STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

(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 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). 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.	F 225	Preparation and execution of this 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 statement of the deficiencies. The plan of correction is prepared and/or solely because it is required by the provisions of federal state and law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date. The facility is of the opinion it was in compliance with requirements of participation or that corrective action was taken. F – 225 Investigations • The facility ensures that all allegations are reported and that they fully investigate the allegation of abuse. • The DNS and SS will be in serviced on the importance of reporting and fully investigating all allegations of abuse. • Administrator will audit all allegations of abuse to ensure they were reported and fully investigated x 90 days. • Audit findings will be reviewed at the monthly QA meeting.	06/01/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/30/14

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.

Changes made per phone call with Todd Hom, WHA on 5/29/14 @ 8:16 am. POC accptd. Janelle Colin, OTR/L

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to report 2 of 2 allegations of abuse reviewed to the state survey and certification agency. The findings were: Review of facility documentation showed the contact person for abuse investigations to be the social services director. Interview with the social services director on 4/17/14 at 11:25 AM confirmed she was the person at the facility who logged allegations and reported allegations to the appropriate authorities. Review of the social services director's log of abuse allegations and investigations revealed no allegations were logged after 11/4/13. Interview with the nurse manager on 4/17/14 at 10:15 AM revealed she had conducted two recent investigations, one, dated 2/18/14, for neglect which resulted in the termination of a nurse, and another, dated 4/3/14, for verbal abuse by a CNA to a resident that was ultimately determined to be unsubstantiated. These investigations were not on the facility logs, the allegations were not reported to the state survey and certification agency, and investigation summaries were not provided to the state survey and certification agency. Interview with the facility administrator on 4/17/14 at 12:55 PM confirmed he was aware of the recent investigations, and further confirmed the facility had failed to notify the state survey agency of the allegations, and had further failed to provide the state survey agency with investigation summaries.	F 225		

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F 241 F 241 SS=D	Continued From page 2 483.15(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 interview and medical record review, the facility failed to promote dignity for 1 of 9 sample residents (#11). The findings were: Review of the 3/3/14 quarterly MDS assessment showed resident #11 required limited staff assistance with most ADLs including dressing and hygiene. Observation on 4/15/14 at 9:05 AM revealed the resident wore a skin protective sleeve covering his right lower arm, around the thumb and over the top of the hand. The sleeve near the resident's wrist and thumb was noted at that time to be soiled with a large area of a darkened brownish-red dried substance. The following concerns were identified: a. Observation at 12:05 PM later that day, showed the soiled area remained. On 4/15/14 at 12:05 PM CNA #1 was asked about the sleeve and when she pulled it away, the skin below was intact. At that time is was also noted the resident's fingernails were long and crusted with a dark substance under the nails. The CNA stated the sleeve was likely soiled from food. The CNA stated there should be another sleeve, and it may be wet because they had to be hand washed and then hung to dry. b. At 8:45 PM on 4/15/14 an observation of	F 241 F 241	F – 241 Dignity • Resident #11 will receive care and services in a dignified manner. • The facility ensures that all residents are cared for in a dignified manner. • C.N.A. staff will be in serviced on the importance of providing nail care and clean clothing daily to ensure resident dignity is maintained. • DNS or designee will conduct three random care observations weekly to ensure that resident's nails and clothing are clean x 90 days. • Audit findings will be reviewed at monthly QA meetings.	06/01/14

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F 241	Continued From page 3 the resident being assisted to bed showed the resident continued to wear the same soiled sleeve, and the resident's fingernails on the right hand remained soiled. c. Observation on 4/16/14 at 12:35 PM showed the resident was seated at the dining table wearing what appeared to be the same soiled sleeve. The resident was observed using his/her right hand to eat. Interview with the nurse manager at 1:12 PM, during that mid-day meal, verified the sleeve was soiled and each night the sleeve should be removed and cleaned.	F 241		06/01/14
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	F – 278 Assessment • Resident #9's MDS was corrected. • The facility ensures that MDS are completed accurately regarding fall history. • The MDS Coordinator will be in serviced on the importance of completing MDS accurately with regards to fall history. • DNS or designee will audit all MDS completed each week to ensure that the residents fall history is accurately completed x 90 days. • Audit findings will be reviewed at monthly QA meetings.	

