, #105) identified as being at risk of pressure ulcers. This failure resulted in an unstageable pressure ulcer for resident #77. The findings were: 1. Review of the medical record for resident #77 revealed s/he was admitted to the facility on 1/18/13 with diagnoses that included diabetes mellitus, chronic pulmonary disease and morbid obesity. The resident's quarterly MDS assessment dated 10/17/13, revealed s/he required extensive assistance from staff for bed mobility, toilet use and hygiene, and was totally dependent on staff assistance for transfers. The resident was assessed as being always incontinent of both bowel and bladder. The following concerns were identified: a. Nursing notes dated 12/16/13, timed at 3:46 PM, revealed "Resident has an open area on [his/her] sacrum that is moisture acquired at this time. Has good blood flow on the borders. Resident already has a draw sheet in place on [his/her] bed. Needs excellent pericare and keep area dry. Will leave open to air and apply blue top remedy cream with barrier protection to heal. Will continue to monitor weekly and as needed." No other assessment of the wound, such as measurements, was included in the nursing note. b. Review of the weekly skin integrity data collection forms revealed nursing skin assessments were completed on 12/26/13 and 1/2/14. Both assessments noted the resident had an open area on his/her coccyx, as well as a shear injury to the right buttock. Neither assessment included any further description of the wounds, such as measurements. c. The next time these wounds were	F 314	3. Nursing staff were in-serviced on or before 1/28/14 regarding the importance of reporting pressure ulcers timely & assessing, measuring & documenting the progress of pressure ulcers. 4. The Director of Nursing or his/her designee will randomly audit residents with pressure ulcers to ensure that the pressure ulcers were reported timely & assessed measured & documented appropriately 5. The Director of Nursing or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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CF 3/5/14

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F 314	Continued From page 30 addressed in the nursing notes was in the nursing notes dated 1/5/14, timed at 1:44 PM, which revealed "Resident has 2 unstageable pressure areas - 1) to coccyx measures 4.5 cm in length by 1.5 cm in width by 1.5 cm in depth covered entirely in slough at 100% - 2) to right hip area measures 1 cm in length by 5 cm in width with 10% slough noted to distal end - will request physical therapy screen for closed pulse irrigation 5 X week - will implement medi-honey to both areas after cleansing with sterile normal saline and apply mepilex dressings to both areas twice daily - MD notified and family notified. Will continue to monitor." d. Review of a physician's record of visit dated 1/7/14 revealed the resident had a "sacral decubitus unstageable but at least a stage III." A physician's interim order dated 1/8/14 revealed orders for physical therapy to provide closed pulse irrigation five times weekly for twelve weeks to help facilitate wound healing. e. Observation of a dressing change on 1/9/14 at 10:10 AM showed the resident received closed pulse irrigation to cleanse the wound. At that time, the wound as measured by the physical therapy aide was 4 cm in length, 3 cm in width, 2 cm in depth, with 2.2 cm deep tunneling noted at the 12 o'clock position. The wound bed was entirely covered in yellow slough. f. Interview with the facility wound care nurse on 1/10/14 at 3:10 PM revealed that he was the nurse that assessed the initial open area on 12/16/13, and confirmed the pressure ulcer discovered on 1/5/14 was in the same location as the open area documented on 12/16/13. He stated when wounds were assessed as being moisture-related they were not tracked by the wound team. He further revealed that non-pressure wounds were supposed to be	F 314		

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F 314	Continued From page 31 assessed and tracked to resolution by nursing staff on a "non-pressure report." He was unable to explain why no such report existed for this wound, and uncertain why there were no measurements of this wound before 1/5/14. g. According to Perry, Potter and Elkin, "Nursing Interventions & Clinical Skills" 5th ed. St. Louis, MO: Mosby, 2012, page 585 "Wound assessment is essential in wound management. The assessment of the following factors: location, dimensions, undermining, drainage, tissue type, exudate, wound edges, and pain, plays an important role in correct diagnosis and proper treatment of wounds and hard-to-heal pressure ulcers. A uniform approach to wound assessment that uses measurements can identify the appropriate treatment plan and appropriately evaluate progress to healing." 2. Review of the 12/22/13 quarterly MDS assessment showed resident #105 was at risk for the development of pressure ulcers. In addition, the resident had one unhealed ulcer. Review of the 2014 treatment administration record showed s/he had diagnoses that included an unstageable pressure ulcer on his/her heel. Review of the resident's care plan for skin dated 8/7/13 showed the resident was at risk for skin breakdown related in part to cognitive loss, functional mobility decline, incontinence and weakness. Approaches included: the CNA was to inspect skin surfaces daily during care and report signs and symptoms of skin irritation as soon as possible. The following concerns were identified: a. An observation on 1/7/14 at 1:10 PM showed CNA #2 and CNA#7 transferred resident #105 from the wheelchair to bed with the use of a total lift in order to provide incontinence care. During the care, it was revealed the resident had	F 314		

