

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

PRINTED: 07/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 83A049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2014
NAME OF PROVIDER OR SUPPLIER GOSHEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 LARAMIE STREET TORRINGTON, WY 82240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADL- Activities of Daily Living BIMS- Brief Interview for Mental Status CAA- Care Area Assessment CDM- Certified Dietary Manager CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set Assessment RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000			
F 226 SS=K	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This will be accomplished by: A. 1) Resident # 55 was given one on one supervision on 6/17 to 6/20/14. On 6/20/14 resident # 55 was transferred to Mountain View Center for Geriatric Psychiatry in Twin Falls, ID. 2) Resident # 27 Skin assessment done on 7/8/14 Bruising noted on arms. Investigation done and determined not to be abuse.		
	This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and review of facility policy, the facility failed to implement their policy and procedures and recognize, report and investigate incidences of resident-to-resident abuse involving 1 sample resident (#55). In addition, the facility failed to follow their policy and procedure and recognize, report, and investigate allegations of abuse and injuries of unknown origins for 3 of 3 sample residents (#13, #27,				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

NHA

7-11-14

Any deficiency statement and plan 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 those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Healthcare Licensing
and Surveys

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5VDF11

Facility ID: WY0010

If continuation sheet Page 1 of 33

[Signature] OX21C

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F 228	Continued From page 1 #52) and 1 non-sample resident (#55). This failure resulted in a determination of immediate jeopardy due to the potential for serious and avoidable resident injury. The findings were: 1. Review of the 5/22/14 quarterly MDS assessment for resident #55 showed diagnoses included Alzheimer's disease, depression, and psychotic disorder. Review of the assessment showed for a cognitive pattern a BIMS score of 0 (indicating severe cognitive impairment) and physical behaviors directed toward others 4 to 6 days a week included hitting, kicking, grabbing and pushing. The resident also displayed verbal behaviors toward others and other behaviors that included hitting and scratching him/herself, rummaging and screaming 1 to 3 days a week. In addition, the resident wandered daily. The following concerns were identified: a. Observation on 6/16/14 at 3:45 PM showed the resident walking in the hallway independently on the unit. S/he walked to a resident who was sitting in a wheel chair, grabbed the arm of the chair, and stood over the seated resident. The staff pried the resident's fingers from the wheel chair and s/he released the arm of the chair. The resident then leaned away from resident #55. At 4:45 PM resident #55 was observed sitting at a table unaccompanied. b. Review of the CNA documentation showed resident #55 exhibited the following abusive behaviors: On 6/8/14 at 4:38 PM... attempted to strangle another resident, wrapped both hands around the resident's neck and started squeezing and yelling. "This lasted for 30 seconds because I happened to see it." On 5/25/14 at 2:01 PM... assaulted another resident "hitting and smacking [him/her]	F 226	3) Resident # 52 Skin Assessment done on 7/4 no bruising observed or noted, no signs of abuse suspected. 4) Resident # 13 New Skin Assessment done on 7/2 bruising to legs noted. Investigation done and determined not to be abuse. B. Implementing the Staff/Resident Abuse Investigation form on 6/18/14. This form includes the following information and will be utilized for each incident identified, for all actual and suspected cases of abuse. Alleged problem, witness statements, administrative action taken, findings, & future actions to be taken, date of complaint, date of investigation initiated, signature/title, investigation completion date. C. Weekly skin assessment will be done to identify bruises of unknown origin. D. The Social Worker or designee will provide all staff re-educated on 6/18/14 and reviewed again at nursing staff meetings on 7/15/14 & 7/16/14 on the following: a. Identifying abuse and protecting all residents from hazards		

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F 226	Continued From page 2 repeatedly while cursing..." On 6/6/14 at 5:09 PM... "kissing up on other residents. Made other resident uncomfortable." On 6/10/14 at 10:07 AM ... tried to grab the breast of another resident and started kissing him/her. Daily from 6/9/14 through 6/15/14... wandered into other resident rooms interfering with care, kicked and hit other residents, screamed and cursed at others. c. Review of the nurses' documentation showed resident #55 exhibited the following abusive behaviors: On 3/29/14 at 11:20 PM... sat in different chairs for brief periods of time while wandering, then sat at a table "swatting" at another resident telling him/her to "get out of here." On 4/5/14 at 9:25 AM... was "picking fight" with one resident and putting hands on another resident. At 5:25 PM... was redirected from hitting a resident and put his/her hands on the back of the neck of a third resident. On 5/8/14 at 5:55 PM... "trying to help" another resident to the bathroom then tried to sit on the same resident. Later that same day resident #55 grabbed another resident's arm and attempted to choke a third resident for yelling. On 5/10/14 at 11:47 PM... "was overly friendly with other residents this shift, squeezing in to sit next to someone, smiling and touching resident's cheeks, squeezing the hand, rubbing their legs, talking to the [residents] in close proximity to their face, remained close even when other residents backed away..." On 6/9/14 at 1:24 AM resident #55 leaned on a chair and put hands on another resident in the sitting area. The other resident yelled and resident #55 hit him/her. Resident #55	F 226	b. Facilities abuse policy and procedures. c. Staff/Resident Abuse Investigation form E. Staff/Resident Abuse Investigation form will be reviewed daily at Dept. QA meeting and at QAPI monthly. F. An incident log will be kept by the Social Worker of all incidents in the facility. Tracking & trending will be analyzed at QAPI. <i>Facility investigation was unable to identify any abuse for resident #55. Res DTS was offered emotional support & counseling as needed. S.W. will check in with Res periodically.</i>	7/31/14	

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F 228	Continued From page 3 continued to wander to different seats, other residents walked away, and resident #55 followed the other residents. Later, resident #55 hit another resident with a pillow. At 9:32 PM resident #55 pushed staff when they attempted to redirect him/her away from other residents during the evening meal. The resident continued to yell and grab other residents' meals. The resident had the following behaviors daily from 6/11/14 to 6/14/14: aggressive behaviors toward other residents, grabbing them, wandering into other resident rooms and yelling. d. Interview with the DON on 6/17/14 at 4:50 PM revealed the staff documented the resident's behaviors for medication dose readjustments. He further stated the incidents of resident to resident abuse were not identified and investigated as abuse; nor were the abuses reported to other agencies. 2. Medical record review showed resident #27 was admitted to the facility on 12/31/08 with diagnoses including non-Alzheimer's dementia and aphasia (absence or impairment of the ability to speak). Review of social service progress notes dated 3/19/14 and 6/18/14 showed the resident was, "rarely understood by others". Review of the annual MDS assessment dated 6/12/14 showed the resident was moderately cognitively impaired, required extensive assistance from staff to complete ADLs, and exhibited verbal and physical behaviors such as cursing, hitting, and kicking daily. Review of the care plan updated 6/13/14 identified the resident as having disruptive verbal and physical behaviors and goals were not met, "continues to fight during cares causing harm to [self] and others". The following concerns were identified:	F 228	This page left blank intentionally		