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F 278	Continued From page 4 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure the accuracy of the MDS assessment for 1 of 11 sample residents (#29). The findings were: Review of the 3/27/14 quarterly MDS assessment showed resident #29 had diagnoses that included seizure disorder and anxiety. The MDS assessment showed the resident had no falls since the prior assessment. Review of nurse's notes dated 1/1/14, timed at 4 PM, and 1/25/14, un-timed, showed the resident had falls with injuries on both of these dates. Interview with the nurse manager on 4/17/14 at 9:55 AM verified these falls were incorrectly coded for this resident's MDS assessment, and a correction was needed.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F – 279 Care Planning • Resident #11's care plan was updated. • The facility ensures that comprehensive care plans are developed to address resident's needs for assistance during meals and the use of adaptive equipment during meals	06/01/14

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F 279	Continued From page 5 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the care plan was updated to reflect current care interventions for 1 of 9 sample residents (#11). The findings were: Review of the 3/21/14 physician communication and order showed resident #11 was having a decreased ability with "self feeding," had been moved to an assisted dining table for increased staff assistance, and was being provided a two-handled cup for beverages. The physician responded on 3/25/14 showing the plan was noted and he agreed. Review of the nutrition and activities of daily living care plans showed both focus areas were initiated on 6/11/13. Review of the care plan interventions failed to show the need for staff assistance with eating other than "set-up assist," or the use of any adaptive equipment to be used at meals. Interview with DON on 4/17/14 at 8:55 AM verified these approaches should have been added to the resident's care plan.	F 279	• Licensed staff will be in serviced on the importance of developing a comprehensive care plan that address residents need for assistance during meals and the use of adaptive equipment during meals. • DNS or designee will audit 3 care plans each week to ensure that the care plan addresses the resident's need for assistance during meals and the use of adaptive equipment during meals x 90 days. • Audit findings will be reviewed at monthly QA meetings.	
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281	F 281 Professional Services	06/01/14

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F 281 SS=D	Continued From page 6 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 ensure physician orders were followed for 1 of 9 sample residents (#11). The findings were: Review of the medical record showed an order dated 3/25/14 for "strict" fluid intake and output (I & O) for resident #11. The physician's progress note from 3/25/14 showed the reason for the visit was related to the resident having excessive thirst and frequent urination. Further review of the medical record showed the I & O record from 3/25/14 to 4/15/14 was incomplete. The intakes were not recorded for each shift, and most days did not include any totals. The fluid output for these days failed to include any measure of the output because the resident was incontinent. A physician communication was sent on 4/16/14 with a request to discontinue the I & O order. As of 4/17/14, the physician had not responded. Interview with the DON on 4/17/14 at 8:55 AM verified the I & O record was incomplete. She further stated the resident was frequently incontinent and it was difficult for staff to determine the output volume. She then acknowledged this should have been communicated to the physician earlier. According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, 2004, if an order is "questionable for	F 281	• Resident #11 is at baseline. • The facility ensures that physicians orders are followed regarding strict I&O documentation. • Licensed staff will be in serviced on the importance of completing the records on those residents on strict I&O ensuring that the physician's orders are being followed. • DNS or designee will review those residents on strict I&O each week to ensure that the records are complete and in accordance with facility policy x 90 days. • Audit findings will be reviewed at the monthly QA meeting.	6/1/14

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F 281	Continued From page 7 any reason, the physician must be notified for clarification." According to the Wyoming Nursing Practice Act and the Administrative Rules and Regulations, nursing must function under the direction of a licensed physician.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility policy and procedure and resident and staff interview, the facility failed to follow the care plan for 1 of 9 sample residents (#22) and 1 non-sample resident (#7). The findings were: 1. Review of the medical record showed resident #7 was most recently re-admitted to the facility on 1/29/13, and had diagnoses including anemia, congestive heart failure and chronic airway obstruction. Review of physician's orders recapitulation dated 3/28/14 showed instructions to "Keep O2 above 89%" and "Oxygen use: May titrate O2 flow to maintain sats [saturations] above 89%." Review of the care plan, initiated 2/24/13, revealed the resident was at risk for altered stamina/endurance related to COPD, CHF, hypothyroidism, and a history of myocardial infarction with pacemaker placement; and that	F 282	F – 282 Services per Care Plan • Residents #7 and #22 will receive services in accordance with their plan of care. • The facility ensures that residents receive ordered oxygen as per physician's orders. • The nursing staff will be in serviced on the importance of administering O2 as per physician's orders as well as how to determine if the O2 tank is full and flowing. and encouraging fluids. • DNS or designee will complete three random observations each week to ensure the resident is receiving their oxygen as per physician s orders and that the O2 tank is full and flowing x 90 days. and fluids encouraged. • Audit findings will be reviewed at the monthly QA meeting.	06/01/14

