STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 05/08/2014

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

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CDM: Certified Dietary Manager CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency	F 000		
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- Investigate/Report Allegations/Individuals** **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)** **1. Executive Director will educate the IDT regarding timeliness for reporting any allegation of abuse or neglect. Report should be submitted no later than 24 hours upon knowledge of incident per Federal requirements.** **2. Administrator will implement check list for all allegations which will be completed upon initiation of investigation. This will ensure proper notification to State and local agencies.**	6-11-14

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

Tonya Munroe ED 5-30-14

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JUN 04 2014
Health Facility Licensing and Surveys

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.

Accepted w/ change on pg 6. per Tonya Munroe, NHA on 6/24/14

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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 policies and procedures, staff interview, and review of facility documentation, the facility failed to ensure allegations of abuse were reported immediately to the State survey agency and other officials in accordance with State law for 2 of 2 allegations reviewed. The findings were: 1. Review of facility abuse investigation documentation on 5/7/14 at 4 PM revealed the following concerns: a. The facility received an allegation of physical abuse involving a CNA and resident #2 on 10/21/13. Further review of the documentation showed no evidence Healthcare Licensing and Surveys (HLS), the survey agency, was notified of the allegation. In addition, there lacked evidence the facility reported the allegation to the Department of Family Services (DFS) or local law enforcement. b. The facility initiated an investigation on 3/21/14 for an allegation of verbal abuse and	F 225	**3. The next three investigations will be reviewed at Performance improvement meetings until substantial compliance has been met.**	

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F 225	Continued From page 2 "rough care" involving a CNA and residents #8, #6, #22, and #63. Further review of the facility documentation showed HLS was not notified of the allegation until 4 days later, on 3/25/14. In addition, there lacked evidence that DFS or law enforcement was notified of the allegation. 2. During an interview on 5/8/14 at 8:35 AM the administrator stated allegations of abuse should be reported immediately to the State survey agency and DFS or law enforcement. She was unable to state why HLS and DFS or law enforcement were not notified for the two allegations of abuse reviewed. 3. Review of the facility's policy "Protection of Residents: Reducing the Threat of Abuse & Neglect" (7/2011) showed "Federal requirements mandate that facilities must ensure all allegations of abuse are reported immediately to their state survey agency..The immediate reports should be submitted as soon as possible, but no later than 24 hours of a facility learning of the allegation." 4. According to Wyoming's Adult Protective Services Act, W.S. 35-20-103, "Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the department."	F 225		
F 241 SS=D	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	F 241	**F241- 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**	

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F 241	Continued From page 3 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to promote dignity related to dining and grooming for 2 of 13 sample residents (#37, #44). The findings were: 1. Review of the medical record showed resident #37 had diagnoses including non-Alzheimer's dementia and persistent mental disorders. Review of the most recent quarterly MDS assessment dated 3/6/14 revealed the resident was severely cognitively impaired and required extensive assistance from staff to complete ADLs including eating. Review of the care plan updated 3/11/14 showed the resident had an ADL deficit related to a diagnosis of dementia and interventions included, "provide the amount of assistance/supervision that is needed." The following concerns were identified: a. Observation of dining on 5/5/14 from 5:40 PM to 6:30 PM revealed the resident was seated at a dining table near the window in the south dining room. The resident was licking a dessert consistent with pudding or whipped topping out of a parfait glass and had food on his/her chin, hands, and down the front of the clothing protector, shirt, and pants. CNA #3 was observed providing meal set up for a resident seated directly to the right of the resident; however, the CNA offered no assistance to resident #37. The resident continued to attempt to eat a casserole type dish, which included rice, with his/her fingers. Food was observed scattered on the resident's clothing and the floor surrounding the	F 241	**1. All meals for Resident #37 have been monitored to ensure staff is respecting dignity while dining. Facial hair was removed from resident #44.** **2. Facial hair was removed on all female residents and fingernails on all residents were trimmed and cleaned.** **3. All nursing staff will be educated to ensure that staff is providing the amount of assistance/supervision necessary for all residents including residents #37 and #44. This education will include A) appropriateness related to feeding techniques, cleanliness of environment and residents and staff to resident interactions during meal services. B) Hygiene in respect to facial hair on females and fingernails at appropriate length.** **4. Random weekly audits will be conducted by nursing administration to ensure residents are receiving necessary ADL assistance and supervision/assistance in the dining rooms. If any problem is noted, immediate re-education and/or corrective action will take place.**	6-11-14