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F 226	Continued From page 4 a. Review of nursing notes dated 4/1/14 through 6/18/14 showed the resident had 11 documented incidences of unexplained bruises and/or skin tears, and 9 of the 11 incidences were unexplained bruises on the hands, wrists, forearms, and thighs. In addition, review of a nursing note dated 4/1/14 revealed the resident had bruises on the upper right wrist, right hand, outer right hand and forearm area, and a yellow fading bruise on the right thigh. This review also showed the bruises on the right hand, wrist, forearm, and thigh were, "11 small circular shaped purple bruises...resident unable to explain bruising...[social worker] notified of bruising to arms and thigh." Review of an e-mail provided by the social worker dated Tuesday April 01, 2014 showed an email from an RN, who no longer worked at the facility, informing the social worker the resident had circular shaped bruising and, "I am notifying you because the bruising looks almost exactly like fingermarks in some areas (right hand/arm especially)." The social worker replied that same day; "While they are circular in shape and could be mistaken for finger prints, I don't believe they are." Interview with the social worker on 6/19/14 at 11:15 AM verified the bruises was not investigated as potential abuse. b. Review of facility incidents 3/1/14 through 6/18/14 showed no incidents or investigations of bruises or skin tears of unknown origin had been completed for the resident.	F 226	This page left blank intentionally		
	3. Interview with alert and oriented resident #33 on 6/18/14 at 4:30 PM revealed s/he was aware that CNA #1 reported an incidence when CNA #2 cursed resident #58 and, "there was nothing done." The interview further showed resident #58 was unable to verbalize, and could not verify or deny any allegations. Resident #33 also stated				

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F 226	Continued From page 5 CNA #2 continued to work with residents and that's why s/he, "felt like it wasn't taken seriously and they didn't look into it". The resident revealed CNA #2 was, "rough with the residents that can't talk for themselves." The resident also revealed this had been reported to a nurse who no longer worked for the facility. Interview with CNA #1 on 6/19/14 at 4:40 PM verified she had witnessed CNA #2 say to resident #58; "I [f-----] hate taking care of you." Interview further showed CNA #1 recognized this as, "verbal abuse", and stated she; "reported it to the administrator on 6/12/14" and CNA #2 was moved to another hall in the facility. The CNA also revealed CNA #2 was "rough with residents when transferring them, grabbing them by the upper arms", which was also reported. The interview additionally showed the CNA stated, "I'll probably lose my job, but I don't care, because [CNA #2] does not need to be working with residents." CNA #1 denied any staff interviewing him/her or obtaining a statement after the incident was reported on 6/12/14. Review of the incident reports showed no incident for resident #58 for 6/12/14. Interview with the administrator on 6/19/14 at 4:50 PM denied she was aware of any staff to resident allegations of verbal or physical abuse. Review of facility policy and procedure titled; "Staff Treatment of Residents-Abuse Prevention"; reviewed 1/11 instructed, "D. Identification: 1. All employees will monitor for any evidence that may constitute resident abuse. b.i. Verbal/mental abuse by others". In addition the policy and procedure included; "E. Investigation 1. The preliminary investigation must be completed within 24 hours of first being reported. 2. The investigation will vary depending upon the type of incident. 3. The Social Worker, or his designee	F 226	This page left blank intentionally		

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F 226	Continued From page 6 will complete the investigation. 4...Step One-there will be a physical assessment of the resident. There will be an interview of the resident...Step Two-There will be interviews of all potential witnesses. Step Three-There will be completion of the Investigational Form." 4. Review of the 5/5/14 annual MDS assessment for resident #52 showed s/he had a BIMS score of 1 indicating severe cognitive impairment. Further, the resident had physical behavioral symptoms directed toward others and behaviors that would put him/her and others at risk for injury. The resident required extensive assistance for transfers, personal hygiene and dressing. The following concerns were identified: a. Review of the nurses' notes dated 5/8/14; timed 4:53 PM showed the resident acquired a bruise to the left hand from hitting the sit-to-stand lift while receiving care. At 10:29 PM the nurse noted a bruise located on the left shin. It was unclear when the resident acquired the bruise. The note speculated the resident may have received the bruise during the use of the sit-to-stand lift. There was no information in the previous note at 4:53 PM about the resident hitting his/her shin. Further there was no additional documentation to show an investigation was completed related to the incident. b. Review of the weekly skin assessment completed 5/9/14 showed there were 2 bruises located on the left shin and the right side of the mouth was red. Review of the previous notes did not indicate how the resident acquired the additional bruises or the reddened area located on the face. c. Review of the weekly skin assessment completed on 5/16/14 showed additional bruises were located on the left forearm, left shoulder and	F 226	This page left blank intentionally		

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F 226	Continued From page 7 2 bruises on the upper right back. Again, there was no documentation to show an investigation was completed regarding the bruises. d. The 6/7/14 skin assessment indicated a scab to the left shin with a large purple bruise. In addition, the resident had scratches on the right buttock. Again, there was no documentation to show how or when the resident acquired the scratches. 5. Review of the 3/31/14 quarterly MDS assessment for resident #13 showed s/he had a BIMS score of 3 indicating severe cognitive impairment. Further, the assessment showed the resident did not exhibit physical or verbal behaviors. The resident required extensive assistance for transfers, dressing and personal hygiene. The following concerns were identified: a. Review of the weekly skin assessment nurse's note dated 5/7/14 showed the resident had abrasions and/or bruises on the left anterior lower leg, right anterior lower leg, and skin tears located on the left outer elbow and left outer arm. Review of the nurses' notes prior to the assessment did not reveal how the resident acquired the injuries. Review of the incident reports did not show an investigation was completed related to the injuries. b. Review of the nurse's note dated 5/9/14 showed the resident fell which resulted in skin tears to the right forearm, right hand and right fourth digit. Further, review showed the resident had not fallen in the past 3 months indicating the injuries noted 2 days previously were not due to a fall. c. The weekly skin assessment completed 5/14/14 showed skin tears located on the right biceps in addition to the right hand. Review of the nurses' notes from the previous week did not	F 226	This page left blank intentionally		