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F 314	Continued From page 32 2 areas of skin breakdown on the right buttock. In addition, there were 2 areas of skin breakdown noted on the resident's sacrum. The CNAs completed perineal care and applied Remedy cream to include the areas of breakdown. The resident was left on his/her back after the CNAs completed the care. An observation of these wounds, with the wound care nurse, on 1/7/14 at 4:20 PM, 3 hours 10 minutes after they were initially observed, revealed he was not aware of the skin breakdown. He confirmed there were two stage II pressure ulcers measuring 0.5 by 0.5 cm (centimeters) and 1.0 by 1.0 cm located on the sacrum. The areas of skin breakdown on the right buttock were identified, but he did not measure them. Interview with the wound care nurse at that time revealed he would expect CNAs to notify the nurse of any skin breakdown. In turn, the nurse would notify the wound care nurse to assess and recommend treatment. b. Review of the facility's policies and procedures for pressure ulcer prevention dated 10/7/10 showed; "The facility's procedures are such that all disciplines are alerted immediately if the resident either has skin breakdown or is at risk for the development of skin breakdown."	F 314		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by:	F 319	F 319 1. On or before 2/6/14 residents #83, #17 and #97 were assessed by the new facility Social Services Director and a PHQ9 assessment was utilized. The physician was notified of the assessment results to determine a treatment plan for these residents if necessary. Additionally, a behavioral interactional guideline was developed to educate the nursing staff on resident #83's, #17 and #97's psychosocial/behavioral and mood needs.	2/6/14

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F 319	Continued From page 33 Based on observation, medical record review, staff and resident interview, and review of facility policy the facility failed to ensure 3 of 10 resident's (#17,#83,#97) assessed as having increased signs and symptoms of depression received appropriate treatment and services. The findings were: 1. Review of the medical record showed resident #83 was admitted to the facility on 5/27/08 with diagnoses including depression. Review of the annual MDS assessment dated 3/1/13 showed the PHQ-9 (a resident mood assessment tool used to assess the signs and symptoms associated with depression based on the resident's response, the higher the score the more depressed the resident presents) score was, "6" on a scale of 0-27. Review of the most current modified quarterly MDS assessment dated 11/12/13 showed the PHQ-9 score was, "17" indicating an increase in the resident's signs and symptoms of depression from mild depression to moderately severe depression. Review of the care plan dated 8/16/13 showed the resident had "verbal expressions of distress" and "severe s/s [signs and symptoms] of depression present and the PHQ-9 assessment was "24/27". Interventions included reporting changes in mood status to the physician and completing PHQ-9 assessments quarterly and as needed. In addition, review of the monthly pharmacy drug regimen review revealed there was no documentation to show behavior tracking forms were reviewed by the pharmacist. The following concerns were identified: a. Review of the medical record showed a physician's order dated 9/9/13 to discontinue Remeron (a medication used to treat depression). Review of the medical record further revealed the	F 319	2. On or before 2/6/14 the Social Services department conducted an audit on all residents to review specific target behaviors, to ensure that there is documentation on the Behavior Tracking Sheets. Any identified errors/missing information was corrected at the time of discovery. 3. On 1/21/14, the Social Services Department was educated, by the Division Director of Clinical Services, regarding the Behavior Tracking Program, the importance of identifying specific target behaviors, monitoring documentation on the Behavior Tracking Sheets, and the importance of developing an individualized behavior care plan addressing those targeted behaviors or needs. 4. The Director of Social Services or his/her designee will conduct random audits of the behavior monitoring sheets ensuring that the behaviors are documented on the behavior sheets	

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F 319	Continued From page 34 resident had received no other medications to treat depression from 9/9/13 to date. Review of the medical record additionally showed no evidence the physician was notified of the resident's reported increase in the signs and symptoms of depression. Review of behavior tracking forms dated 10/2/13 through 12/20/13 showed the resident regularly had behaviors of yelling, "nurse", and "help", in addition to verbal abuse towards staff. The last documentation that behaviors had been reviewed was on 9/18/13 by the social services assistant, however, there was no documentation the physician was notified of the resident's behaviors. Review of a physician's progress note dated 11/4/13 showed the resident had a depressed mood and reported that s/he had "lived too long". b. Interview with the resident on 1/7/14 at 9:30 AM revealed the resident stated, "I just lie here, I can't get up anymore". The resident further stated, "I stopped using my call light and started yelling because nobody answers the call lights, but if I yell long enough and loud enough eventually somebody will come". c. Observation of the resident on 1/7/14 at 10:16 AM revealed the resident was calling out, "nurse help". The ADON entered the resident's room and the resident stated, "I just want to die, I've lived too long". Observation of the resident at 1:40 PM the same day revealed CNA's #2 and #4 performed incontinence care and the resident informed them, "I have just lived too long, I want to die". d. Interview with the resident's physician on 1/10/14 at 10 AM revealed the physician had discontinued the Remeron on 9/9/13 because the resident's appetite had improved and the resident's signs and symptoms of depression had improved. The physician revealed he had not	F 319	5. The Director Social Services or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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F 319	Continued From page 35 been made aware of the increased signs and symptoms of depression as assessed on the PHQ-9, or the resident's increase in behaviors. 2. Review of the medical record showed resident #17 was admitted to the facility on 4/1/10 with diagnoses that included Alzheimer's disease and depression. Review of the resident's annual MDS assessment dated 6/10/13 and quarterly MDS assessment dated 12/4/13 revealed the resident's score on the PHQ-9-OV (Staff Assessment of Resident Mood) had doubled from a score of 6 to a score of 12, indicating an increase from mild depression to moderate depression. There was no evidence in the medical record this increase in symptoms of depression was referred to the resident's physician for treatment evaluation. 3. Review of the medical record revealed resident #97 was admitted to the facility on 12/5/11 with diagnoses that included non-Alzheimer's dementia and depression. Review of the resident's annual MDS assessment dated 8/12/13 and quarterly MDS assessment dated 11/7/13 revealed the resident's score on the PHQ-9-OV increased from a score of 6 to a score of 14, indicating an increase from mild depression to moderate depression. There was no evidence in the medical record this increase in symptoms of depression was referred to the resident's physician for treatment evaluation. 4. Interview with the DON on 1/9/14 at 4:40 PM revealed the social services director and assistant were responsible for completing PHQ-9 assessments on the MDS, however, nursing staff began performing the assessments around the middle of November 2013 following vacancies in both the social services director and the social	F 319		