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F 282	Continued From page 8 supplemental oxygen was required. Interventions specified "Administer oxygen per nasal cannula 1/Lpm." The following concerns were identified: a. Observation on 4/14/14 at 4:48 PM revealed the resident seated in a wheelchair, and wearing a nasal cannula that was connected to an oxygen tank on the wheelchair. The oxygen tank meter indicated the oxygen tank was empty. Interview with the activity director at that time confirmed the tank was empty, and a full tank would be obtained immediately. During interview at that time, the resident stated, "I'm not getting enough air, but she'll get another one." b. Observation on 4/16/14 at 12:15 PM revealed LPN #1 was administering medication to the resident in his/her room. The resident was seated in a wheelchair and was wearing a nasal cannula that was connected to an oxygen tank on the wheelchair. The oxygen tank meter registered nearly empty, and the flow rate was set to "0." Measurement of oxygen saturation done by LPN #1 at that time showed the resident's oxygen saturation level was 79%. c. On 4/17/14 at 12 PM the resident was again observed in his/her room, wearing a nasal cannula connected to an oxygen tank. The oxygen tank meter indicated the tank was empty. Measurement of oxygen saturation done by LPN #1 at that time showed the resident's oxygen saturation level was 68%. During interview at that time the resident stated, "I don't feel good." Interview with LPN #1 and CNA #1 at 12:05 PM revealed the oxygen tank was, in fact, full but the main valve was turned off which caused the meter to register the tank as empty. They further confirmed the resident was not able to turn on the main valve without assistance. 2. Review of the medical record showed	F 282		

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F 282	Continued From page 9 diagnoses for resident #22 that included a stroke, and left sided weakness/paralysis. Review of the 3/3/14 quarterly MDS assessment showed the resident was independent for eating, requiring only set-up assistance from staff. Additionally, the resident required extensive assistance for transfer and did not ambulate. Review of the care plan for dehydration showed it was initiated on 8/19/13 and approaches included encourage fluid intake frequently. Review of the revised December 2011 facility policy and procedure for prevention of dehydration showed, "Nurse's aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care." The following concerns were identified: a. Observation on 4/15/14 at 9:05 AM showed CNAs #1 and #2 transferred the resident from the wheelchair to bed. At that time it was noted there was a water pitcher on a table; however, the table was out of the resident's reach while in bed. The CNAs completed their tasks and, without offering the resident any water, left the room. b. Interview with CNA #2 on 4/15/14 at 11:45 AM revealed the resident's room had been re-arranged a few months previous and the oxygen concentrator was placed next to the bed instead of the table. The CNA further stated due to left-sided weakness the resident could not independently get a drink of water from the pitcher. She explained the style of water pitcher required taking the cap off which then served as the cup. The CNA also verified they were expected to offer and encourage fluids when they were providing cares.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312	F – 312 ADL Care • Resident #11 will be provided needed assistance with [illegible]	06/01/14

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F 312	Continued From page 10 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, staff interview, and medical record review, the facility failed to provided needed assistance with dining for 1 of 4 sample residents (#11) who required such assistance. The findings were: Review of the 3/21/14 physician communication and order showed resident #11 was having a decreased ability with "self feeding," had been moved to an assisted dining table for increased staff assistance, and was being provided a two-handled cup for beverages. The physician responded on 3/25/14 showing the plan was noted and he agreed. The following concerns were identified: a. Observation on 4/16/14 at 12:50 PM showed the resident was seated at the assisted dining table, had been served his/her meal, and was attempting to eat without staff assistance. As the resident ate pudding from a cup, the cup turned over onto its side, and the resident struggled to scoop out the food with the cup rolling. During this observation CNA #3 sat assisting another resident across the table, however, at no time during the meal was resident #11 provided assistance or cueing with eating. The resident managed to eat the pudding, some applesauce and drank all of the beverages, which were in non-handle cups. The resident did not attempt, nor did staff encourage or assist with any	F 312	• The facility ensures that residents receive assistance with meals as outlined in their plan of care. • The C.N.A. staff will be in serviced on the importance in providing residents cueing and assistance with their meals as outlined in their plan of care. • DNS or designee will complete three random meal observations each week to ensure the residents are being providing cueing and assistance with their meals as outline in their plan of care x 90 days. • Audit findings will be reviewed at the monthly QA	