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F 228	Continued From page 8 Include information about where the resident acquired the injury located on the right upper arm. d. Review of the nurse's note dated 6/28/14 showed the skin assessment included 2 areas of bruising on each of the lower extremities. The previous skin assessments only showed 1 bruise located on each the right and left lower extremity. Review of the nurses' notes from the previous week did not show any incidents of injury or falls. 6. Review of the policy and procedure for Abuse Neglect Exploitation of the Incapacitated or Vulnerable Adult dated 11/5/13 showed injuries should be classified as an injury of unknown source when the source of the injury was not observed by any person or the source of the injury could not be explained and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incident of injuries over time. Further, it showed for resident to resident abuse, the facility was to take appropriate steps to protect other residents, prevent further harm to the residents and reassess actions taken for on-going effectiveness.	F 228	This page left blank intentionally		
	7. Review of the policy and procedure titled; Staff Treatment of Residents-Abuse Prevention, dated 10/4/11 showed all employees were to monitor residents for evidence of abuse. The physical criteria for identifying possible victims of abuse or neglect included physical trauma such as scratches, cuts, and bruises.				
	8. During an interview on 6/19/14 at 2:35 PM, the administrator verified the lack of additional investigations and documentation related to the injuries described.				

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F 228	Continued From page 9 On 6/17/14 at 4:40 PM the administrator was notified of the immediate jeopardy related to resident-to-resident abuse and injuries of unknown origin. The facility's action plan included the following immediate changes: a. One to one continuous supervision for resident #55 to help ensure the safety of other residents as well as him/herself. b. Staff education about protecting residents from abuse, including reviewing the policy and procedure for abuse. c. Arrangements for transportation to transfer resident #55 to another facility. The facility's action plan was accepted on 6/18/14 at 3:40 PM and the immediate jeopardy was removed on 6/18/14 at 6:30 PM. However, deficient practice remained at a scope and severity level of an H.	F 228			
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. 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	F 279	The facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. This will be accomplished by: A. 1) Resident # 55 was transferred to Mountain View Center for Geriatric Psychiatry in Twin Falls, ID. 2) Resident # 19 care plan updated to include alarms in place, monitoring of alarms, and current interventions. Completion date 7/8/14		

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F 279	Continued From page 10 §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, staff interview and review of the policies and procedures the facility failed to ensure the care plan was updated for 3 of 18 sample residents (#5, #19, #55). The findings were: 1. Review of the 6/22/14 quarterly MDS assessment for resident #55 showed diagnoses included Alzheimer's disease, depression, and psychotic disorder. The assessment showed for cognitive pattern, a BIMS score of 0 indicating severe cognitive impairment. Further, physical behaviors directed toward others 4 to 6 days a week included hitting, kicking, grabbing and pushing. The resident also displayed verbal behaviors toward others and other behaviors that included hitting and scratching him/herself, rummaging and screaming 1 to 3 days a week. The resident wandered daily. The following concerns were identified: a. Review of the nurses' notes and CNA documentation for April through June 2014 showed the resident was physically and verbally abusive toward other residents. Behaviors included hitting and wandering into other resident rooms disrupting care. The resident yelled at other residents who responded negatively by yelling and striking back. S/he also made sexual advances including kissing, and touching other residents breasts.	F 279	3) Resident # 5 the restorative care plan was updated to reflect interventions to maintain resident's functional mobility and general strength. Completion date 7/9/14 B. All residents require an updated care plan to ensure objectives, interventions and timetables are current to meet their medical, nursing and mental and psychosocial needs. All residents care plans will be reviewed for accuracy of current care. Completion date 7/9/14 C. A care plan log will be implemented on each hall to document when a care plan is updated for DON or designee to review at daily QA meeting. Implemented on 7/17/14 D. The MDS coordinator will provide education at the CNA & Nurse Meetings on 7/15/14 & 7/16/14 on the following: a. Value of accurate care plans as a living document and following the care plans. b. Care plan update process E. A quality improvement monitoring tool will be implemented and completed by the nurse hall manager monthly, following the MDS calendar for chart selection, to		

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NAME OF PROVIDER OR SUPPLIER GOSHEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2009 LARAMIE STREET TORRINGTON, WY 82240		
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F 279	Continued From page 11 b. Review of the care plan for behaviors last updated 6/3/14 showed the resident began to lay on the floor and staff were to make him/her comfortable if the area was safe. The staff was not to disturb the resident because s/he may become violent. It did not include the safety of other residents. Further, the care plan updated on 11/14/13 showed the resident's behaviors had rapidly escalated. The 9/28/12 care plan update only showed the CNA was to maintain the safety of other residents. It was not updated after the resident's behaviors had escalated related to protecting other residents. It did not include the safety measures needed to be taken, under what circumstances and what situations needed to be avoided for the resident to prevent further escalation of behaviors toward other residents. The care plan did not address any preventive measures. 2. Review of the 3/30/14 annual MDS assessment for resident #19 showed his/her diagnoses included Alzheimer's disease and s/he had fallen. The CAA updated 4/3/14 identified the resident as having the potential for falls and trauma. The care plan updated 4/27/14 revealed the resident had sustained an unwitnessed fall. Review of post fall notes revealed the resident had a fall assessment score of "10", identifying the resident as being at risk for falling. Additional review of post fall notes showed a sensor alarm was attached to the bed and chair, however, the sensor alarm in the residents' chair was not in place at the time of the fall and, "did not alarm staff." Review of the care plan revealed no new interventions were initiated to prevent falls, including staff checking alarms to ensure they were in place and functioning properly. The care plan was not updated until 6/16/14, 21 days after	F 279	assure care plans are current with the needs of the resident. F. Audit information will be reported monthly at the QAPI Meeting until 90% compliance has been achieved for 3 consecutive months.	7/31/14	