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F 319	Continued From page 36 services assistant positions. The DON revealed the facility had identified around the first of November 2013 that review of behavior tracking forms, "fell through the cracks." The process had been for the social services director to review the behavior tracking forms and bring any behavior concerns to the IDT, but this did not get done. The DON further revealed an action plan was developed on 12/31/13 (approximately 2 months later). Additionally, the DON confirmed she expected all staff to document and report increased behaviors to nurses and the physician. 5. Interview with the MDS Coordinator on 1/10/14 at 3:30 PM revealed the responsibility for performing resident mood assessments had fallen to the MDS coordinators following the vacancies for the social services director and the social services assistant positions. She confirmed that MDS coordinators were not notifying physicians of increased symptoms of depression. 6. Review of the facility's policy titled, "Behavior Monitoring and Tracking" dated October 23, 2012, showed the "purpose" of monitoring behaviors was achieved by.."a) Establish an accurate pattern of resident targeted behavior(s) as determined by resident's history, psychiatric/psychosocial evaluation, Minimum Data Set Assessment, etc." The policy also showed, "C 2..If a resident displays related behaviors without being on a psychoactive medication, behaviors may be monitored on a Behavior Monitoring Form. Additionally, Social Services staff will also initiate a Behavior Tracking Tool.." and "C. 3. The Social Services Staff will train facility staff regarding resident's preferred non-pharmacological interventions and the purpose of the Behavior Monitoring Form". In	F 319		

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F 319	Continued From page 37 addition the policy further showed, "7. The social service staff will review each behavior monitoring form entry after the morning meeting in the form of a "behavior huddle" on the unit where the resident resides. Social service staff or other IDT [interdisciplinary team] members may recommend care plan interventions, or addition staff training..". F 323 SS=J 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, staff and resident interviews and medical record review, the facility failed to ensure 1 of 9 sample residents (#79) identified with swallowing problems was provided adequate supervision while eating. As a result, the potential for serious avoidable injury to sample resident #79 was identified and a determination of immediate jeopardy was made. In addition, the facility failed to ensure adequate supervision/education for 1 sample resident using a gel pack for heat therapy (#114), which resulted in burns to the resident's ankle. The findings were: 1. Review of a physician's note dated 11/7/13 showed resident #79 had diagnoses that included	F 319 F 323	F 323 Abatement: 1.Resident #79: 100% of all care staff has been in-serviced with respect to the nutrition-related component of the 1/8/2014 current care plan. Resident #79 Nutrition Care Plan was updated to include interventions summarized below: a. Report to nurse any signs and symptoms of chewing and/or other problems consuming meals, included but not limited to: i. Choking ii. Coughing during eating or drinking iii. Nose dripping iv. Eyes tearing while eating v. Pocketing of food vi. Excessive drooling vii. Eats less than 50% of meal (and) b. Resident #79 will be supervised during all meals.	2/6/14

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F 323	Continued From page 38 Barrettes Esophagus (damage to the lining of the esophagus) and dysphagia (difficulty swallowing). Further, the note showed the resident reported problems with food sticking in his/her throat and having to cough the food up. A physician's note dated 12/2/13 showed the resident had moderate dementia. Review of a physician's note dated 12/16/13 revealed a swallow study was completed with the following recommendations from speech therapy: "...small drinks, double swallows with thin liquids. If pulmonary compromise occurs, consider nectar thick liquids..." Review of the quarterly nutrition assessment dated 12/6/13 showed the resident received a mechanical soft diet due to it being easier to swallow. Further, the resident remained in his/her room for most of the meals. Review of the care plan for nutrition dated 12/6/13 showed the licensed nursing staff was to observe the resident for signs and symptoms such as "chewing/swallowing problems, worsening of tremors that affect ability to hold utensils." Further, the care plan showed the CNA staff was to report any signs and symptoms of chewing/swallowing or other problems consuming meals to include: choking, coughing while eating or drinking, nose dripping or eyes tearing while eating, pocketing food or excessive drooling. Review of the 12/8/13 MDS assessment showed the resident required one person assistance with eating. Review of the nurses' notes showed the following entries: 1. On 9/30/13 the resident was observed having problems eating while in the dining room with food sticking in his/her throat. 2. On 11/7/13 the resident felt [s/he] was more shaky. Review of the physician notes dated that same day showed the resident had food stuck in his/her throat	F 323	2. Resident #79: An inspection of resident room was conducted at 7:30 PM on 1/8/14, to ensure that no food items were present in the room. The resident affirmed there were no food items present in the room. 3. Resident #79: Diet was downgraded on 1/9/14 to puree, pending further assessment(s). Patient expresses agreement with the downgrade. Resident #79 is on thin liquids. 4. A whole house audit was conducted on 1/9/14 to identify other residents at risk as Resident #79. This audit was completed by utilizing the : a. CMS-802 b. Identified list of resident with mechanically altered diet. c. Identified list of residents with like diagnoses. 5.A total of three residents were identified with similar risks of choking/swallowing. 6.The care plan of each of those three residents identified with the same risks as Resident #79 was reviewed on 1/9/14.	

