STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - RAWLINS	542 [illegible] RAWLINS, WY 82301

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WY Dept of Health
MAY 06 2014
Healthcare Licensing and Surveys

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CAAs Care area assessments CNA Certified Nurse Aide DNS Director of Nursing Services LPN Licensed Practical Nurse MAR Medication Administration Record MDS Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	*This Plan of Correction is Kindred Healthcare, Inc., Rawlins facility, credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute 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 federal and state law.*	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	**F225 483.13(c)(1)(ii-)-(iii), (c)(2)-(4)-Investigative Report/Allegations/Individuals** **5/25/2014** **Corrective Action:** The facility administrator/designee faxed the incident report to the state survey and certification agency, Carbon County DFS and the Wyoming Regional Ombudsman, the investigative report involving residents #22 and #52 on 1/17/14. The facility administrator will report to the state survey and certification agency, along with other appropriate agencies, within 24 hours any alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of Residents' property and to other appropriate officials in accordance with State law. The results of these investigations will be provided to the state survey and certification agency along with other appropriate agencies.	

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

Accepted 5/16/14, no changes Required by [illegible]

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.

[illegible] Administrator 5/2/14

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility investigation information, and staff interview, the facility failed to ensure 1 of 6 allegations of resident abuse/mistreatment reviewed were reported to the state survey and certification agency as required. The findings were: Review of the facility investigation regarding an incident between residents #22 and #52 showed it occurred on 1/17/14. The details of the investigation showed one resident "stabbed" the other with a fork at the dining table. According to the investigation, there was no significant injury to the resident, and the incident was reported to family and the physicians. However, there was nothing reported to the state survey and certification agency. Interview with the administrator on 4/10/14 at 1:40 PM verified this resident to resident altercation had not been reported to the state agency.	F 225	**Identification of Others Potentially Affected by Same Deficiency:** The Administrator will review the facility's Abuse and Neglect log, the Wyoming Reporting Requirements for Skilled Nursing Facilities, and the Kindred Healthcare Health Services Division "Reporting Guidelines for Suspected Cases of Abuse, Neglect, Misappropriation, Endangered Adults, or Death by Unnatural Causes" for compliance. No further Residents were identified who were affected by the same deficiency. **Systemic Changes:** The facility administrator will report to the state survey and certification agency, along with other appropriate agencies, within 24 hours any alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of Residents' property and to other appropriate officials in accordance with State law. The results of these investigations will be provided to the state survey and certification agency along with other appropriate agencies. **Monitoring:** Allegations of abuse/mistreatment will be audited monthly for timeliness of reporting. The results of the audit will then be presented to the Performance Improvement Committee	

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F 250	Continued From page 2	F 250		
F 250 SS=D	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 medical record review, observation, and resident and staff interview, the facility failed to evaluate an increase in signs and symptoms of depression for 1 of 9 sample residents diagnosed with depression (#43). The findings were: Review of the medical record showed resident #43 was admitted to the facility on 12/30/13 with diagnoses that included anxiety disorder, depression, generalized pain and alcohol-induced persisting amnestic disorder. Observation and interview with the resident on 4/7/14 at 4:27 PM revealed s/he desired to leave the facility, and asked about a list of affordable housing. At that time, the resident was noted to be disheveled, with soiled clothing, and a dirty face. Review of the resident's care plan revealed s/he had depression related to lifestyle and long term care placement. Goals for this focus, initiated on 1/14/14, included the resident "will remain free of s/sx [signs and symptoms] of depression, anxiety or sad mood by/through review date." Interventions included "Monitor/document/report to Nurse/MD s/sx of depression including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints,	F 250 F 250	**F 250: 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE** 5/25/2014 **Corrective Measures :** On 4/30/14 Social Services reevaluated Rt #43's mood as part of MDS PHQ-9 interview. The mood state score improved from 27 to a 15. Education provided to SSD and staff regarding interventions for residents exhibiting s/sx of depression. Interventions for Res #43 will be care planned and followed. **Identification of Others:** Current resident PHQ-9 scores have been audited against previous MDS scores to evaluate for changes. Residents identified with significant change will be re-evaluated and interventions will be added to care plan and followed. **Measures/Systemic Changes:** SSD will maintain log of PHQ-9 scores for current residents. This log will be updated with scores as the MDS is complete. Interventions will be care planned and follow through on. Staff will be educated regarding dignity and recognizing s/sx of depression. Facility will set up services with Tele-health to aid with psychosocial evaluations and treatment for residents. **Monitoring:** Social Services will coordinate with MDS Nurse over residents' State of Mood. Social Services will bring identified concerns of Mood State to work with IDT team for potential changes of condition. Mood state will be discussed at monthly PI meetings for review and recommendations.	