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NAME OF PROVIDER OR SUPPLIER GOSHEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 LARAMIE STREET TORRINGTON, WY 82240		
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F 279	Continued From page 12 the resident fell and sustained a left hip fracture that required surgical intervention. 3. Review of the 5/22/14 quarterly MDS assessment showed resident #6 had diagnoses that included lumbago and non-Alzheimer's dementia. This review showed the resident had limited range of motion in upper and lower extremities, used a wheelchair or walker for locomotion, required extensive assistance with ADLs, and needed assistance to balance during transition and walking. Review of the 2/4/14 physical therapy evaluation showed the resident required restorative nursing for safety awareness with ambulation. Review of the 2/27/14 physical therapy follow-up evaluation showed a recommendation for restorative nursing to focus on functional mobility, safety awareness, and general strengthening. Review of the February through June 2014 restorative records showed restorative nursing was not provided after February 2014. Review of the care plan, updated on 5/29/14, showed interventions regarding restorative nursing were not developed. During an interview on 6/19/14 at 11:35 AM nursing unit manager #2 stated interventions for restorative nursing should have been included in the care plan.	F 279			
	4. Review of facility policy and procedure titled, "Fall Prevention Protocol", reviewed 9/11 showed, "IV. Procedure/Interventions: C...The plan of care will specifically address approaches that will decrease risk of falls".				
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281	F 281 will begin on the next page		

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F 281	Continued From page 13 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 notify the physician of elevated blood pressures for 1 of 1 sample residents (#79). Further, the facility failed to ensure physical therapy was initiated in a timely manner for 1 of 1 sample residents (#46) ordered to receive physical therapy. The findings were: 1. According to the Merck Manual, 19th edition; 2011, it showed for classifications of hypertension, normal was less than 120/80, stage 1 hypertension was 140-159/90-99 and stage 2 hypertension was over 180/100. Further, it showed stroke was a common consequence of inadequate treatment of hypertension. Review of the 3/28/14 quarterly MDS assessment for resident #79 showed s/he had diagnoses to include hypertension (elevated blood pressure) and CVA (cerebrovascular accident). Review of the June 2014 MAR showed the resident received the medications Lopressor and hydrochlorothiazide for hypertension and aspirin for CVA prophylaxis. Review of the nurses' notes showed the following blood pressures: On 5/5/14- 167/107, 5/16/14- 148/101, 5/26/14- 204/96, 6/3/14- 160/95, 6/7/14- 203/97, 6/8/14- 181/89, 6/11/14- 186/93, 6/18/14- 180/99. Further review of the nurses' notes showed the blood pressures were not re-taken to check accuracy at the time of the high readings or the physician was notified. During an interview with the corporate nurse on 6/18/14 at 4:46 PM, she acknowledged the nurse should have re-checked the resident's blood pressure. She further stated if the blood	F 281	The facility will ensure that it meets professional standards of quality. This will be accomplished by: A. 1) Resident # 79 Director of Nursing and Nurse Managers working with Medical Director to implement blood pressure parameters. Blood pressure parameters will be in place by 7/17/14 2) Resident #46 received signed orders for PT on 6/11/14 and PT was started on 6/23/14. Resident is continuing with PT at this time. B. New guidelines from Medical Director to implement blood pressure parameters. To be implemented on 7/17/14. C. DON or designee will educate Licensed nursing staff on the following on 7/16/14 - New guidelines for standard parameters - Notifying the doctor outside those parameters 24 hr. chart check procedures. D. Chart audits will be done monthly. A minimum of 30 records will be reviewed monthly by the RN Nurse Manager or designee.		

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NAME OF PROVIDER OR SUPPLIER QOSHEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2009 LARAMIE STREET TORRINGTON, WY 82240		
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F 281	Continued From page 14 pressure remained elevated, the nurse should have notified the physician due to the resident's diagnoses and medications. 2. Review of the 5/4/14 quarterly MDS assessment for resident #46 showed the resident had non-Alzheimer's dementia, limited range of motion in the lower extremities and used a wheelchair for locomotion. Further review showed the resident required supervision with ADLs, and had an unsteady gait, but was able to stabilize without staff assistance. Review of the March 2014 to June 2014 post fall assessments showed the resident fell 11 times. Review of the physician orders showed a physical therapy evaluation was requested on 5/13/14. During an interview on 6/19/14 at 4:05 PM unit manager #2 stated the order for the evaluation had not been signed until the week of 6/16/14 and the evaluation was scheduled 6/23/14. He further stated he did not know why the nursing staff had not followed up to ensure the evaluation was done timely.	F 281	B. Audit information will be reported monthly at the QAPI meeting until 90% compliance has been achieved for 3 consecutive months.		7/31/14
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318	The Facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. This will be accomplished by: A. 1) Resident # 5 was referred for PT consult on 6/19/14. PT evaluated and recommended continuation of restorative care. Restorative care plan in place to reflect interventions to maintain resident's functional		
	Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.				
	This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview				

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F 318	Continued From page 15 and medical record review the facility failed to ensure restorative nursing was provided for 3 of 10 sample residents (#5, #19, #48) who were identified as needing this service. The findings were: 1. Review of the 5/22/14 quarterly MDS assessment showed resident #6 had diagnoses that included lumbago and non-Alzheimer's dementia. This review showed the resident had limited range of motion in upper and lower extremities, used a wheelchair or walker for locomotion, required extensive assistance with ADLs, and needed assistance to balance during transition and walking. Review of the February 2014 to June 2014 post-fall assessments showed the resident fell 7 times. Review of the 2/4/14 physical therapy evaluation showed the resident required restorative nursing for safety awareness with ambulation. Review of the 2/27/14 physical therapy follow-up evaluation showed a recommendation for restorative nursing to focus on functional mobility, safety awareness, and general strengthening. Review of the 2014 restorative records showed the resident walked 100 to 600 feet two to three times weekly with the restorative aide during February 2014. This review also showed restorative nursing was not provided after February 2014. Review of the care plan, updated on 5/29/14, showed interventions regarding restorative nursing were not developed. During an interview on 6/16/14 at 4:45 PM, CNA #6 stated sometimes staff assisted the resident to the bathroom and s/he used a walker, but mostly the resident used the wheelchair. On 6/18/14 at 3:40 PM, the resident was observed walking approximately 20 feet from the wheelchair to the dining room table. Continued	F 318	mobility and general strength. Completed on 7-8-14. 2) Resident # 46 received signed orders for PT on 6/11/14. PT started on 6/23/14. Resident is continuing with PT at this time. 3) Resident # 19 was referred to PT. PT was ordered 5/27/14, (OT) started on 5/29/14 (PT) started on 6/02/14. Resident is continuing with PT at this time. B. All residents will receive a mobility assessment at admission. C. Quarterly assessments completed on all residents to identify ROM decline. D. Level One Restorative Therapy Program implemented on 7/18/14 E. All Residents identified as having ROM decline will be evaluated for PT or restorative therapy. Goals and treatment plans will be established on each resident participating in restorative therapy to assist in achieving & maintaining his/her highest level of self-care and independence. F. The Restorative Therapy RN Manager will re-educate nursing staff at CNA & Nurse Meeting on July 15 & 16, 2014: a. Restorative care program and how nursing staff		