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F 241	Continued From page 4 resident's chair. At 6:10 PM CNA #1 while standing over the resident began to feed the resident. The CNA did not engage the resident in conversation or make eye contact, she was having a conversation with CNA #2 at another table. The CNA did not wipe the food from the resident's face or hands. At 6:20 PM trays were removed from tables and staff began assisting residents out of the dining room. At that time, the resident was observed licking his/her dietary place card. At 6:30 PM the resident remained seated at the table with food on his/her face, hands, clothing and scattered on the floor surrounding the chair. b. Observation of dining on 5/7/14 at 12:15 PM showed the resident was again seated by the window in the south dining room. The resident was observed eating a brownie type dessert with his/her fingers, and mashing it between his/her fingers. The resident picked up a spoon and began mashing the dessert on the table with the spoon. The resident then picked up a butter knife and looked at the spoon and knife. The resident attempted eating pieces of steamed vegetables with his/her hands. The resident's face, hands, including under nailbeds, clothing and floor surrounding his/her chair were covered with scattered bits of food. At 12:30 PM CNA #6 went to stand over the resident and attempted to assist the resident with eating; however, the CNA did not clean the resident's face, hands, clothing or the floor surrounding the chair. 2. Observation on 5/6/14 at 8:35 AM showed resident #44 was seated at the dining table. At that time it was noticed the resident had long dark whiskers on her upper lip, and on her chin. On 5/7/14 at 4:40 PM interview with the resident revealed she did not know she had long whiskers	F 241	**5. Results of the audits will be reported to the Performance Improvement committee for the next three months or until the committee determines substantial compliance has been achieved.**	

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F 241	Continued From page 5 and she relied on staff to pluck or shave them when she was showered. The resident verified she had a shower the day before; however, did not recall anything being done about the whiskers. Review of the bathing record showed the resident had received a shower the evening of 5/6/14. 3. Interview with CNAs #6 and #7 on 5/8/14 at 9:30 AM revealed resident facial hair was removed and fingernails were to be cleaned as needed when the residents were showered. However, the aides stated sometimes these tasks did not get done due to time constraints.	F 241		
F 283 SS=B	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on review of closed medical records and staff interview, the facility failed to complete a discharge summary, including a recapitulation of stay, for 2 of 2 closed records reviewed (#61, #62). The findings were: 1. Review of the closed medical record revealed resident #62 was discharged to home on 2/25/14. Further review of the medical record showed no	F 283	**F283-Anticipate Discharge: Recap Stay/Final Status** **When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay: and a final summary of the resident's status to include items in paragraph (B)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.** **1. Upon notification of discharge, SSD will initiate discharge assessment summary and instructions to include recapitulation of stay.** **2. SSD will educate nursing staff regarding discharge summary and discharge instructions.** **3. Random audits will be conducted by ED to ensure that recapitulation of resident's stay falls within compliance of paragraph (B)(2).**	6-11-14

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F 283	Continued From page 6 evidence of a discharge summary, including a recapitulation of the resident's stay. 2. Review of the closed medical record showed resident #61 was discharged to home on 2/25/14. Further review of the medical record showed no evidence of a discharge summary. 3. On 5/7/14 at 11:10 AM the medical records manager looked at the two closed records with the surveyors. She stated the discharge summary should be located in the front of the medical records, and confirmed she was unable to locate it for either record. In addition, she stated she had noticed issues with the discharge summaries not making it back to the records.	F 283	**4. Results of the audits will be reported to the Performance Improvement committee for the next three months or until the committee determines substantial compliance has been achieved.**	
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, and staff and resident interview, the facility failed to ensure residents received assistance with grooming and eating for 3 of 11 sample residents (#9, #37, #44) requiring assistance with ADLs. The findings were: 1. Review of the medical record showed resident #9 had diagnoses including non-Alzheimer's dementia. Review of the most current quarterly	F 312	**F312-ADL Care Provide 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.** **1. Facial hair was removed and finger nails cleaned and trimmed on residents #9, #37, and #44.** **2. All nursing staff will be in-serviced by the DON and/or the SDC regarding the following; a) appropriate length and hygiene of finger nails, b) appropriateness related to feeding techniques during meal service, c) appropriateness of staff to resident interactions during meal services, d) ensuring then residents faces, hands, clothing protectors and**	6-11-14