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F 250	Continued From page 3 tearfulness." Review of the resident's admission MDS assessment, dated 1/6/14, revealed a score of 5 on the patient health questionnaire (PHQ-9), indicating mild depression. Review of the resident's quarterly MDS assessment, dated 3/12/14, revealed an increase in that score to 24, indicating severe depression. No changes were made to the resident's care plan subsequent to the quarterly MDS assessment, and review of nursing notes and physician notifications revealed no indication the resident's physician was notified of the increased depression score. Interview with the social services director on 4/10/14 at 2:50 PM confirmed no specific actions were taken with regard to the increase in the resident's depression score, and the resident's physician was not notified.	F 250		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272	**F272:483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Corrective Measures for Identified Residents:** Residents will have a comprehensive assessment completed with their next scheduled assessment for the following Residents identified in F-272: #35,#44,#31,#11,#25,#32,#42,#43, #45 **Identification of Others:** Comprehensive assessments performed after 4/21/14 have been monitored and completion of CAAs that required RN oversight/performance have been completed by DNS/designee.	5/25/2014

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F 272	Continued From page 4 Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments in a variety of areas for 9 of 12 sample residents (#11, #25, #31, #32, #35, #42, #43, #44, #45). The findings were: Interview with the MDS coordinator on 4/9/14 at 2:15 PM revealed she had been working in the position for approximately one year. She was an LPN and was responsible for completing the CAA analyses. She further stated a registered nurse "reviewed and signed" the completed MDS assessments. She acknowledged some of the CAAs were lacking detailed analysis and were not	F 272	**Measures/Systemic Changes:** 4/21/14 MDS nurse and social service director were educated by DNS on performance of CAA's and needed information. Activity director has received education from corporate activity director on 4/29/14. Assessments done since 04/21/2014 have been monitored by DNS/ RN designee. Nursing assessments have been completed by RN. MDS assessments will be audited by DNS/SDC/designee for completion and accuracy. Assessments requiring completion by RN will be completed by DNS/SDC/designee. **Monitoring:** MDS nurse will monitor and report on comprehensive assessments at PI committee meeting once a month.	

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F 272	Continued From page 5 comprehensive. The following resident assessments were identified: 1. Review of the 2/3/14 admission MDS assessment for resident #35 showed the resident triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive loss/Dementia, Nutritional status, and Activities. Review of the corresponding CAAs for these areas showed an assessment/analysis of the findings was not comprehensive. 2. Review of the 3/17/14 admission MDS assessment for resident #44 showed the resident triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive loss/Dementia, Activities, Nutritional status, Dehydration/fluid maintenance, and Activities. Review of the corresponding CAAs for these areas showed an assessment/analysis of the findings was not comprehensive. 3. Review of the 9/24/13 significant change MDS assessment for resident #31 showed the resident triggered for multiple areas which required additional comprehensive assessment. These areas included: Nutritional status, Activities, and Communication. Review of the corresponding CAAs for these areas showed an assessment/analysis of the findings was not comprehensive. 4. Review of the 2/17/14 admission MDS assessment for resident #11 showed the resident triggered for multiple areas which required additional comprehensive assessment. These areas included: Nutritional status,	F 272		

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F 272	Continued From page 6 Dehydration/fluid maintenance, Activities, and Psychotropic drug use. Review of the corresponding CAAs for these areas showed an assessment/analysis of the findings was not comprehensive. 5. Review of the 3/17/14 significant change MDS assessment for resident #25 showed the resident triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive loss/Dementia, Nutritional Status, and Pressure Ulcer. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. 6. Review of the 4/3/13 admission MDS assessment for resident #32 showed the resident triggered for multiple areas which required additional comprehensive assessment. These areas included: Delirium, Cognitive loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, and Pressure Ulcer. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. 7. Review of the 2/3/14 admission MDS assessment for resident #42 showed the resident triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was	F 272		