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F 318	Continued From page 16 observation revealed staff were not present and the resident used furniture and the fireplace wall for support. At 3:58 PM, LPN #1 saw the resident standing while using a chair for support. At that time the LPN got a wheelchair and directed the resident to sit in the wheelchair. During an interview on 6/19/14 at 11:35 AM nursing unit manager #1 stated staff education was needed to make staff aware that positioning the resident in the wheelchair was not the best approach on 6/18/14 when the resident demonstrated the desire to walk. The unit manager also verified restorative nursing had not been provided for the resident since February 2014 and she did not know why it was not continued after that time. 2. Review of the 8/8/13 admission MDS assessment showed resident #46 had diagnoses that included non-Alzheimer's dementia and s/he performed all ADLs independently, including walking with a walker. This review also showed the resident did not have functional limitations in range of motion. Review of the 5/4/14 quarterly MDS assessment showed the resident declined in the following areas: range of motion in the lower extremities was limited, used a wheelchair for locomotion, required supervision with ADLs, and had an unsteady gait. Review of the March 2014 to June 2014 post fall assessments showed the resident fell on 3/20/14, 5/6/14, 5/12/14, 5/13/14, 5/15/14, 5/23/14 (two times), 5/30/14, 6/01/14, 6/03/14, and 6/17/14. This review revealed three of the falls resulted in skin tears, bruises, and/or abrasions. Review of the physician orders showed a physical therapy evaluation was requested on 5/13/14. During an interview on 6/19/14 at 4:05 PM unit manager #2 stated the order for the evaluation had not been signed until the week of 6/16/14 and the	F 318	contributes to resident's functional independence. b. Level One Restorative Therapy Program G. A quality improvement monitoring tool will be implemented by the Restorative Therapy RN Manager to ensure that all resident restorative needs are being met. This audit will be reviewed at QAPI until 90% compliance has been achieved for 3 consecutive months.	7/31/14	

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F 318	Continued From page 17 evaluation was scheduled 6/23/14. The unit manager stated he did not know why it was not done timely, nor did he know why the resident had not been evaluated for restorative nursing. During an interview on 6/18/14 at 4:09 PM a family member stated s/he visited the resident daily and noted the resident had gotten weaker and fell more often. The family member stated s/he had requested therapy or some type of exercise strengthening program for the resident over a month ago, but staff had not responded to the request. 3. Review of the medical record for resident #19 showed the care plan dated 5/29/13 identified the resident as having the potential for decline in strength. Interventions included restorative nursing 3-5 times weekly. Review of the restorative log calendar 4/1/14 through 5/20/14 showed the resident received restorative nursing 10 times in April and 5 times in May prior to sustaining a fall which resulted in a fractured hip on 5/20/14. There was no documentation available to clarify why the resident had not received restorative nursing 3 to 5 times weekly.	F 318			
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	The facility will ensure that the resident's environment will remain as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by: A. 1) Resident #55 was given one-on-one supervision on 6/17 to 6/20/14. On 6/20/14 resident # 55 was		

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F 323	Continued From page 18 by: Based on observation, medical record review, staff interview and review of policies and procedures, the facility failed to ensure residents on the secured unit received adequate supervision and were protected from a resident (#55) with documented abusive behavior. In addition, preventive interventions for falls were not put in place for 1 of 1 sample resident (#19) that resulted in a fall with fracture. Finally, post fall evaluations were incomplete for 2 of 3 sample residents (#5, #46). This failure resulted in a determination of Immediate Jeopardy related to resident #55 and his/her history of physical abuse toward other residents and the potential for serious and avoidable injury. The findings were: 1. Review of the 5/22/14 quarterly MDS assessment for resident #55 showed diagnoses included Alzheimer's disease, depression, and psychotic disorder. Review of the assessment showed for a cognitive pattern a BIMS score of 0 (indicating severe cognitive impairment) and physical behaviors directed toward others 4 to 6 days a week included hitting, kicking, grabbing and pushing. The resident also displayed verbal behaviors toward others and other behaviors that included hitting and scratching him/herself, rummaging and screaming 1 to 3 days a week. In addition, the resident wandered daily. The following concerns were identified regarding staff's failure to ensure safety for residents affected by resident #55's behaviors: a. Observation on 6/18/14 at 3:45 PM showed the resident walking in the hallway independently on the unit. S/he walked to a resident who was sitting in a wheel chair, grabbed the arm of the chair, and stood over the seated resident. The staff pried the resident's fingers	F 323	transferred to Mountain View Center for Geriatric Psychiatry in Twin Falls, ID. 2) Resident # 19 Care plan updated with fall interventions on 6/3/14. Spot audits will be done to ensure interventions are in place and working properly. Post fall investigation was updated on 7/9/14 3) Resident # 5 fall section of care plan updated to show current status of resident and fall interventions in place. Restorative section of care plan in place that reflects interventions to maintain resident's functional mobility and general strength. Completion date 7/9/14 4) Resident #46 new fall risk evaluation done on 6/25/14. Resident's room was moved closer to the nurse's station for closer observation on 5/30/14 Resident is under close supervision. PT started on 6/23/14. B. Implemented an Emergency plan protocol on 5/21/14 and fall packets on 6/18/14 to guide nursing staff on how to assess, investigate & document a fall and notify emergency personnel if needed. C. Implemented the Staff/Resident Abuse Investigation form on 6/18/14. This form includes the following information and will be utilized for each incident identified,		