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F 312	Continued From page 7 MDS assessment dated 3/25/14 showed the resident was severely cognitively impaired and required extensive assistance from staff to perform ADLs including hygiene. Review of the care plan updated 3/25/14 showed the resident had an ADL self care deficit related to dementia, long and short term memory loss, and periods of confusion. Interventions included staff providing the, "amount of assistance/supervision that is needed", and staff anticipating the resident's needs. In addition, the resident had a current dietary order for finger foods. The weekly bath record showed the resident had a shower on 5/5/14. The following concerns were identified: a. Observation on 5/5/14 at 5:40 PM revealed the resident was seated in the south dining room eating the evening meal with his/her hands. The resident's fingernails were jagged and the nailbeds were encrusted with brown matter. b. Observation again on 5/7/14 at 12:15 PM showed the resident was seated in the south dining room eating with his/her hands. The resident's fingernails continued to be jagged and the nailbeds continued to be encrusted with thick, brown matter. 2. Review of the medical record showed resident #37 had diagnoses including non-Alzheimer's dementia and persistent mental disorders. Review of the most recent quarterly MDS assessment dated 3/6/14 revealed the resident was severely cognitively impaired and required extensive assistance from staff to complete ADLs including hygiene. Review of the care plan updated 3/11/14 showed the resident had an ADL deficit related to a diagnosis of dementia and interventions included, "provide the amount of assistance/supervision that is needed." Review of the weekly bath record showed the resident had	F 312	**environment are kept clean during meal services, e) removal of facial hair on female residents.** **3. Re-education of nursing staff will be conducted by the DON and/or SDC regarding where to locate information related to the level of assistance a resident requires with ADL's including eating and hygiene/grooming.** **4. Random audits will be conducted on residents who are unable to carry out their activities of daily living in order to maintain good nutrition, grooming, and oral hygiene. These audits will include residents #9, #37, and #44.**	

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F 312	Continued From page 8 received showers on 5/4/14 and 5/7/14. The following concerns were identified: a. Observation of dining on 5/5/14 from 5:40 PM to 6:30 PM revealed the resident was seated at a dining table near the window in the south dining room. The resident was licking a dessert consistent with pudding or whipped topping out of a parfait glass. CNA #3 was observed providing meal set up for a resident seated directly to the right of resident #37; however, the CNA offered no assistance. The resident continued to attempt to eat a casserole type dish, which included rice, with his/her fingers. At 6:10 PM CNA #1 came to stand over resident and began feeding the resident. The CNA did not engage the resident in conversation or make eye contact, and was making conversation with CNA #2 at another table. The CNA provided the resident with 2 bites of food from the plate, then instructed the resident to, "use your spoon", and walked away. The resident looked at the spoon, however, continued eating with his/her fingers. At 6:20 PM trays were removed from tables and staff began assisting residents out of the dining room. At that time, the resident was observed licking his/her dietary place card. At 6:30 PM the resident remained seated at the table with food on his/her face, hands, clothing and scattered in the floor surrounding the chair. The resident consumed approximately 25% of the meal. b. Observation of dining on 5/7/14 at 12:15 PM showed the resident was again seated by the window in the south dining room. The resident was observed eating a brownie type dessert with his/her fingers, and mashing it between his/her fingers. The resident picked up a spoon and began mashing the dessert on the table with the spoon. The resident then picked up a butter knife and looked at the spoon and knife. The resident	F 312		

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F 312	Continued From page 9	F 312		

attempted eating pieces of steamed vegetables and a potato dish with his/her hands. The resident's face, hands, including under nailbeds, clothing and floor surrounding his/her chair were covered with scattered bits of food. At 12:30 PM CNA #6 went to stand over the resident and offered the resident 2 bites of food, however, the resident was resistive and turned his/her head. The CNA then walked away and went back to assisting resident's at another table. The resident consumed approximately half the dessert and a few bites vegetables. Interview with CNA #6 at 12:35 PM revealed the resident didn't eat very well and was resistive and often combative to being fed.

c. Observation of the female resident on 5/8/14 at 8:30 AM also revealed thick white facial hair on the resident's chin and upper lip.

3. Observation on 5/6/14 at 8:35 AM showed resident #44 was seated at the dining table. At that time it was noticed the resident had long dark whiskers on her upper lip, and on her chin. On 5/7/14 at 4:40 PM interview with the resident revealed she did not know she had long whiskers and she relied on staff to pluck or shave them when she was showered. The resident verified she had a shower the day before; however, did not recall anything being done with the whiskers. Review of the bathing record showed the resident received a shower the evening of 5/6/14.