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F 323	Continued From page 39 during breakfast. 3. On 11/25/13 a family member notified the facility the resident was choosing inappropriate food due to his/her dementia and as a result was choking on the food. The family member reported the resident called "frequently" reporting s/he was choking on food. 4. On 11/28/13 a family member reported, while out of the facility for a meal,the resident had an episode of difficulty with swallowing. 5. On 12/19/13 the note showed the resident was oriented to person and sometimes to place. Further, it showed the resident was forgetful and easily confused. a. Observation on 1/7/14 at 1:40 PM showed resident #79 was brought to his/her room in a wheel chair and placed next to the foot of the bed with his/her back to the door, facing the window. A staff member brought the resident's meal into the room and then left after setting up the tray. At 1:55 PM the surveyor entered the room and the resident stated s/he was having difficulty swallowing. S/he was tearing and drooling; however, it was not evident the resident was having difficulty from the hallway due to having his/her back to the door. The resident's call light was located on the bed and out of reach of the resident. Assistance was requested from the nursing staff at that time. The following concerns were identified: b. Observation on 1/8/14 at 5:50 PM showed the resident was again sitting on the side of the bed with his/her back to the door. CNA #8 brought the resident's meal tray and left the room. Continuous observation until 6 PM did not show staff entered the resident's room until s/he had completed his/her meal. An interview with the resident at 6:10 PM revealed s/he was not supervised during meals when eating in his/her room, only when in the dining room. c. An interview with CNA#8 on 1/8/14 at 6:45	F 323	7.The care plans for those 3 identified residents were amended on 1/9/14 to ensure individualized interventions were included. 8.All care staff on 1/9/14 will be in-serviced, prior to their shift on the Care Plan(s) of those three residents identified in #5 above. 9.The three identified residents (as well as Resident #79) will be supervised/monitored during each meal to ensure that the Care Plan related to their swallowing risk is being followed. 10.Individuals assigned to monitor these residents (i.e Restorative Aide and/or C.N.A) during their meals will complete a Meal Monitoring Tool designed to capture evidence of compliance with the residents' Care Plan. 11. The tool(s) will be turned into the Director of Nursing (or her designee) each day for review and action if necessary. 12.The Director of Nursing will summarize the results of the Meal Monitoring Tools each month at the facility's Performance Improvement Committee	

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F 323	Continued From page 40 PM revealed she was not aware the resident had problems with eating and was to be observed for swallowing difficulty. Additional interviews with CNA #9 and CNA #10 on 1/8/14 at 6:20 PM and 6:30 PM respectively revealed they were not aware of any precautions related to swallowing for this resident. d. An interview with RN #1 on 1/8/14 at 7:25 PM revealed she was aware the resident had swallowing problems. She was not aware the CNAs did not know the resident was to be observed for swallowing difficulty while eating. On 1/8/14 at 7:10 PM, the administrator was informed of an immediate jeopardy situation in the area of patient safety related to lack of supervision of residents with known swallowing issues. The facility's action plan included the following: 1. Resident #79: 100% of all care staff has been in-serviced with respect to the nutrition-related component of the 1/8/2014 current care plan. Resident #79 Nutrition Care Plan was updated to include interventions summarized below: a. Report to nurse any signs and symptoms of chewing and/or swallowing or other problems consuming meals, included but not limited to: i. Choking ii. Coughing during eating or drinking iii. Nose dripping iv. Eyes tearing while eating v. Pocketing of food vi. Excessive drooling vii. Eats less than 50% of meal (and) b. Resident #79 will be supervised during all meals. 2. Resident #79: An inspection of resident	F 323	1. Resident #79 has not choked on any of his meals he has consumed. He continues to eat in the dining room with oversight. Resident's care plan has been updated to support his diagnosis of Barrett's Esophagus. Resident # 114 was discharged from the facility on 10/3/13. 2. As noted in the 2567, the facility submitted a plan to abate the immediate jeopardy which in pertinent part stated: a whole house audit was conducted on 1/9/14 to identify other residents at risk as resident #79. This audit was completed by utilizing the CMS 802 document, a list of resident with mechanically altered diet and identified list of resident with like diagnoses. Facility policy disallows residents' use of any form of heat pack as a treatment modality.	