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F 272	Continued From page 7 not comprehensive. 8. Review of the 1/6/14 admission MDS assessment for resident #43 showed the resident triggered for multiple areas which required additional comprehensive assessment. These areas included: Cognitive loss/Dementia, Psychosocial Well-Being, Behavioral Symptoms, Nutritional Status, and Psychotropic Drug Use. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive. 9. Review of the 10/18/13 significant change MDS assessment for resident #45 showed the resident triggered for multiple areas which required additional comprehensive assessment. These areas included: Delirium, Cognitive loss/Dementia, Communication, Urinary Incontinence, Mood State, Behavioral Symptoms,Activities, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Review of the corresponding CAAs for these areas showed the assessment/analysis of the triggered areas was not comprehensive.	F 272		
F 281 SS=F	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain vital signs, including oxygen saturation, blood pressure and pulse measurements as ordered by a physician	F 281		

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F 281	Continued From page 8 for 3 of 12 sample residents (#25, #32, #44). In addition, the facility failed to ensure assessments were completed in accordance with professional standards for 12 of 12 sample residents (#2, #3, #11, #25, #30, #31, #32, #35, #42, #43, #44, #45). The findings were: 1. Review of the medical record revealed resident #25 was admitted to the facility on 3/16/11, and had diagnoses that included anemia. Review of physician's orders revealed an order dated 1/3/13 for "O2 sats [oxygen saturations] to be checked every week and as needed." Review of the care plan revealed the resident received oxygen therapy related to shortness of breath. Interventions dated 2/25/13 included, "Monitor for s/sx [signs and symptoms] of respiratory distress and report to MD PRN [as needed]: Respirations, Pulse oximetry [a tool for measuring oxygen saturation], Increased Heart Rate..." Review of recorded oxygen saturations for the resident between 6/1/13 and 3/31/14 revealed oxygen saturations for the resident were only recorded once in June, 2103, 0 times in July, twice in August, 2013 (on the same day), 0 times in September, 2103, twice in October, 2013, once in November, 2013, once in December, 2013, once in January, 2014, once in February, 2014 and once in March, 2014. Of the 43 weeks in the time period between 6/1/13 and 3/31/14, oxygen saturations were recorded on only 9 weeks (21%). Interview with the DNS on 4/10/14 at 1:15 PM confirmed the missing vital signs for resident #25. 2. Review of the medical record revealed resident #32 was admitted to the facility on 8/23/10, and had diagnoses that included hypertension. Review of physician's orders revealed an order	F 281	**F 281: 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANARDS** **Corrective Measures for Identified Residents:** Reviewed records of the identified residents. We looked at documented vital signs, oxygen saturation, blood pressure, and pulse. Documentation sent to MD for evaluation and orders received. #25 oxygen saturations were sent to MD and orders changed due to stable readings. #32 blood pressure and pulse reading sent to MD and orders changed due to stable readings. #44 blood pressure readings sent to MD and orders received for change in medication and monitoring to twice a day. CAA's will be completed by RN with future MDS completions. #2, #3, #11, #25, #30, #31 ,#32, #35 ,#42 ,#43, #44,#45, MDS, annual assessment, will be open and completed by May 25th. CAA's will be completed by IDT team with a RN completing needed assessments. 4/29/14 LN meeting with information and education given. Reviewed findings of survey and responsibility of LN with completing audits. **Identification of Others:** All resident's orders reviewed by DNS/designee for orders and worked with MD to structure process with delivery of information. Vitals/oxygen saturation was reviewed on all residents. Ordered vitals/oxygen saturation status was sent to MD for evaluation and new orders received.	5/25/14