4. Interview with CNAs #6 and #7 on 5/8/14 at 9:30 AM revealed resident facial hair was removed and fingernails were to be cleaned as needed when the residents were showered. However, the aides stated sometimes these tasks did not get done due to time constraints. The interview also revealed the aides were unaware

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F 312	Continued From page 10 where to locate information related to the level of assistance a resident required with ADLs including eating and hygiene/grooming.	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: Based on observation, staff interview, and review of manufacturer instructions, the facility failed to ensure staff safely utilized slings for mechanical lifts during 1 of 2 observations. The findings were: Observation on 5/6/14 at 10:40 AM showed CNAs #4 and #5 utilized a mechanical lift to transfer resident #31 from a wheelchair to the commode. The sling was observed to be a "Liko HygieneVest Type, 50" sling with an open area at the buttocks, a belt that fastened around the resident's waist, and a looped strap that crossed between the resident's legs for toileting. CNA #5 pulled the bottom loops of the sling between the resident's legs and attached the loops to the lift, however, she did not cross the loops and attach them to the alternating sides of the lift, nor fasten the belt around the resident's waist. Interview with both CNAs at the time of the observation revealed they used the sling that was in the resident's room. CNA #5 revealed it was not the	F 323	**F323-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.** **1. Resident #31 is being transferred with a mechanical lift/sling according to manufacturers instructions.** **2. Re-education of the nursing staff will be conducted regarding how to properly use the mechanical lifts and their sling placement according to manufacturer's instructions. This education will be conducted by the SDC and /or restorative nurse.** **3. A performance improvement audit tool will be used to randomly audit residents' care to ensure that all safety interventions and appropriate lift/sling usage is being utilized. If noncompliance is noted, immediate re-education and/or corrective action will occur. The audits will be conducted by the SDC and/or nursing administration or appointed designee.**	6-11-14

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F 323	Continued From page 11 usual practice, and she had never fastened the belt around the resident's waist prior to transferring the resident. Interview further revealed the last training relating to the use of mechanical lifts had been, "3 or 4 years ago." Review of the manufacturer's "Liko HygieneVest Type, 50" Instructions showed the belt was supposed to be fastened around the resident's waist. The bottom loops were then to be pulled under the resident's legs behind the lower thighs and crossed before being attached to the mechanical lift to prevent slipping and provide a stable sitting position for toileting.	F 323	**4. Results of the audits will be reported to the Performance Improvement committee for the next three months or until the committee determines substantial compliance has been achieved.**	
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT Is not met as evidenced by: Based on observations, medical record review, and staff interview, the facility failed to ensure effective measures were implemented to ensure good nutritional status for 1 of 1 sample residents (#37) reviewed for weight loss. This failure resulted in a six month significant weight loss and	F 325	**F325- Maintain Nutritional status Unless Unavoidable** **Based on a resident's comprehensive assessment, the facility must ensure that a resident (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible: and (2) Receives a therapeutic diet when there is a nutritional problem.** **1. Resident # 37 has gained weight since survey.** **2. The Registered Dietitian completed a nutritional assessment on resident #37 and appropriate interventions were implemented. In addition, the care plan was updated to reflect the changes and residents current nutritional and physical status.** **A. Offering a late breakfast upon arising as resident will tolerate/accept**	6-11-14

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F 325	Continued From page 12 harm for the resident. The findings were: Review of the medical record showed resident #37 had diagnoses including non-Alzheimer's dementia and persistent mental disorders. Review of the most recent quarterly MDS assessment dated 3/6/14 revealed the resident was severely cognitively impaired and required extensive assistance from staff to complete ADLs including eating. Review of the care plan updated 3/11/14 identified the resident as being at risk for nutrition related to fluctuating intake and history of weight loss. Interventions included offering substitutes if 50% or less of a meal was consumed and to observe the resident and report to the physician. The care plan also showed the resident had an ADL deficit related to a diagnosis of dementia and interventions included, "provide the amount of assistance/supervision that is needed." Review of a physician's progress note dated 2/6/14 showed the resident, "tries to eat by [her/himself], apparently does not have to be fed...is probably progressively more demented." Review of the physician's progress note dated 3/5/14 showed no reference to the resident's weight loss or eating abilities. On 4/3/14 the physician noted the resident "will be given less medication, given [his/her] weight loss." Review of the resident's weight record for a 6 month period from 11/12/13 (116 pounds) to 5/5/14 (100 pounds) showed the resident had weight loss ranging between 1 to 4 lbs each month resulting in a significant weight loss of 13.79% for the 6 month time period. Review of a nursing note dated 4/17/14 from a resident at risk team meeting showed the resident triggered for weight loss and finger foods would be continued and the resident, "plays with food." Recommendations dated 4/16/14 from the resident at risk team	F 325	**B. Snacks TID are offered between meals and are on the MARS for tracking** **C. 4 oz milk shake is being offered TID between meals and is on the MARS for tracking** **3. The dietary staff will be in-serviced by the Regional Registered Dietitian & Dietary Manager on June 6, 2014 regarding the importance of following therapeutic diets/textures, including finger foods per spread sheets to ensure the nutritional needs are being provided to all residents.** **4. A 100% chart audit will be completed, where all residents will be reviewed for significant weight variances including weekly, 1 month, 3 months and 6 month weights. Insidious gradual weight loss will also be noted. In addition, the Registered Dietitian will complete assessments on all residents as necessary, adding necessary interventions and revising/updating the care plan as needed.**	