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F 323	Continued From page 41 room was conducted at 7:30 PM on 1/8/14, to ensure that no food items were present in the room. The resident affirmed there were no food items present in the room. 3. Resident #79: Diet was downgraded on 1/9/14 to puree, pending further assessment(s). Patient expresses agreement with the downgrade. Resident #79 is on thin liquids. 4. A whole house audit was conducted on 1/9/14 to identify other residents at risk as Resident #79. This audit was completed by utilizing the: a. CMS-802. b. Identified list of residents with mechanically altered diet. c. Identified list of residents with like diagnoses. 5. A total of three residents were identified with similar risks of choking/swallowing. 6. The care plan of each of those three residents identified with the same risk as Resident #79 was reviewed on 1/9/14. 7. The care plans for those 3 identified residents were amended on 1/9/14 to ensure individualized interventions were included. 8. All care staff on 1/9/14 will be inserviced, prior to their shift on the Care Plan(s) of those three residents identified in #5 above. 9. The three identified residents (as well as Resident #79) will be supervised/monitored during each meal to ensure that the Care Plan related to their swallowing risk is being followed. 10. Individuals assigned to monitor these residents (i.e. Restorative Aide and/or CNA) during their meals will complete a Meal Monitoring Tool designed to capture evidence of compliance with the residents' Care Plan. 11. The tool(s) will be turned into the Director of Nursing (or her designee) each day for review	F 323	3. Nursing staff were in-serviced by the Director of Nursing or his/her designee on or before 02/03/14 regarding the importance of utilizing care directives as a guide on care needs for each resident, including the need for supervision with eating. Residents requiring supervision with meals will be monitored by a restorative C.N.A/designee. Staff were also educated on the facility policy that disallows use of any form of heat pack for resident use 4. The Director of Nursing or his/her designee will randomly observe/audit residents who required supervision with meals to ensure supervision is provided. 5. The Director of Nursing or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved.	

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F 323	Continued From page 42 and action if necessary. 12. The Director of Nursing will summarize the results of the Meal Monitoring Tools each month at the facility's Performance Improvement Committee. The action plan was accepted on 1/9/14 at 3:10 PM, and based on verified implementation of the plan, the immediate jeopardy was abated on 1/9/14 at 6:30 PM. However, deficient practice remained at a scope and severity of D. 2. Review of the medical record for resident #114 revealed s/he was admitted to the facility on 10/3/13 with diagnoses that included nontraumatic compartment syndrome of the right lower extremity. Review of the admission MDS assessment dated 10/10/13 showed the resident was cognitively intact, ambulated under supervision with the assistance of a walker, required limited assistance with most ADLs, and had almost constant pain that limited day to day activities. Review of the physical therapy plan of treatment dated 10/3/13 showed the resident received therapy five times a week for difficulty walking and muscle weakness. The following concerns were identified: a. Review of a PT [physical therapist] Daily Treatment Note dated 10/15/13, timed at 3:41 PM, showed "Therapist saw the patient walking in the hall by him/herself without his/her walker, s/he said s/he heated up a gel pack in the microwave, she was just on his/her way back to his/her room. [Resident] agreed to therapy, was complaining of being hot and needed a drink. Therapist thought if the [resident] is getting more steady on his/her feet, s/he should trial a SPC [single point cane]. [Resident] was only able to go ~15'	F 323		

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F 323	Continued From page 43 [approximately 15 feet] with CGA [contact guard assist], had the [resident] sit down because s/he was too unsteady. EDUCATION: Instructed the patient to use his/her walker if s/he is by him/herself. [Resident] then performed the Tinetti Balance Assessment, scored 22/28 which put him/her in the moderate risk for falls category. [Resident] performed the assessment without an assistive device. This intervention is medically necessary in order to determine the [resident] fall risk." No evidence of a safety assessment for the gel pack, or resident education on hot pad safety was found in the record. b. Review of a non-pressure skin condition record dated 10/22/13 revealed the resident had four blisters on his/her right ankle. Review of the facility's investigation report dated 10/22/13 revealed the resident had heated a gel pack in a microwave, and applied it to his/her right ankle. The investigation report did not show where the resident obtained the gel pack, information about who authorized the hot gel pack as an effective treatment modality, or whether the resident and/or staff had received instructions regarding safe usage. c. Interview with the DON on 1/9/14 at 4:30 PM revealed the facility had been unaware the resident was using the gel pack, and the facility usually did not use gel packs due to the potential for injury. The DON stated the therapist should have reported the resident was using the gel pack so staff could have removed it or provided instructions on safe use. The DON was not aware of the gel pack being part of therapy treatment or a doctor's order, and assumed the resident had brought the gel pack from home. d. Interview with the rehabilitation director on 1/10/14 at 9:40 AM revealed the facility had, at one time, used gel packs, but only for cold	F 323		

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F 323	Continued From page 44 therapy. She said the facility no longer used gel packs. The rehabilitation director further confirmed no assessment for the safety of the resident while using the gel pack was made, and no resident education on gel pack usage and safety was performed.	F 323		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of facility menu spreadsheets the facility failed to ensure the planned amount of food was served during 1 of 2 meal observations in the main dining room. The findings were: Observation of the evening meal on 1/6/14 at 4:45 PM showed the meat alternative was chicken tenders. Review of meal tray cards showed 23 residents received the meat alternative for a regular portioned diet in the main dining room and were served 1 chicken tender. Interviews with residents #71, #75 and #84 revealed when chicken tenders were served they only received 1 piece but they would have liked 2 pieces. Interview with the CDM on 1/6/14 at 5:25 PM revealed she wasn't sure why residents were only served 1 chicken tender. The CDM further	F 363	F 363 1. All dietary staff was in-serviced on or before 02/05/14 by the registered dietitian or designee on the following: Ensure menu spreadsheets are followed/served correctly for all diets and textures. 2. All residents with a PO diet have the potential to be affected by the deficient practice. 3. All dietary staff will be in-serviced on or before 02/05/14 by the registered dietitian or designee on the following: Ensure menu spreadsheets are followed/served correctly for all diets and textures. 4. The Dietary Manager or his/her designee will randomly audit meals to ensure therapeutic menu spreadsheets are followed and residents are served the correct diet.	2/6/14