RP 5/12/14

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F 281	Continued From page 9 dated 3/13/13 to "Monitor BP [blood pressure] & pulse every week on Wednesday evening to monitor effectiveness of lisinopril and clonidine [medications to treat high blood pressure]." Review of recorded blood pressure measurements for the time period between 9/1/13 and 3/31/14 revealed, while there were 30 Wednesdays in that time period, blood pressure was recorded only 14 times, and only 7 of those blood pressure measurements were recorded on a Wednesday. Review of recorded pulse measurements for the same time period revealed that pulse measurements were recorded only 7 times, with only one of those times being on a Wednesday. Interview with the DNS on 4/10/14 at 1:15 PM confirmed the missing vital signs for resident #32. 3. Review of the medical record for resident #44 showed a physician's order dated 11/26/13 for blood pressures to be taken every eight hours. Further review showed the reason to take the blood pressure was related to the 11/24/13 order for "Clonidine HCL 0.1 mg as needed every hour for systolic blood pressure greater than 150." Review of the March 2014 MAR showed 28 times when the blood pressure was not initialed on the MAR as being taken. Review of the electronic record "Blood Pressure Summary" for March 2014 also failed to show the blood pressures were taken or recorded as ordered. Interview with the DNS on 4/10/14 at 1:15 PM verified the blood pressures needed to be taken and recorded as ordered to allow for proper administration of the medication. 4. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, nursing must	F 281	**Measures/Systemic Changes:** On 4/29/14 Educated LN and on 4/28/14, educated CNA's on vitals and oxygen saturation findings. Reviewed documentation guidelines per Kindred Healthcare, Inc. and following MD orders. We reviewed the importance of documenting findings. Educated staff on reporting results to provider when findings are outside the norm. 4/21/14 changed all MDS that require CAA's to have DNS/designee that is an RN complete assessments. **Monitoring:** Will have nurses complete a daily audit of vitals/oxygen saturation form with verification of completeness of gathered information. Will have DNS/SCD/ or designee monitor and calculate information with report given at PI committee meeting. Will evaluate all admission, change of condition, annual MDS's for RN completing all nursing assessments. Will report to the PI committee once a month with the information monitored.	

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F 281	Continued From page 10 function under the direction of a licensed physician. 5. Review of the following MDS assessments revealed the CAAs were completed by an LPN, and not an RN: a. The 2/10/14 admission MDS assessment for resident #2 b. The 9/24/13 significant change MDS assessment for resident #3 c. The 2/17/14 admission MDS assessment for resident #11 d. The 3/17/14 significant change MDS assessment for resident #25 e. The 12/18/13 annual MDS assessment for resident #30 f. The 9/24/13 significant change MDS assessment for resident #31 g. The 4/3/13 admission MDS assessment for resident #32 h. The 2/3/14 admission MDS assessment for resident #35 i. The 2/3/14 admission MDS assessment for resident #42 j. The 1/6/14 admission MDS assessment for resident #43 k. The 3/17/14 admission MDS assessment for resident #44 l. The 10/18/13 significant change MDS assessment for resident #45 Interview with the MDS coordinator on 4/9/14 at 2:15 PM revealed she had been working in the position for approximately one year. She was an LPN and was responsible for completing the CAA analyses. She stated a registered nurse reviewed and signed the completed MDS assessments, and was not aware it was not within her scope to complete the analyses on the CAAs. Further, she	F 281		

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(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 281	Continued From page 11 acknowledged some of the CAAs were lacking detailed analysis and were not comprehensive. According to the Wyoming Board of Nursing, Chapter 3, Scope and Standards of Nursing Practice and CNA Role: Section 3. Scope and Standards of Nursing Practice for the RN. (d) The RN shall implement the nursing process: (i) Conduct a comprehensive health assessment that is an extensive data collection (initial and ongoing) regarding individuals, families, groups, and communities; and Section 4. Standards related to the LPN's contribution to the nursing process. (i) Contribute to the nursing assessment by collecting, reporting, and recording objective and subjective data in an accurate and timely manner. Data collection includes observations about the condition or change in condition of the client.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to evaluate the	F 309	***F309: 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING*** **Corrective Measures for Identified Residents:** Evaluate #43 for pain documentation and follow up	5/25/14

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	535036	A. BUILDING _____ B. WING _____	C 04/10/2014