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F 325	Continued From page 13 showed "finger foods, provide snacks." The following concerns were identified: a. Observation of dining on 5/5/14 from 5:40 PM to 6:30 PM revealed the resident was seated at a dining table near the window in the south dining room. The resident attempted to eat without assistance and licked a dessert consistent with pudding or whipped topping out of a plastic dish. The resident also attempted to eat a casserole type dish, which included rice, with his/her fingers. The resident was observed to have food on his/her chin, hands, and down the front of the clothing protector, shirt, and pants. CNA #3 was observed providing meal set up for another resident at the same table, and did not offer assistance to resident #37. At 6:10 PM CNA #1 came to stand over resident and began feeding the resident. The CNA provided the resident with 2 bites of food from the plate, then instructed the resident to, "use your spoon", and walked away. The resident looked at the spoon; however, continued eating with his/her fingers. At 6:20 PM trays were removed from tables and staff began assisting residents out of the dining room the resident was observed licking his/her dietary place card. At 6:30 PM the resident remained seated at the table with food on his/her face, hands, clothing and scattered in the floor surrounding the chair. The resident consumed approximately 25% of the meal. b. Observation of dining on 5/7/14 at 12:15 PM showed the resident was again seated by the window in the south dining room. The resident was observed eating a brownie type dessert and mashing it between his/her fingers. The resident picked up a spoon and began mashing the dessert on the table with the spoon. The resident then picked up a butter knife and looked at the spoon and knife. The resident attempted eating	F 325	**5. The resident at risk meeting will review significant weight reports each week. This will include 1 month, 3 month and 6 month significant changes as well as weekly 2% variances. Those who triggered will be reviewed by the team. A nutritional assessment will be completed for all significant weight changes with appropriate interventions implemented. In addition, there will be a physician order for all interventions so nursing can track acceptance and report poor intakes/acceptances to the resident at risk team. The Registered Dietitian will review the significant change reports each month and conduct additional nutritional reviews for those with ongoing weight loss which is not unavoidable.** **6. Those with significant weight loss will be reviewed weekly by reviewing their weekly weights in the resident at risk meeting, where nursing and dietary will review resident's nutritional progress. The Registered Dietitian will review the weight variance reports and resident at risk meeting minutes on each visit.**	

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F 325	Continued From page 14 pieces of steamed vegetables with his/her hands. The resident's face, hands, including under nailbeds, clothing and floor surrounding his/her chair were covered with scattered bits of food. At 12:30 PM CNA #6 went to stand over the resident and attempted to assist the resident with eating, however, the resident was resistive and turned his/her head. The CNA then walked away and went back to assisting residents at another table. The resident consumed approximately half the dessert and a few bites vegetables. Interview with CNA #6 at 12:35 PM revealed the resident didn't eat very well and was resistive and often combative to being fed. c. Review of the 8/15/13 nutrition data collection/assessment completed by the CDM showed the resident received a regular diet, weighed 116 pounds, and had an average daily consumption of 0% for breakfast, and "25/100%" for lunch, and "25/75%" for dinner. There was no information related to snack consumption recorded. Further review of the document showed the registered dietitian (RD) failed to complete the assessment portion, and there was nothing to show the resident's estimated energy, protein, or fluid needs. d. Interview with the CDM on 5/8/14 at 10:15 AM revealed the resident had been identified as being at risk for weight loss and currently had interventions including a fortified diet, finger foods, and provided snacks. The CDM verified she had not actually observed the resident eat, "in a while" and was not sure of the level of assistance the resident required. She further revealed she was unsure the last time the RD assessed the resident. e. Review of monthly intake records from 1/1/14 through 5/8/14 (128 days) showed the resident consumed 0% of breakfast 121 days,	F 325	**7. Results of the audits will be reported to the Performance Improvement committee for the next three months or until the committee determines substantial compliance has been achieved.**	