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F 312	Continued From page 11 bites of the main meal, which consisted of mechanical ground chicken-fried steak, potatoes and gravy, and green bean casserole. At 1:20 PM CNA #3 asked the resident if s/he was done and removed the plate of uneaten food. b. Review of the 4/11/14 registered dietitian note indicated the resident was showing a downward weight trend. The note further showed "now at assisted table as intervention and improving intakes are being noted." c. Review of the nutrition and activities of daily living care plans showed both focus areas were initiated on 6/11/13. Review of the care plan interventions failed to show the need for staff assistance with eating other than "set-up assist", or the use of any adaptive equipment to be used at meals. d. Review of the 4/16/14 noon meal intake record showed the resident ate 10%. e. Interview with the DON on 4/17/14 at 8:56 AM verified the nutritional approaches should be followed. She also verified the resident prefers sweet tastes and needs encouragement and assistance to attempt the other foods served.	F 312		
F 323 SS=D	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:	F 323	F - 323 Accidents • Residents #4, 5, 15, 21, 31 and 34 will receive adequate supervision to prevent accidents. • The facility ensures that residents are effectively supervised to ensure their safety is maintained. • The facility ensures that residents with barricading behaviors have	06/01/14

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F 323	Continued From page 12 Based on observation, review of staffing schedules, medical record review, and resident and staff interview, the facility failed to ensure effective supervision for 6 residents (#4, #6, #15, #21, #31, #34) on the secured unit during 1 random observation. In addition, the facility failed to develop and implement effective approaches for 1 of 1 sample residents (#21) known to barricade themselves into their room. The findings were: 1. Observation of the secured unit on 4/15/14 at 7:50 PM revealed CNA #5 was lying on the couch in the television room. The CNA's eyes were closed, and there were no other staff observed to be present on the unit at that time. When disturbed, CNA #5 rose from the couch and stated, "I am so sorry, I do not do this." She further stated she was on duty, and not on a break. Observation showed while the CNA rested on the couch, residents #4 and #34 were awake and wandering the main hallways of the unit. Residents #6, #15 and #31 were asleep in their rooms. Resident #21 was awake and had barricaded him/herself into his/her room. Review of the staffing schedule board on 4/15/14 at 7:53 PM showed 1 CNA was on duty in the secure unit. Review of the planned staffing schedule showed it was the usual pattern to have 1 CNA on duty during the evening and night shifts. Interview with LPN #2 on 4/15/14 at 8 PM verified she was the nurse who had charge of the secure unit, and further verified the residents needed to be supervised and it was not appropriate for staff to rest/lie down while on duty. 2. Review of the medical record for resident #21 showed s/he was admitted to the facility on 8/2/13 and had diagnoses that included anxiety state,	F 323	effective approaches implemented. • Nursing staff will be in serviced the on importance of providing effective resident supervision and that no sleeping while on duty is allowed as per facility policy. • The Admin/DNS/SS will be in serviced on the importance of implementing effective approaches with residents exhibiting barricading behaviors. • DNS or designee will conduct three random observations each week to ensure that the residents are effectively supervised and that no staff are sleeping while on duty. • DNS or designee will review those residents exhibiting barricading behaviors to ensure that the identified approaches are effective. • Audit findings will be reviewed at monthly QA meetings.	

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F 323	Continued From page 13 syncope and collapse, and transient cerebral ischemia. Review of the care plan showed the resident frequently had delusion of harmful peers and tended to barricade him/herself in his/her room with the extra bed. Interventions for this focus area, initiated on 8/8/13, included "Stop sign to doorway stoop for personal etification (sic) of safety for [his/her] beliefs that someone is coming in on [him/her]" and "Offer reassurance to [resident] when [s/he] becomes delusional regarding other residents, that [s/he] is in a safe secure environment and no harm will come to [him/her] - offer redirection with activities, etc." Further review of the care plan, initiated 8/8/13, revealed the resident was at risk for falls with injury. The following concerns were identified with the resident's safety; a. Observation on 4/15/14 at 7:50 PM, showed resident #21 was in his/her room with the door closed. Attempts to open the door were unsuccessful because the second bed in the room had been moved to block the door. Interview through the slightly opened door with the resident at 7:55 PM revealed s/he was afraid that someone would enter his/her room, so s/he pushed the bed in front of the door. b. Observation of the resident's room on 4/16/14 at 9:10 PM revealed the room to be occupied by a single resident, however furniture, including a bed, for an additional resident was present in the room. c. Interview with the social services director on 4/17/14 at 11:25 AM revealed the facility had not considered removing extra furniture from the resident's room as a safety measure. Interview with CNA #5 on 4/15/14 at 8:25 PM revealed that although the CNA felt confident she could "usually" convince the resident to move the bed blocking the door and	F 323		