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F 309	Continued From page 12 effectivness of as needed pain medication for 1 of 5 sample residents (#43) who had pain. In addition, orders for 1 of 1 sample residents (#44) with specific blood pressure parameters were not followed. The findings were: 1. Review of the medical record for resident #43 revealed s/he was admitted to the facility on 12/30/13 with diagnoses that included anxiety disorder, and generalized pain. Review of the resident's care plan revealed the resident had acute pain related to alcohol withdrawal and generalized pain. Interventions on the care plan included "Administer medications as ordered...Monitor for effectiveness and side effects." Review of the physician orders recapitulation for the month of April, 2014 revealed an order dated 2/12/14 for Oxycodone [an opiod pain medication] extended release 5 mg by mouth every 4 hours as needed for pain. Review of the resident's MAR and pain monitoring flow sheet for March, 2014 revealed the resident received Oxycodone on 3/1/14, 3/20/14, 3/21/14, 3/24/14, 3/25/14, 3/26/14, and 3/27/14 with no corresponding assessment of the resident's pain before and after administration recorded on the pain monitoring flow sheet. Additionally, on 7 occasions, while a pre-administration assessment of pain level was recorded on the pain monitoring flow sheet, there was no post-administration assessment. Interview with the DNS on 4/10/14 at 1:15 PM verified PRN medications were expected to have follow-up assessments. 2. Review of the medical record for resident #44 showed a physician's order dated 11/26/13 for blood pressure to be taken every eight hours. Further review showed the reason to take the	F 309	evaluation. Notified MD with findings and new orders received. Evaluated #44 for blood pressure results. Weekly monitoring was performed since survey. Findings sent to MD and new orders received with changes in monitoring and medication. #44 chart, reviewed medical records on 3/13/14 and 3/23/14 for missed medication administration. Evaluated findings with the nurses and will have an action plan in place by 5/15/14 to monitor medication administration. Will report findings in PI. #43 chart, reviewed medical records on 3/1/14, 3/20/14, 3/21/14, 3/24/14, 3/25/14, 3/26/14, 3/27/14, for missed documentation on main. We had nursing students in the building and three days were missed by student. Will educate nursing instructor on pain documentation by 5/15/14. Will have the nurses that missed the documentation complete an action plan by 5/15/14 to improve on pain documentation. Will report findings in PI. **Identification of Others:** DNS/SCD/designee reviewed all resident's medical orders, documented vitals, and blood pressures. Reviewed pain assessments and completeness of data collected. MD notified of findings with changes made as prescribed. **Measures/Systemic Changes:** On 4/29/14, educated LN on collecting and documenting vitals and pain assessments. Introduced to LN, our new audit forms that will need to be completed by them at the end of their shift.	

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F 309	Continued From page 13 blood pressure was related to the 11/24/13 order for "Clonidine HCL 0.1 mg as needed every hour for systolic blood pressure greater than 150." Review of the March 2014 MAR showed 28 times with no initials on the MAR to show the blood pressure was taken as ordered. Review of the electronic record "Blood Pressure Summary" for March 2014 also failed to show blood pressures were taken or recorded as ordered. The following concerns were identified: a. Review of the 3/13/14 timed at "22 hr 15 min" blood pressure summary report showed the resident had a BP of 160/80. Review of the corresponding MAR for the administration of the Clonidine HCL showed the medication was not documented as being administered. b. Review of the 3/23/14 timed at "20 hr 19 min" blood pressure summary report showed the resident had a BP of 171/92. Review of the corresponding MAR for the administration of the Clonidine HCL showed the medication was not documented as being administered. c. Interview with the DNS on 4/10/14 at 1:15 PM verified these physician orders were not being consistently followed.	F 309	**Monitoring:** Will have each nurse complete an audit form at the end of their shift. The DNS/SCD/designee will evaluate findings and educate when results demonstrate incomplete documentation. Will report findings to PI committee meeting once a month.	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 386	**F 386 483.40(b) PHYSICIAN VISITS-REVIEW CARE/NOTES/ORDERS** 5/25/2014 Corrective Action: A copy of the progress notes was requested from the physician's office on 4/9/14 for Resident #42 and a copy of the progress notes was put into Resident #42's medical record on for the visit on 1/31/14 . Progress notes from the physician's visit on 2/21/14 and 3/27/14 to Resident #35 were requested on 4/9/10 and a copy of each visit was put into their medical record. The Medical Records Clerk/designee reviewed Federal Regulations F 386 483.40(b) on Physician visits and F 387 483.40(c) Regarding Frequency of Physician Visits with the facility administrator.	