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F 325	Continued From page 15 50% or less of lunch on 93 days, and 50% or less of dinner on 92 days. Additional review of AM, PM and Bedtime recorded snacks for this 128 day period showed the resident had a snack 16 times.	F 325		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain a medication error rate under 5 percent (%). Out of 25 opportunities for errors, 6 errors were made, resulting in an error rate of 24%. The residents affected by the errors were non-sample residents #28 and #35. The findings were: 1. During an observation of a medication administration pass on 5/7/14 at 4:12 PM LPN #1 was observed administering medications to resident #28. The LPN administered a potassium chloride tablet used for the treatment of low levels of serum (blood) potassium. Review of the medication administration record (MAR) at the time showed the patient was supposed to receive the medication at 8 PM. Interview with the nurse at the time revealed the medication could be given in the PM and the resident usually took the medication during the 4 PM medication pass. Review of the 4/30/14 physician recapitulation of orders showed the potassium was ordered to be given twice a day with the times shown as 8 AM and 8 PM.	F 332	**F332-Free of Medication Error Rates of 5% or More** **The facility must ensure that it is free of medication error rates of five percent or greater.** **1. LPN was given immediate education regarding medication administration.** **2. All nurses will be in-serviced and re-educated regarding the appropriate administration of all medications. The in-service will also include proper notification procedures to the pharmacy of medication administration changes.** **3. Surveillance of med pass will be randomly conducted by the DON, SDC, and/or nursing administration to include residents #28 and #35. If noncompliance is noted during any med pass, immediate re-education and/or corrective action will occur.** **4. Results of the audits will be reported to the Performance Improvement committee for the next three months or until the committee determines substantial compliance has been achieved.**	6-11-14

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F 332	Continued From page 16 2. Observation of medication administration pass on 5/7/14 at 4:16 PM showed LPN #1 administered medications to resident #35. The LPN administered trazodone, potassium chloride, seroquel, mirapex and Tylenol PM tablets or capsules. Trazodone is used to treat depression, potassium chloride is used to treat low serum levels of potassium, seroquel is used to treat schizophrenia and/or bipolar disorder, mirapex is used to treat Parkinson's disease or moderate restless leg syndrome, and Tylenol PM is used to treat mild to moderate pain and insomnia. Review of the MAR at the time of the observation showed the resident was supposed to receive these medications at 6 PM. Review of the 4/30/14 physician recapitulation of orders showed these medications were scheduled at 6 PM. Interview with LPN #1 at the time of the observation revealed the resident had, "psychiatric problems and liked to take all [his/her] medications at one time, rather than several different times." Interview additionally revealed the resident's physician was, "aware the resident liked to take all of [his/her] medications at one time in the afternoon." 3. Interview with the DON 5/7/14 at 4:30 PM verified she expected staff to give medications as scheduled or notify the physician for clarification.	F 332		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs.	F 365	**F365- Food in Form to Meet Individuals Needs** **Each resident receives and the facility provides food prepared in a form designed to meet individual needs** **1. The Regional Registered Dietitian revised the finger food diet spread sheets, which will be implemented on June 6, 2014**	6-11-14

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F 365	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of dietary menus, the facility failed to ensure foods were provided in a form to meet the needs of 2 of 13 sample residents (#9, #37). The findings were: 1. Review of the medical record showed resident #9 had diagnoses including non-Alzheimer's dementia. Review of the most current quarterly MDS assessment dated 3/25/14 showed the resident was severely cognitively impaired and required extensive assistance from staff to perform ADLs including eating. Review of the care plan updated 3/25/14 showed the resident had altered nutrition, interventions included providing finger foods. Goals included providing therapeutic meals to meet the resident's nutritional needs. The following concerns were identified: a. Observation of dining in the south dining room on 5/5/14 at 6:40 PM revealed the resident was eating a casserole type dish, which contained rice and a marinated vegetable salad with his/her hands. Review of the menu showed for finger foods, the "stuffed pepper casserole" was to be served in a pita pocket/bun. b. Observation on 5/6/14 at 8:30 AM showed the resident eating scrambled eggs with his/her hands. c. On 5/7/14 at 12:15 PM the resident was observed eating steamed vegetables and a sauteed potatoes, which were visibly greasy, with his/her hands. 2. Review of the medical record showed resident #37 had diagnoses including non-Alzheimer's dementia and persistent mental disorders.	F 365	**2. The Regional Registered Dietitian will in-service all dietary staff on June 5, 2014 related to finger food options and the updated/revised spreadsheets; in-service will reiterated the importance of following spreadsheets to ensure the nutritional needs are being met for all residents, including those on therapeutic diets.** **3. The dietary manager or designee will conduct audits 3 x per week x 30 days to ensure the Finger food diet is served as indicated on the therapeutic spread sheet.** **4. Results of the audit, including action plans will be taken to the monthly Performance Improvement Committee. The PI committee will review the audits to ensure sustained compliance.**	