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F 363	Continued From page 45 revealed the menu listed the chicken tenders serving size as 2 oz (ounces). Review of the facility's menus titled and dated, "Fall/Winter 2013, Menu #11, week 2 day 9" showed the resident was supposed to receive "2 chicken tenders each". At 5:30 PM the CDM confirmed residents were supposed to receive 2 pieces of chicken tenders as a meat alternative.	F 363	5. The Dietary Manager or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	
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 fixed food contact equipment, and ready to eat foods were maintained in a sanitary condition. The findings were: 1. Initial kitchen observation with the CDM on 1/6/14 at 2:30 PM revealed the following equipment was identified as requiring additional cleaning: a. Two out of 3 ovens in the kitchen had black burned-on food on the back, sides and doors that was crumbling and flaking on the floor of the oven.	F 371	F 371 1. During the survey, the ovens, juice machine, including underneath, the mixer, mixer attachment and underneath the mixer and slicer were all deep cleaned and sanitized. The 12 pack of hot dog buns were thrown out and the surrounding area by the bread rack, including the prep-table & areas surrounding the microwave were cleaned & sanitized. In addition, the cheese identified as moldy was tossed immediately. The Dietary Manger and Regional Dietitian made rounds in the kitchen around 2:50 to ensure there were no other outdated, spoiled and/or expired foods. On 1/6/14 there were additional rodent traps set throughout the kitchen by Director of Maintenance. The cleaning schedule was revised to include the following: 1) clean juice machine, including underneath in am and pm, 2) deep cleaning of the ovens were added to the weekly deep cleaning schedule, 3) clean mixer, including underneath surfaces after	2/6/14

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F 371	Continued From page 46 b. The automatic juice dispenser had a build-up of a red and orange substance that was sticky to touch underneath where juice was dispensed into a cup. c. The standing electric mixer was encrusted with a thick white substance on the underneath surface where the mixer attachments were attached. There was a sign located on the top of the mixer that instructed, "Clean after every use". d. The electric meat slicer had a build up of food and grime on the slicer blade and guide, which the CDM easily removed with a gloved hand. The CDM then verified the slicer should be cleaned after each use. e. According to Food Code 2013, U.S. Public Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Non-food Contact Surfaces, And Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES AND UTENSILS shall be clean to sight and touch. 2. Initial kitchen observation with the CDM on 1/6/14 at 2:30 PM further revealed a 12-pack of hot dog buns containing 7 buns located on the bread storage rack, ready to eat. There was a silver-dollar-sized area where the plastic wrapper covering and the bread beneath had been gnawed. There were also several rodent droppings on a food preparation counter located to the left side of the bread rack, and under a microwave oven. According to Food Code 2013, U.S. Public Health Service: 3-307.11 FOOD shall be protected from contamination that may result from a factor or source not specified under subparts 3-301-3-306. 3. Initial kitchen observation with the CDM on 1/6/14 at 2:30 PM revealed a block of white cheese with a hand written use by date of 1/9/14	F 371	each use, 4) clean slicer, including underneath and blade after each use. 2. All residents with a PO diet have the potential to be affected by the deficient practice. 3. The Dietary Manager or her designee will in-service dietary staff on or before 02/05/14 which included the following: Cleaning schedule revisions, proper procedures on how to deep clean stoves, ovens, mixer and slicer, how to report any suspected rodent droppings and/or observed sign of potential rodents. In addition, the in-service will cover proper food storage and foods safety. 4. The Dietary Manager or her designee will complete random audits to ensure kitchen equipment is clean/sanitized, there is no evidence of rodents, and there is no outdated, expired or spoiled foods.	

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F 371	Continued From page 47 written on the plastic wrap covering the cheese. There was a nickel-sized hairy greenish-black area on one corner of the cheese, visible through the clear plastic wrapper. The CDM identified the cheese as mozzarella and indicated it had been used during lunch that day. According to Food Code 2013, U.S. Public Health Service: 3-701.11 Discarding or Reconditioning Unsafe, Adulterated, or Contaminated Food. (A) A FOOD that is unsafe, ADULTERATED, or not honestly presented as specified under 301-101.11 shall be discarded or reconditioned according to an approved procedure.	F 371	5. The Dietary Manager or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	
F 425 SS=F	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F 425 1. The facility procedure for medication administration was changed from a block medication administration time to a scheduled medication administration time 2. All resident's block time for medication administration was changed to a scheduled medication administration time 3. Nursing staff were in-serviced by the Director of Nursing or his/her designee on or before 1/28/14 regarding the change from a block medication administration time to a scheduled medication administration time 4. The Director of Nursing or his/her designee will randomly audit that the procedure for scheduled medication administration time is being followed	2/6/14