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F 323	Continued From page 10 from the wheel chair and s/he released the arm of the chair. The resident then leaned away from resident #65. At 4:45 PM resident #65 was observed sitting at a table unaccompanied. b. Review of the CNA documentation showed resident #65 exhibited the following abusive behaviors: On 6/8/14 at 4:38 PM... attempted to strangle another resident, wrapped both hands around the resident's neck and started squeezing and yelling: "This lasted for 30 seconds because I happened to see it." On 6/25/14 at 2:01 PM... assaulted another resident "hitting and smacking [him/her] repeatedly while cursing..." The DON, nurse manager and social services were notified. On 6/3/14 at 1:44 PM... came up on other sleeping residents and put him/her in a choke hold. The nurse manager and DON were notified. On 6/6/14 at 5:09 PM... "kissing up on other residents. Made other resident uncomfortable." On 6/10/14 at 10:07 AM ... tried to grab the breast of another resident and started kissing him/her.	F 323	for all actual and suspected cases of abuse. Alleged problem, witness statements, administrative action taken, findings, & future actions to be taken, date of complaint, date of investigation initiated, signature/title, investigation completion date. D. Implemented 24 hour order review on 07/09/14 to ensure all new orders are implemented. E. The Social Worker or designee will provide all staff re-educated on 6/18/14 and reviewed again at nursing staff meetings on 7/15/14 & 7/16/14 on the following: a. Identifying abuse and protecting all residents from hazards b. Facility's abuse policy and procedures. c. Staff/Resident Abuse Investigation form F. Staff/Resident Abuse Investigation form will be reviewed daily at Dept. QA meeting and at QAPI monthly. G. An incident log will be kept by the Social Worker of all incidents in the facility. Tracking & trending will be analyzed at QAPI monthly.		
	Daily from 6/9/14 through 6/15/14... wandered into other resident rooms interfering with care, kicked and hit other residents, screamed and cursed at others. c. Review of the nurses' documentation showed resident #65 exhibited the following abusive behaviors: On 3/29/14 at 11:20 PM... sat in different chairs for brief periods of time while wandering, then sat at a table "swatting" at another resident telling him/her to "get out of here." On 4/6/14 at 9:25 AM... was "picking fight" with one resident and putting hands on				
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F 323	Continued From page 20 another resident. At 5:25 PM... was redirected from hitting a resident and put his/her hands on the back of the neck of a third resident. On 5/8/14 at 5:55 PM... "trying to help" another resident to the bathroom then tried to sit on the same resident. Later that same day resident #55 grabbed another resident's arm and attempted to choke a third resident for yelling. On 5/10/14 at 11:47 PM... "was overly friendly with other residents this shift, squeezing in to sit next to someone, smiling and touching resident's cheeks, squeezing the hand, rubbing their legs, talking to the [residents] in close proximity to their face, remained close even when other residents backed away..." On 6/9/14 at 1:24 AM resident #55 leaned on a chair and put hands on another resident in the sitting area. The resident yelled and resident #55 hit him/her. Resident #55 continued to wander to different seats, other residents walked away, and resident #55 followed the other residents. Later, resident #55 hit another resident with a pillow. At 9:32 PM resident #55 pushed staff when they attempted to redirect him/her away from other residents during the evening meal. The resident continued to yell and grab other residents' meals. The resident had the following behaviors daily from 6/11/14 to 6/14/14: aggressive behaviors toward other residents, grabbing them, wandering into other resident rooms and yelling. d. Review of the care plan for behaviors last updated 6/3/14 showed the resident began to lay on the floor and staff were to make him/her comfortable if the area was safe. The staff was not to disturb the resident because s/he may become violent. It did not include other residents and what needed to be done to protect them. Further, the 11/14/13 care plan update indicated	F 323	This page left blank intentionally		

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F 323	Continued From page 21 the resident's behaviors had rapidly escalated. The 9/28/12 care plan update only showed the CNA was to maintain the safety of other residents and had not been updated since the escalation of behaviors. It did not identify safety measures needed to be taken to protect the other residents, under what circumstances and what situations needed to be avoided that would cause an escalation of behaviors for the resident. Preventive measures had not been included in the care plan. e. Review of the policy and procedure for Abuse Neglect Exploitation of the Incapacitated or Vulnerable Adult dated 11/5/13 showed for resident-to-resident abuse; the facility was to take appropriate steps to protect other residents, prevent further harm to the residents and reassess actions taken for on-going effectiveness. f. Interview with the DON on 6/17/14 at 4:50 PM revealed the staff documented the resident's behaviors for medication dose readjustments. He further stated the incidents of resident-to-resident abuse were not identified and investigated as abuse; nor were the abuses reported to other agencies. On 6/17/14 at 4:40 PM the administrator was notified of the immediate jeopardy related to resident #55. The facility's action plan included the following immediate changes: a. One to one continuous supervision for resident #55 to help ensure the safety of other residents as well as him/herself. b. Staff education about protecting residents from abuse, including reviewing the policy and procedure for abuse. c. Arrangements for transportation to transfer resident #55 to another facility.	F 323	This page left blank intentionally		

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F 323	Continued From page 22 The facility's action plan was accepted on 6/18/14 at 3:40 PM and the immediate jeopardy was removed on 6/18/14 at 6:30 PM. However, deficient practice remained at a scope and severity level of a G. Identified concerns related to falls and resident safety: 2. Medical record review showed resident #19 was admitted to the facility 3/29/13 with diagnoses including Alzheimer's disease, memory loss, and personal history of a fall. Review of the CAA dated 6/6/14 identified the resident as having the potential for trauma and falls. Review of the care plan updated 1/29/14 revealed the resident had interventions including sensor alarms for the chair and bed, assistive devices including using a walker with assistance, staff assisting with transfers, instructing the resident to call for help, and hourly staff rounding. The following concerns were identified: a. Review of the nursing notes showed the resident sustained an unwitnessed fall on 4/27/14. Review of post-fall notes revealed the resident had a fall assessment score of "10", identifying the resident as being at risk for falling. Additional review of post fall notes showed s/he had sensor alarms in the bed and chair, however, the sensor alarm in the resident's chair was not in place at the time of the fall and, "did not alarm staff." Review of the care plan revealed no new interventions were implemented to prevent falls, including staff checking alarms to ensure they were in place and functioning properly. Review of the nursing notes dated 6/20/14 showed the resident sustained a witnessed fall resulting in a fractured left hip that required surgical	F 323	This page left blank intentionally		

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F 323	Continued From page 23 Intervention: The care plan was not updated until 6/16/14, 21 days after the resident fell and sustained a left hip fracture that required surgical intervention. b. Interview with LPN #2 on 6/17/14 at 5:30 PM revealed she recalled the resident falling on 6/20/14. CNA #3 found the resident walking behind his/her wheelchair in the hall and witnessed the resident fall. The interview further revealed the resident had been transferred from the floor to a wheelchair after the fall but should have been assessed while on the floor prior to being moved, however, she, "really didn't think [resident's name] had a broken hip". c. Interview on 6/17/14 at 5:40 PM with CNA #3 revealed she had been alerted by the resident's sensor alarm and found the resident up in his/her room walking unassisted. The resident was, "confused and going to make a peanut butter and jelly sandwich." The interview further revealed the more the CNA offered assistance to the resident the more agitated s/he became until the resident tried to push her away and fell. d. Review of 6/20/14 post fall documentation revealed no post-fall investigation was completed. Interview with the administrator on 6/19/14 at 10:10 AM verified the lack of post fall follow-up documentation for the fall sustained on 6/20/14. In addition, the facility had adopted a new fall protocol related to assessing residents where they lay after a fall; however, staff were not in-serviced until 6/18/14 or 29 days after resident #19 fell on 5/20/14. e. Review of facility policy and procedure titled, "Fall Prevention Protocol", reviewed 9/11 showed; "IV. Procedure/Interventions: D. All falls will warrant an occurrence report and be immediately investigated by the nurse in charge to assess for contributing factors".	F 323	This page left blank intentionally		