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F 365	Continued From page 18 Review of the most recent quarterly MDS assessment dated 3/6/14 revealed the resident was severely cognitively impaired and required extensive assistance from staff to complete ADLs including eating. Review of the care plan updated 3/11/14 identified the resident as being at risk for nutrition related to fluctuating intake and history of weight loss. Review of a resident at risk meeting note dated 4/17/14 showed the resident triggered for weight loss. The recommendations from the team meeting included providing snacks, and providing finger foods. The following concerns were identified: a. Observation of dining on 5/5/14 from 5:40 PM to 6:30 PM revealed the resident was seated at a dining table near the window in the south dining room. The resident was licking a dessert consistent with pudding or whipped topping out of a parfait glass and had food on his/her chin, hands, and down the front of the clothing protector, shirt, and pants. The resident was also eating a casserole type dish, which included rice, with his/her fingers. Review of the menu showed for finger foods, the "stuffed pepper casserole" was to be served in a pita pocket/bun. b. Observation of dining on 5/7/14 at 12:15 PM showed the resident was again seated by the window in the south dining room. The resident was observed eating a brownie type dessert and mashing it between his/her fingers. The resident attempted eating pieces of steamed vegetables and a potato dish, that was visibly greasy, with his/her hands. The resident's face, hands, including under nailbeds, clothing and floor surrounding his/her chair were covered with scattered bits of food. The resident consumed approximately half the dessert and a few bites vegetables. Interview with CNA #6 at 12:35 PM revealed the resident didn't eat very well and was	F 365		

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F 365	Continued From page 19 resistive and often combative to being fed. 3. Interview with the CDM on 5/8/14 at 10:10 AM revealed she had noticed some foods that were on the planned menu for the finger foods diet which may need changed. She also verified the potatoes and the steamed vegetables served on the 5/7/14 noon meal were on the planned menu for those with finger foods, but, were not easily eaten with one's fingers.	F 365	**F371· 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.** **During the survey, the mixer, counter mounted can opener, the hoods and surrounding areas and air vents were all cleaned and the soiled ceiling tiles were cleaned.** 1. **The Dietary Manager implemented new cleaning schedules to ensure foods are being served/stored and distributed in a sanitary manner. Deep cleaning of the hoods and vents were added to the weekly cleaning schedule. The ceiling tiles were added to the bi-monthly cleaning schedule (2 x per month). In addition, the can opener and mixer were added to the am and pm cooks cleaning schedules to ensure cleaning after every use. The Dietary Manger will conduct an all dietary staff in-service by June 6, 2014, instructing the staff on the revised cleaning schedules and how to wash, clean, and sanitize equipment appropriately per manufactures recommendations.**	6-11-14
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure sanitary conditions in the kitchen. The findings were: 1. Observation on 5/7/14 at 11:45 AM showed a shelving unit in the food production area where clean dishes and utensils were stored. On the bottom shelf of this unit two chemical products (a degreaser and an oven cleaner) were stored next to a bottle of cooking oil and a bottle of lemon juice. Interview and observation with the CDM on 5/7/14 at 2:30 PM verified the chemicals should	F 371		

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F 371	Continued From page 20 be stored away from food and clean dishes. In addition, Observation on 5/5/14 at 4:55 PM and on 5/7/14 at 11:20 AM showed an opened box of hamburger patties in the freezer. The package was open and the food was exposed. According to Food Code 2013, U.S. Public Health Service: 3-305.11 "(A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination;" 2. Observation on 5/7/14 at 11:28 AM showed three skillets that had been washed were drying on the side of the sink. The interior of these skillets showed the non-stick coating was scrapped and flaking and the pans were in an uncleanable condition from extensive use. In addition, there was a wooden handled spatula and knife being used to served dessert which had separation of the wood on the handles. The utensils were in poor condition and due to the separation could not be effectively cleaned and sanitized. According to Food Code 2013, U.S. Public Health Service: 4-101.11 "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be: (A) Safe; (B) Durable, CORROSION-RESISTANT, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated WAREWASHING;	F 371	**2. The Dietary Manger or designee will audit the cleaning schedules and completion of cleaning, which includes the hoods, vents, can openers, mixer and ceiling tiles of the kitchen 3 times per week x 30 days. In addition, the Registered Dietitian will note compliance in her routine monthly site visit report.** **3. Results of the audits will be reported to the Performance Improvement committee for the next three months or until the committee determines substantial compliance has been achieved.**	