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F 425	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and review of the facility's policies and procedures, the facility failed to ensure procedures were put in place for accurate administration of medications for 20 of 22 sample residents (#6, #8, #11, #17, #34, #35, #37, #41, #48, #49, #64, #69, #77, #79, #83, #94, #96, #97, #105, #109). The findings were: Review of the January 2014 medication administration record (MAR) for residents #6, #8, #11, #17, #34, #35, #37, #41, #48, #49, #64, #69, #77, #79, #83, #94, #96, #97, #105, #109 showed the medications were allowed up to a four hour window to be given. The following concerns were identified: a. The times the medications were given by the nursing staff were not documented on the MARs. b. Review of medications ordered to be given 3 times daily showed there could potentially be only 1-2 hours between doses. The allowable time ranges for the medications were 8-11 AM, 1-5 PM and 7-10 PM. c. Further, medications ordered to be given twice daily showed the routine times were noted to be 8-11 AM and 1-5 PM or 7-10 PM. d. Examples of medications to be given on an empty stomach or with meals were also timed to be given within blocks of time rather than timed based on the meal schedules. An interview with the pharmacist on 1/8/14 at 12:50 PM revealed block times for medication administration allowed the nurses flexibility. In addition, she stated the conventional scheduling for administration sets the nurses up for failure	F 425	5. The Director of Nursing or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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F 425	Continued From page 49 due to the number of residents that require their medications at the same time. The block times also allowed for emergencies and therapy. An interview with LPN #2 on 1/8/14 at 12:55 PM revealed the block times were established in the rehabilitation unit to more closely mimic the residents' schedules for home use. Further, she revealed the nursing staff did not have time to write the times on the MAR to show when the medication was actually given. An interview with the medical director on 1/10/14 at 10 AM revealed he was not aware of how long the facility had used block times for medication administration. Further, he acknowledged there could potentially be problems associated with giving the same medication doses too close together since the times the medications were given was not documented. In addition, medications that were time specific, for example medications that needed to be given on an empty stomach or given with meals, should not be timed with a 3 hour window. Review of the policies and procedures for medication administration last revised on 2/09 showed medications to be given twice a day were to be timed at 9 AM and 5 PM. Medications ordered to be given 3 times daily were to be timed at 9 AM, 1 PM and 5 PM. In addition, the policy showed; "Certain groups of medications require special time schedules to obtain optimum effectiveness, either to maintain an even blood level at all times or to avoid adverse interactions with other medications or food."	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F 441 1. Resident # 83 experienced no negative outcomes as a result of improper peri-care 2. Residents requiring assistance with peri-care were identified & monitored to ensure proper peri-care was performed	2/6/14

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F 441	Continued From page 50 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	3. Nursing staff were in-serviced by the Director of Nursing or his/her designee on or before 2/3/14 regarding proper peri-care procedures 4. The Director of Nursing or his/her designee will conduct random audits of residents requiring assistance with peri-care to ensure proper peri-care procedures are being followed 5. The Director of Nursing or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	

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F 441	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and current standards for infection control, the facility failed to ensure standard precautions were followed for 1 of 3 sample residents (#83) observed for incontinent/perineal care. The findings were: Review of the medical record showed resident #83 was admitted to the facility on 5/27/08 with diagnoses including hemiplegia/hemiparesis. Review of the MDS quarterly assessment dated 11/12/13 showed the resident was moderately cognitively impaired and required extensive assistance with ADLs including toileting. The MDS assessment further showed the resident had limited range of motion in bilateral upper and lower extremities and had frequent bowel incontinence. Review of the CAA dated 3/1/13 indicated the resident's care plan for assistance with ADLs should continue. Review of the care plan updated 11/9/13 showed the resident required extensive to total assistance with all ADLs related to limited range of motion, and residual effects from a CVA (cerebrovascular accident or stroke). Interventions included staff providing all ADL care, and support to ensure daily needs were met. The following concerns were identified: a. Observation of incontinence care with CNA #2 and CNA #4 on 1/7/14 at 1:45 PM revealed the resident was incontinent of stool. CNA #2 did not assemble supplies prior to cleaning stool from the resident. The CNA's gloves were visibly soiled with brown stool and she was observed to open drawers on the bedside table with the soiled gloves. The CNA reached into a clean container of disposable wipes located in the second drawer 4 times while cleaning the stool from the	F 441		

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F 441	Continued From page 52 resident's peri-rectal area and buttocks. The drawer also contained several visible personal items: pictures, a hairbrush, and a clear plastic cup, which were located in front of the plastic container of wipes. The CNA continued to wear the gloves, soiled with stool, and walked to a lotion dispenser located on the wall and dispensed lotion into her gloved hands and applied the lotion to the resident's buttocks. The CNA then stated, "I forgot to change my gloves." b. Interview with the DON on 1/10/14 at 11:15 AM revealed she expected staff to change soiled gloves appropriately when providing incontinence care. c. According to, "The Long Term Care Guide for Infection Control" copyright 2008, "Gloves serve an important purpose in infection control...and are worn to provide a barrier against pathogens and prevent contamination...gloves should be worn in all situations where you may come in contact with blood or body fluids (providing incontinence care)...gloves should be changed when contaminated and between soiled and clean areas". In addition, current standards of practice from the Centers for Disease Control (CDC) dated May 2011, "Standard Precautions are the minimum prevention practices that apply to all patient care...2. use of personal protective equipment [gloves] should be worn when there is contact with blood and/or body fluids...4. safe handling of soiled material, items soiled with blood and/or body fluids should be disposed of immediately after use in the appropriate container..."	F 441		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest	F 469	F 469 1.The mouse droppings were cleaned up immediately during the survey on 01/07/14. No other evidence of mouse droppings or mice activity has been identified since the survey. During the survey, the ovens, juice machine, including underneath, the mixer, mixer attachment and underneath the mixer and slicer were all deep cleaned and sanitized. The 12 pack of hot dog buns were thrown out and the surrounding area by the bread rack, including the prep-table & areas surrounding the microwave were cleaned & sanitized. In addition, the cheese identified as moldy was tossed immediately. The Dietary Manger and Regional dietitian made rounds in the kitchen around 2:50 to ensure there were no other outdated, spoiled and/or expired foods	2/6/14