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F 323	Continued From page 24 3. Review of the 5/22/14 quarterly MDS assessment showed resident #5 had diagnoses that included lumbago and non-Alzheimer's dementia. This review showed the resident had limited range of motion in upper and lower extremities, used a wheelchair or walker for locomotion, and required extensive assistance with ADLs. This review also showed the resident needed assistance to balance during transition and walking. Review of the February 2014 to June 2014 post-fall assessments showed non-injury falls occurred on 2/20/14, 3/7/14, 3/9/14, 4/25/14, 5/9/14, 5/14/14, and 8/12/14. Review of the 2/4/14 physical therapy evaluation showed the resident required restorative nursing for safety awareness with ambulation. Review of the 2/27/14 physical therapy follow-up evaluation showed a recommendation for restorative nursing to focus on functional mobility, safety awareness, and general strengthening. Review of the 2014 restorative records showed the resident walked 100 to 600 feet two to three times weekly with the restorative aide during February 2014. This review also showed restorative nursing was not provided after February 2014. Review of the care plan, updated on 6/29/14, showed interventions regarding restorative nursing were not developed. On 6/18/14 at 3:40 PM, the resident was observed walking approximately 20 feet from the wheelchair to the dining room table. Continued observation revealed staff were not present and the resident used furniture and the fireplace wall for support. At 3:58 PM, LPN #1 saw the resident standing while using a chair for support. At that time the LPN got a wheelchair and directed the resident to sit in the wheelchair. During an interview on 6/19/14 at 11:35 AM unit manager #1	F 323	This page left blank intentionally		

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F 323	Continued From page 25 stated staff education was needed to make staff aware that positioning the resident in the wheelchair was not the best approach on 8/18/14 when the resident demonstrated the desire to walk. The unit manager also verified restorative nursing had not been provided for the resident since February 2014 and she did not know why it was not continued after that time. 4. Review of the 8/8/13 admission MDS assessment showed resident #46 had diagnoses that included non-Alzheimer's dementia and s/he performed all ADLs independently, including walking with a walker. This review also showed the resident did not have functional limitations in range of motion. Review of the 5/4/14 quarterly MDS assessment showed the resident's abilities declined. This review showed the resident had limited range of motion in the lower extremities and used a wheelchair for locomotion. The review also showed required supervision with ADLs, and had an unsteady gait, but was able to stabilize without staff assistance. Review of the March 2014 to June 2014 post-fall assessments showed the resident fell on 3/20/14, 5/6/14, 5/12/14, 5/13/14, 5/15/14, 5/23/14 (two times), 5/30/14, 6/01/14, 6/03/14, and 6/17/14. This review revealed three of the falls resulted in skin tears, bruises, and/or abrasions. This review and the care plan, updated on 5/11/14, showed no evaluation of the effectiveness of the current approaches. During an interview on 6/18/14 at 4:09 PM a family member stated this family member saw the resident daily and noted the resident had gotten weaker and fell more often. The family member stated s/he had requested therapy or some type of exercise strengthening program for the resident over a month ago, but staff had not	F 323	This page left blank intentionally		

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F 323	Continued From page 26 responded to the request. At that time the family member also stated staff repeatedly positioned the resident in the wheelchair at the nurses' desk for prolonged periods of time. Review of the physician orders showed a physical therapy evaluation was requested on 6/13/14. During an interview on 6/19/14 at 4:05 PM unit manager #2 stated the order for the evaluation had not been signed until the week of 6/16/14 and the evaluation was scheduled 6/23/14. The unit manager stated he did not know why it was not done timely, nor did he know why the resident had not been evaluated for restorative nursing.	F 323			
F 371 SS-E	483.35(l) 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	F 371	The facility will ensure food preparation and service equipment is in a cleanable condition. This will be accomplished by: A. No specific residents noted on Form CMS 2567. All residents have the potential to be affected by this deficiency B. Dirty ceiling tiles will be replaced and chipped and peeling paint will be repaired in the main kitchen by July 31, 2014. C. The oven in the kitchen on the secured unit will be cleaned by culinary staff weekly and documented accordingly beginning July 9, 2014. D. The microwave on the secured unit will be cleaned daily by culinary staff and documented accordingly beginning July 9, 2014.		
	This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of cleaning logs, the facility failed to ensure a sanitary environment was maintained in 2 of 2 kitchen/food areas (the main kitchen and the secured unit). The findings were: 1. Observation of the main kitchen on 6/16/14 at 11:30 AM showed 4-5 ceiling tiles above 2				

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F 371	Continued From page 27 separate food preparation areas were spotted with stains and coated with dust. Interview with cook #1 at the time of the observation revealed the stains looked, "kinda like beets or food splatter." Additional observation revealed chipped and peeling paint on the wall above 2 separate food preparation areas. At the end of the buffet where food was plated, there was an area of peeling paint that measured approximately 4 by 6 inches. In addition, near the handwashing sink there was an area of peeling paint that measured approximately 7 by 4 inches. Interview with the CDM on 6/18/14 at 12:30 PM verified the tiles in the kitchen should have been replaced. The CDM also stated the kitchen had not been painted in the 11 years she had worked at the facility. In addition, the CDM verified the kitchen needed to be painted. 2. Observation of the oven located in the secured unit kitchen on 6/18/14 at 11:45 AM showed the back and sides of the oven had black burned on food that was crumbling and flaking on the floor of the oven. Review of the cleaning logs showed the stove was supposed to be cleaned monthly, on the second Sunday of the month, which would have been 6/8/14. However, there was no documentation that the stove had been cleaned. Interview with cook #2 at the time of the observation revealed she was unsure when the oven was last cleaned. 3. Observation of the microwave on the secured unit on 6/18/14 at 11:45 AM showed it was not clean. The interior of the microwave had dried spilled food on the top, back, sides and bottom. Interview with cook #2 at the time of the observation revealed activities was responsible for cleaning the microwave and verified the	F 371	B. RD or designee will provide education to facility culinary staff on the following by 7/31/14 a. Replacement of ceiling tiles, repair of chipped and peeling paint. b. Cleaning and documentation of oven and microwave on the secured unit. F. The facility RD or designee will conduct audits on cleaning and documentation of the oven and microwave weekly. Plant Operations will conduct audits on ceiling tiles and paint during environmental and safety rounds and if any are found to be out of compliance work orders will be placed. G. The results of the audits will be tabulated and reported at the facility's monthly QAPI meeting until 90% compliance has been achieved for 3 consecutive months.	7/31/14	

