8-8/14/14

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

PRINTED: 07/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535034	A. BUILDING _____ B. WING _____	07/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

(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: ADLs: Activities of Daily Living ADON: Assistant Director of Nursing CNA: Certified Nursing Assistant CDM: Certified Dietary Manager DON: Director of Nursing LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	8/22/14 Physician Communication F 157 **Correct deficiency to individual**--Resident # 28 received breathing treatments per nebulizer three times a day as ordered by physician on 7/2/14 in response to faxed orders. Resident's physician performed monthly rounds on resident #28 on 7/10/14. No new medication or orders were prescribed at this time. **How others are identified and correction to others in similar situations**--Nurses will use internal 24 hour report book to communicate between shifts on residents' status. Nurses will receive education on making phone calls to physicians, and use of the SBAR form for communication. Nurses will be educated on on-call physician schedules and phone numbers. **Measures/systematic changes to prevent recurrence**--On-call schedule will be obtained for all providers, and all practitioners' phone numbers will be obtained and posted in the nurses' report room. --In-service will be completed on or before August 22nd, 2014, regarding 24 hour report book procedures, physician on-call schedules, completion of the SBAR for communication to physicians, and the necessity of follow-up phone calls on fax communication. **Monitor permanent solution**--Weekly audits will be performed by the DON and/or ADON or their designee for 60 days for documentation of communication between nurses and physicians on residents who have a significant change of condition, as identified by the interdisciplinary team. --Results of audits will be discussed at monthly QA meetings.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Kovall — TITLE: Administrator — (X6) DATE: 8/1/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 01 2014

Accepted as 8/4/14

Healthcare Licensing and Surveys

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Korell — TITLE: Administrator — (X6) DATE: 8/1/14

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F 157	Continued From page 1 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the physician of a resident's condition in a timely manner for 1 of 1 sample residents (#28) with new respiratory symptoms. The findings were: Review of interdisciplinary progress notes dated 6/29/14, timed 1:30 PM, revealed resident #28, who had a history of pneumonia, developed a productive cough, expiratory wheezes, and rhonchi in the right lower lung. The note further revealed a message was left for the resident's physician. The following concerns were identified: 1. Interdisciplinary progress notes dated 6/30/14, timed 12:45 PM and 6:30 PM, showed the resident continued to have diminished lung sounds and expiratory wheezing, with no indication the physician had responded to the facility's phone call, or that the facility had attempted to contact the physician again. 2. Interdisciplinary progress notes dated 7/1/14, timed 5:50 PM, showed the resident continued to	F 157		

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F 157	Continued From page 2 have diminished lung sounds, with no indication of physician contact. 3. Review of a faxed communication to the physician dated 7/2/14 revealed the resident had been complaining of a cough on a daily basis, and had diminished lung sounds. The physician responded to this fax with an order for breathing treatments via nebulizer three times daily. The physician further questioned whether there had been any other attempts to contact him since the 6/29/14 attempt. 4. Interview with the DON on 7/10/14 at 12:10 PM revealed nursing should have followed up with the physician until a response was received.	F 157		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility policy, the facility failed to ensure residents who required extensive assistance performing ADLs received assistance with hygiene for 1 of 6 sample residents (#5) and 3 non-sample residents (#12, #34, #45) identified as requiring extensive assistance. The findings were: 1. Review of the most recent quarterly MDS	F 312	ADL Care Provided for Dependent Residents F 312 **Correct deficiency to individual--**Resident #5, and three non-sample residents, #12, #34 and #45 received assistance with care of fingernails, including cleaning and trimming, per facility policy, on July 9th, 2014. **How others are identified and correction to others in similar situation--**Audit will be completed by August 22, 2014 to identify all dependent residents who require nail care. Identified residents will be reviewed for needed assistance and list of residents will be available for all nursing staff. **Measures/systematic changes to prevent recurrence--**Staff will be educated on or before August 22nd, 2014 regarding the need to provide nail care to all dependent residents. **Monitor permanent solution--**The DON, ADON, or their designee will conduct random weekly audits on grooming and hygiene of all dependent residents for the next 60 days. --Staff education for all new hires will be provided on caring for dependent residents' needs, grooming and hygiene, with follow up in-service competencies per facility policy. --Results of audits will be discussed at monthly QA meetings.	8/22/14