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F 323	Continued From page 14 allow staff into the room, no plan for getting access to the room was in place in the event the resident should fall or otherwise become incapacitated.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and resident and staff interview, the facility failed to ensure residents with orders for supplemental oxygen received it as indicated by the physician for 2 non-sample residents (#7, #30). The findings were: 1. Review of the medical record showed resident #7 was most recently re-admitted to the facility on 1/29/13, and had diagnoses including anemia, congestive heart failure and chronic airway obstruction. Review of physician's orders recapitulation dated 3/28/14 revealed instructions to "Keep O2 above 89%" and "Oxygen use. May titrate O2 flow to maintain sats [saturations] above 89%." Review of the care plan, initiated	F 328	F – 328 Treatment and Care for Special Needs • Residents #7 and #30 will receive supplemental oxygen in accordance with physician orders. • The facility ensures that residents receive ordered oxygen as per physician's orders. • The nursing staff will be in serviced on the importance of administering O2 as per physician's orders as well as how to determine if the O2 tank is full and flowing. • DNS or designee will complete three random observations each week to ensure the resident is receiving their oxygen as per physician s orders and that the O2 tank is full and flowing x 90 days. • Audit findings will be reviewed at the monthly QA meeting.	06/01/14

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F 328	Continued From page 15 2/24/13, revealed the resident was at risk for altered stamina/endurance related to COPD, CHF, hypothyroidism, and a history of myocardial infarction with pacemaker placement, and that supplemental oxygen was required. Interventions specified "Administer oxygen per nasal cannula 1/Lpm." The following concerns were identified: a. Observation on 4/14/14 at 4:48 PM revealed the resident seated in a wheelchair, and wearing a nasal cannula that was connected to an oxygen tank on the wheelchair. The oxygen tank meter indicated the oxygen tank was empty. Interview with the activity director at that time confirmed the tank was empty, and a full tank would be obtained immediately. During interview at that time, the resident stated, "I'm not getting enough air, but she'll get another one." b. Observation on 4/16/14 at 12:15 PM revealed LPN #1 was administering medication to the resident in his/her room. The resident was seated in a wheelchair and was wearing a nasal cannula that was connected to an oxygen tank on the wheelchair. The oxygen tank meter registered nearly empty, and the flow rate was set to "0." Measurement of oxygen saturation done by LPN #1 at that time showed the resident's oxygen saturation level was 79%. c. On 4/17/14 at 12 PM the resident was again observed in his/her room, wearing a nasal cannula connected to an oxygen tank. The oxygen tank meter indicated the tank was empty. Measurement of oxygen saturation done by LPN #1 at that time showed the resident's oxygen saturation level was 68%. During interview at that time the resident stated, "I don't feel good." Interview with LPN #1 and CNA #1 at 12:05 PM revealed the oxygen tank was, in fact, full but the main valve was turned off which caused the meter to register the tank as empty. They further	F 328		

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F 328	Continued From page 16 confirmed the resident was not able to turn on the main valve without assistance. 2. Observation in the resident's room on 4/14/14 at 4:55 PM showed resident #50 was seated in his/her wheelchair wearing an oxygen nasal cannula which was attached to the tank on the back of the chair. Interview with the resident revealed s/he thought the oxygen was flowing; but was not certain. Observation of the dial on the tank showed it was in the red area and registering zero. Interview with RN #1 at that time verified the oxygen tank was empty and needed to be changed.	F 328		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F – 431 Drug Storage • The facility ensures that expired medications are removed from use. • The nursing staff will be in serviced on the importance of reviewing for medication expiration dates and to remove those identified medications from use. • DNS or designee will audit the medication carts weekly to ensure all expired medications have been removed from use. • Audit findings will be reviewed at the monthly QA meeting.	06/01/14

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F 431	Continued From page 17 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that medications that were open and available for use were not expired for 2 of 3 medication carts. The findings were: 1. Observation of medication cart #1 on 4/17/14 at 10:40 AM revealed the following expired medications that were open and available for use: Fexofenidine HCL 60 mg tablets (expired 6/13), ferrous sulfate 5 gram tablets (expired 11/13), aspirin 81 mg tablets (expired 1/2/13), diphenhydramine HCL 25 mg (expired 1/27/14), bisacodyl 5 mg tablets (expired 3/24/14) and loperamide hydrochloride 2 mg tablets (expired 1/14). 2. Observation of medication cart #2 on 4/17/14 at 10:50 AM revealed the following expired medication that was open and available for use: Famotidine 10 mg tablets (expired 1/14/14). 3. Interview with LPN #1 on 4/17/14 at 10:40 AM verified the expired medications were in the carts. She further revealed the facility had no formal	F 431		

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F 431	Continued From page 18 procedure for purging the medication carts of expired medications, and that "each nurse tried to do it." She was unaware of when the carts had last been purged of expired medications.	F 431		