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F 386	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain physician progress notes to be included in resident medical records in a timely manner for 2 of 12 sample residents (#35, #42). The findings were: 1. Review of the medical record for resident #42 revealed s/he was admitted to the facility on 1/28/14, however, no record of a physician's visit before 3/14/14 could be located in the record. Following a request by surveyors, physician progress notes dated 1/31/14 were faxed to the facility from the physician's office, and added to the record. Interview with the DNS on 4/10/14 at 1:15 PM confirmed the progress notes had not been in the resident's medical record, and had to be obtained from the physician's office. 2. Review of the medical record showed reference of two physician visits for resident #35, on 2/21/14 and 3/27/14. Further review of the medical record failed to show any progress notes from these visits. Interview with the DNS on 4/10/14 at 1:15 PM revealed the notes had been requested on 4/9/14 from the physician and on that day a copy was included in the resident's medical record.	F 386	Identification of Others Potentially Affected by the Same Deficiency: Medical Records Clerk/designee will review current Resident charts for physician visits to monitor that progress notes for the physician visits have been written, signed and dated at placed into the charts within the time frames of the regulations. Missing progress notes will be requested from the physician and put into Resident charts as identified. Systemic Changes: Medical Records Clerk/designee will put into place a tracking form for all physicians to utilize in order to ensure proper, updated and tracked information for each Resident who has been visited that same day. This form will also serve as a tracking tool for communication with physician offices on a weekly basis to assure recovery of any misplaced, signed and/or dated resident progress summaries to assure that progress notes and documentation are received and filed according to regulation. The Medical Records Clerk/designee will alert the physician if progress notes are not written, signed, dated and placed into the Resident charts on a weekly basis until notes are in compliance. Monitoring: Medical Records Clerk/designee will report to the monthly Performance Improvement Committee on any progress notes that are not written, signed, dated and placed into Resident charts. Monitoring of progress notes will occur on a weekly basis. The procedure outlined to track and contact the physician will be followed by the PI Committee to ensure that compliance of this regulation is met. The Committee will follow this procedure or will formulate a plan of action if needed to ensure that the facility maintains continued compliance.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		

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F 502	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain obtain laboratory testing for 1 of 12 sample residents (#45) in a timely manner. The findings were: Review of the medical record showed resident #45 was most recently re-admitted to the facility on 6/1/09, and had diagnoses of non-Alzheimer's dementia, and alcohol induced persistent amnestic disorder. Review of physician's orders revealed an order dated 8/2/10 for "Risperdal (risperidone) [an anti-psychotic medication] 0.5 mg PO every night at bedtime, and an order dated 5/16/13 for "CBC [complete blood count] every six months (June/Dec) D/T [due to] risperidone administration." Review of the resident's care plan revealed the resident was at risk for adverse effects related to the use of psychoactive drugs including Risperdal. Care plan interventions dated 1/31/13 included, "Labs as ordered by MD [medical doctor]." Further review of the medical record did not reveal any results of CBC testing from the month of December, 2013. Interview with LPN #1 on 4/10/14 at 12:50 PM confirmed the CBC had not been completed as ordered, and would be completed that day.	F 502	**F 502: 483.75(j)(1) ADMINISTRATION** **Corrective Measures for Identified Residents:** CBC was drawn on 4/10/14 on resident #45. MD notified of results with no changes in orders. **Identification of Others:** SCD/designee on 4/28/14, reviewed current residents physician orders for scheduled lab orders to monitor that they were complete for the month of March and April. Labs completed and MD notified of results. **Measures/Systemic Changes:** Night shift LN will audit MARS/TARS for lab draws due and will report the labs to be drawn to SDC/designee using a lab tracking form. SDC/designee will create an ongoing tickler file to organize future lab draws by month they are due. SDC will update list with additional review of physician orders at the end of the month. **Monitoring:** SDC/designee will audit MARS/TARS at the end of the month for completion. The audit will be conducted monthly and the results will be reported to the PI committee meeting.	5/25/2014