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F 371	Continued From page 21 (D) Finished to have a SMOOTH, EASILY CLEANABLE surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition." 3. On 5/7/14 from 11:20 AM to 12 PM the following items were identified in the kitchen which required more frequent cleaning: a. The stand mixer which was stored with a plastic cover and was not in use was soiled on the interior with dried splattered food. b. The counter mounted can opener blade was soiled with dried on food. c. The ceiling near the refrigerator/freezer units by the back preparation tables was soiled with multiple areas of brown splattered substance. d. The metal sides of the hood located above the range and grill were dripping with grease and there was accumulated dust and grease in the removable vents. e. An air vent located in a hood above the stand mixer and the dessert cart had an accumulation of dust. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." Interview with the CDM on 5/7/14 at 2:30 PM verified the above mentioned items in the kitchen required additional cleaning.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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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 441	Continued From page 22 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	**F441-Infection control, Prevent Spread, Linens** **The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.** **1. Ecolab will resume monthly service visits and reports will be sent to the facility to ensure the washing machine temperatures and the chemical sanitizing additive ratios are being monitored for effectiveness of decontaminating laundry and linens during the wash cycle.** **2. Environmental Services Director will conduct monthly audits to ensure that reports are being received and that monthly services are completed.** **3. Results of the audits will be reported to the Performance Improvement committee for the next three months or until the committee determines substantial compliance has been achieved.**	6-11-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 05/08/2014

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F 441	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and current standards of practice, the facility failed to ensure a process was in place for monitoring the decontamination of linens laundered by the facility. The findings were: Observation of the facility's laundry facilities with housekeeper #1 on 5/8/14 at 8:35 AM revealed the facility did not observe and record laundry wash temperatures. Interview further showed the facility used a chemical sanitizing additive for linens and laundry that was serviced by a contracted company about once a month. Interview with maintenance staff #1 at 8:40 AM revealed no service records were available indicating the washing machine temperatures had been assessed or the chemical sanitizing additive's ratio had been monitored to ensure the effectiveness of decontaminating laundry and linens during the wash cycle. In addition, there was no documentation available that included the sanitizing agent's parts per million (ppm) of chlorine bleach. Interview with the administrator on 5/13/14 at 3:20 PM verified no service records were available. According to current 2008 CDC guidelines for infection control, "An effective way to destroy microorganisms in laundry items is through hot water washing at temperatures above 160 degrees Fahrenheit for 25 minutes. Alternately, low temperature washing at 71 to 77 degrees Fahrenheit plus a 125-ppm chlorine bleach rinse has been found effective and comparable to high temperature wash cycles."	F 441		

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F 520 F 520 SS=E	Continued From page 24 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and medication pass observations, the facility failed to develop and implement an effective quality plan to sustain the correction of identified medication error practices. These practices were found to be non-compliant during the current and previous re-certification surveys. The findings were:	F 520 F 520	**F520- QAA Committee** **A facility must maintain a quality and assessment assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility staff.** **1. The facility is now utilizing the QAPI process to evaluate and address concerns regarding medication errors** **2. Performance Improvement committee will be in serviced at the next meeting on utilizing the QAPI process to identify concerns regarding medication errors. Monthly audits by the ED will be conducted to ensure compliance.** **3. Results of the audits will be reported to the Performance Improvement committee for the next three months or until the committee determines substantial compliance has been achieved.**	6-11-14

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F 520	Continued From page 25 Observation on 5/7/14 at 4:12 PM and 4:17 PM showed medication errors occurred. The error rate was determined to be 24% based on 6 errors out of a possible 25. Review of the facility compliance report (Casper 4 report) showed medication errors greater than 5% was also cited on the previous survey on 3/14/13. Interview with the DON and NHA on 5/8/14 at 9:30 AM revealed medication errors were reported by nurses who made the errors, and the numbers were included in an incident report and discussed at monthly quality assurance performance improvement meetings. The DON and NHA stated they had been actively monitoring and analyzing the medication errors to resolve the previous years deficient practice until about July 2013. The two then verified the information on medication errors was no longer being analyzed to determine continued compliance.	F 520		