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F 371	Continued From page 28 microwave should have been cleaned. Interview with the DON on 6/18/14 at 12:20 PM showed environmental services was supposed to clean the microwave on the secured unit as needed. Interview with the CDM on 6/18/14 at 12:30 PM verified the microwave on the secured unit was supposed to be cleaned by environmental services as needed.	F 371			
F 441 SS=D	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." 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it-- (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This will be accomplished by: A. 1) Resident #27 -- Appropriate peri-care observed. Monitoring for signs and symptoms of infection. Completed on 7/10/14 2) Resident # 44 Appropriate peri- care observed. Monitoring for signs and symptoms of infection. Completed on 7/10/14 B. Secret shopper hand hygiene audits is an on-going Infection Prevention activity and will continue. All instances on non- compliance will be addressed with the individual and		

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F 441	Continued From page 29 Isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food. If direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to ensure infection control measures were followed during perineal care for 2 of 6 observations affecting 2 residents (#27, #44). The findings were: 1. Observation of perineal care for resident #27 with CNA #5 on 6/16/14 at 3:30 PM revealed the resident was toileted using a sit-to-stand lift. The CNA applied gloves and used disposable wipes to clean the resident and first cleaned the rectal area using a back and forth motion then discarded the wipe. She did not change her gloves or perform hand hygiene, but proceeded to clean the resident's perineal area in a back and forth motion from the urinary opening to the rectal area and back toward the urinary opening using the same disposable wipe. The CNA then adjusted the resident's adult brief and clothing prior to discarding gloves and washing hands.	F 441	education/counseling will occur on an individual basis as deemed necessary. C. The DON or designee will provide infection prevention education to nursing staff on 7/15/14 & 7/16/14 including: a. Hand hygiene & proper glove use. b. Peri-care Procedures. D. Peri-care competencies will be evaluated twice a year then annually thereafter. E. Three spot audits will be performed monthly for the next 3 months by RN nurse managers for the next 3 months to ensure correct peri-care procedures.	7/31/14	

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F 441	Continued From page 30 2. Observation on 6/17/14 at 5:25 AM showed CNA #4 transfer resident #44 to the bathroom with a sit-to-stand lift. The CNA removed the incontinence pad with gloved hands then removed the gloves, donned a second pair after washing her hands. The CNA then retrieved the resident's slippers. She placed the slippers on the resident's feet then proceeded with perineal care without first changing her gloves and performing hand hygiene. Further, during incontinence care, the CNA scrubbed the resident's anterior perineum back and forth and not in one direction with a single wipe. Review of the 6/6/14 quarterly MDS assessment showed the resident required extensive assistance with toileting and personal hygiene. Review of the undated policy and procedure for female perineal care showed before initiating the care, the staff member is to perform hand hygiene and don gloves. Further, the perineum should be washed "using a clean washcloth or perineal wipe, wipe in the direction from perineum to rectum (front to back). Repeat on the opposite side, using a new washcloth or perineal wipe."	F 441			
F 520 SS=E	During an interview with the administrator on 6/19/14 at 2:20 PM, she verified the CNA should have removed her gloves and washed her hands after placing the slippers on the resident's feet and before starting perineal care. Further, the CNAs needed to wipe the resident's perineum in one direction and not back and forth. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	Tag F520 will begin on the next page		

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F 520	Continued From page 31 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of falls documentation and staff interview, the facility failed to ensure an effective quality assurance and performance improvement (QAPI) program was in place. The failure to sustain an effective plan impacted resident care related to safety and lack of adequate supervision. The findings were: Review of the data provided by the facility showed residents experienced 80 falls from April 2014 to 6/18/14 (within 77 days) and one resulted in a fractured hip. Further review of this data showed	F 520	The facility will continue to maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility staff. This will be accomplished by: A. The quality assessment and assurance committee will continue to meet monthly to identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified deficiencies. B. No specific residents noted on Form CMS 2567. All residents have the potential to be affected by this deficiency. C. All department audit forms will be collected and analyzed at the monthly QAPI. D. All areas receiving less than 90% compliance will receive an action plan to increase compliance. E. Tracking and trending of falls by location, time, frequency, observation status, injury and activity will continue. These numbers will be reported and		

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

PRINTED: 07/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 63A049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2014
NAME OF PROVIDER OR SUPPLIER GOSHEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2009 LARAMIE STREET TORRINGTON, WY 82240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	Continued From page 32. there were 26 falls in April, 37 falls in May and 17 falls as of June 18, 2014. Review of past surveys revealed citations related to injuries from falls were cited on 10/25/13 and again on 1/29/14. CNA #6 was interviewed on 6/16/14 at 4:45 PM. CNAs #7 and #8 were interviewed on 6/17/14 at 6:20 AM. LPN #3 was interviewed on 6/17/14 at 6 AM. During the above interviews all stated staff were frequently pulled from other areas to work in areas where they were not familiar with the residents. They further stated residents were more likely to have falls when the primary care-giver during the shift did not have knowledge of the resident's individual care needs and the resident did not know them. Interview with the administrator on 6/19/14 at 2:30 PM revealed the number of resident falls had been identified as a problem through the QAPI process and measures had been implemented to reduce the number of falls. Review of the documented measures that were implemented and QAPI data analysis showed no information about falls in relation to the residents' medications, number of staff and acuity, and staff knowledge about resident's individual care needs.	F 520	analyzed in the weekly fall committee for evaluation and potential preventative actions. F. Education will be done by the NHA or designee with the QAPI committee on the following by 7/31/14 a. Importance and fundamentals of quality assessment and assurance program. b. The five elements of QAPI 1) Design & Scope, 2) Governance & Leadership 3) Feedback, Data Systems & Monitoring, 4) Performance Improvement Projects, 5) Systematic Analysis & Systemic Action. c. Review of new Dashboard to incorporate new audits being implemented included in this POC. G. A QAPI self-Assessment tool will be used to evaluate the extent to which components of QAPI are in place. Completion date will be July 31st.	7/31/14	