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F 469	Continued From page 53 control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain an effective pest control program. The findings were: Initial kitchen observation with the CDM on 1/6/14 at 2:30 PM revealed a 12-pack of hotdog buns located on the bread storage rack. There was a silver-dollar-sized area where the plastic wrapper covering and into the bread beneath had been gnawed. There was also several rodent droppings on a food preparation counter located to the left side of the bread rack, and underneath a microwave oven. No traps were observed on floors under preparation areas or dry storage areas. Interview with the CDM revealed she had been aware of mice in the kitchen prior to leaving for vacation around 12/20/13 but thought the issue was resolved. The CDM verified staff were supposed to inform the maintenance director when they identified an issue and the maintenance director was responsible for pest control. Interview with the maintenance director on 1/9/14 at 11:30 AM revealed he was responsible for providing pest control for the facility. Staff informed him if they saw mice or there was any evidence of mice. He was notified by kitchen staff prior to Christmas that mice had been seen in the kitchen and traps were set. Interview further revealed he was unable to recall if any mice were caught at that time. He also indicated that a pest	F 469	2. Any resident who dines in the facility might have been at risk. 3. The Director of Maintenance notified the facility's Pest Control vendor on 01/30/14 about the findings. The vendor provides a monthly pest control service. The vendor conducted a site visit and inspected the entire facility (inside and outside) on 1/30/14. No other evidence of a problem was identified in their inspection. In addition, the Director of Maintenance conducted an all staff in-service on or before 01/28/14 advising staff of the protocol to immediately notify their supervisor and/or the Director of Maintenance if the discover mouse droppings and/or mouse activity. 4. The Director of Maintenance will randomly audit this facility for any signs of mouse droppings or mouse activity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	C 01/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 469	Continued From page 54 control company visits the facility monthly, however, he was unable to provide a log of the services the company provided to the facility. The maintenance director verified copies of bills were retained but logs documenting actual services performed by the pest control company were not maintained.	F 469	5. The Director of Maintenance or his/her designee will report the results of the audits at the monthly Performance Improvement meeting. The report will include any problems and/or trends noted. Reporting will occur for no less than three months or until substantial compliance has been achieved	
F 520 SS=D	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:	F 520	F 520 1.No specific residents were identified with respect to unresolved grievances and resident #83's pain has been addressed. Specific, identifiable residents who had expressed concerns with the linen and/or the lack of attentiveness of CNAs to resident's needs were polled on or by 02/05/14 by the Executive Director or his/her designee. On 2/4/14 a pain assessment was completed by the unit manager for resident #83 to determine the acceptable level of pain and to determine what factors exacerbated the pain. Based on the pain assessment completed on this date, resident #83's acceptable level of pain was a 3. As of 2/2/14 resident #83's pain level has been at or below his acceptable level of pain.	2/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

3/5/14

(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 520	Continued From page 55 Based on staff interview, review of the CMS 2567 (Centers for Medicare and Medicaid) Statement of Deficiencies, and review of facility documents, the facility failed to ensure the quality assurance and performance improvement program (QAPI), known in the facility as the Performance Improvement Committee was effective in identifying pertinent issues, and developing and implementing appropriate interventions to resolve those issues, and in establishing a program that enabled sustained compliance with previously identified issues. The findings were: 1. Review of the facility's Performance Improvement Committee program showed the facility failed to identify, resolve, and/or maintain compliance with the following pertinent issues: a. Issues with the facility's grievance resolution measures were cited during the previous two surveys in October of 2011 and November of 2012. A plan of correction was developed and monitored through the facility's Performance Improvement Committee, but the facility was unable to sustain compliance. Issues related to grievance resolution were again cited during the current survey (F244). b. Issues with the facility's implementation of pain management measures for residents with identified pain were cited during the previous two surveys in October of 2011 and November of 2012. A plan of correction was developed and monitored through the facility's Performance Improvement Committee, but the facility was unable to sustain compliance. Issues related to pain management were again cited, at a scope and severity of "G" during the current survey (F309).	F 520	2. All resident's had the potential to be affected. 3. The facility meets monthly for Performance Improvement (QA) with Executive Director, Director of Nursing, Medical Director and Department Heads in attendance. Recent survey results and resulting Plans of Correction will be reviewed at this meeting for on-going compliance. A Regional/Divisional Staff member will attend the PI Committee meeting x90 days for additional oversight 4. The Performance Improvement Committee meets monthly. Plans are modified as needed and upon recommendation of the Performance Improvement Committee. This monitoring of each area cited will be done per the POCs addressed above in this document. A Regional/Divisional Staff member will attend the PI Committee meeting x90 days for additional oversight.	