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F 312	Continued From page 3 assessment dated 6/24/14 showed resident #5 was moderately cognitively impaired, had impaired vision, and required extensive assistance from staff to complete ADLs including bathing and hygiene. Review of the care plan updated 4/1/14 identified the resident as having a self care deficit. Interventions included staff assisting him/her with bathing and hygiene. Observation on 7/7/14 at 5:20 PM revealed the resident was seated in the main dining room. The resident's fingernails were long, jagged, and the nailbeds were encrusted with thick, brown matter. Observation further showed the resident eating the evening meal using his/her hands. Subsequent meal observations on 7/8/14 at 8:30 AM, and 7/9/14 at 12:20 PM, revealed the resident continued to have long, jagged fingernails, and the nailbeds continued to be encrusted with thick, brown matter. In addition, the resident continued using his/her hands to consume meals. 2. Review of the most recent quarterly MDS assessment dated 6/14/14 showed resident #12 was moderately cognitively impaired, had difficulty communicating, and required extensive assistance from staff to complete ADLs including bathing and hygiene. Review of the care plan updated 12/24/13 revealed the resident required staff assistance to complete all ADLs due to cerebrovascular dementia. Observation of the evening meal on 7/7/14 at 5:33 PM showed the resident was seated in the main dining room. The resident fingernails had chipped pink polish, were jagged, and the nailbeds were encrusted with thick brown matter. Observation further revealed the resident eating quiche and a muffin with his/her hands. Additional meal observations on 7/8/14 at 8:30 AM, and 7/9/14 at 12:20 PM	F 312		

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F 312	Continued From page 4 showed the resident continued using his/her hands to eat, and the resident's fingernails continued to be jagged, have chipped, pink polish, and the nailbeds continued to have thick brown matter. 3. Review of the quarterly MDS assessment dated 5/3/14 showed resident #34 was moderately cognitively impaired and required extensive assistance from staff to complete bathing and hygiene. Review of the care plan updated 5/26/14 identified the resident as having confusion related to dementia and a self care deficit. Interventions included staff assisting the resident with performing hygiene and bathing. Observation on 7/7/14 at 5:15 PM revealed the resident used his/her hands to eat a muffin in the main dining room. The resident's fingernails had chipped light colored polish and the nailbeds were encrusted with thick, brown matter. Observations on 7/8/14 at 8:30 AM and 7/9/14 at 12:20 PM showed the resident's fingernails continued to have chipped, light polish and the nailbeds continued to have brown matter. 4. Review of the quarterly MDS assessment dated 6/9/14 showed resident #45 was severely cognitively impaired, was visually impaired, and required extensive assistance from staff to complete hygiene and bathing. Review of the care plan updated 3/11/14 revealed the resident required assistance from staff to complete ADLs related to decreased vision. Interventions included, "supervision and at times assist with ....grooming, bathing." Observation during the facility tour on 7/7/14 at 3:30 PM revealed the resident was seated in his/her room. The resident's fingernails were long, jagged and the nailbeds were encrusted with thick	F 312		

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F 312	Continued From page 5 brownish-black matter. Additional meal observations on 7/7/14 at 5:20 PM, 7/8/14 at 8:30 AM, and 7/9/14 at 12:20 PM showed the resident continued to have long, jagged fingernails encrusted with thick brownish-black matter, and used his/her hands to eat meals. 5. Interview with CNA #3 on 7/9/14 at 10:05 AM revealed bath aides were responsible for trimming and cleaning resident fingernails on shower days. 6. Interview with the ADON on 7/9/14 at 1:10 PM confirmed the bath aides were supposed to trim resident fingernails as needed during showers and all staff was responsible for assisting residents with cleaning fingernails. Interview further verified residents #5, #12, #34, and #45's fingernails should have been trimmed and cleaned. 7. Review of facility policy entitled, "Care of Fingernails/Toenails", revised October, 2010 showed, "General Guidelines 1. Nail care includes daily cleaning and regular trimming."	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	F 323	Free of Accident Hazards/Supervision/Devices F323 **Correct deficiency to individual--**Resident has code alert bracelet in place at all times to alert staff to possible elopement attempts. Elopement risk manual is kept current at all times by the Social Services designee, and elopement drills are performed regularly per facility protocol. Resident #31 has not had an elopement attempt since 5/8/2014. --Nursing staff will be educated on resident's status and need for stand-by assistance at all times when ambulating, due to unsteady balance and gait.	8/22/14

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F 323	Continued From page 6 by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff implemented consistent interventions to ensure safety for 1 of 9 sample residents (#31) identified as having safety risks. The findings were: Review of the medical record showed resident #31 was admitted to the facility on 7/16/12 with diagnoses including dementia. Review of the quarterly MDS assessment dated 5/15/14 revealed the resident was moderately cognitively impaired, made poor decisions, exhibited wandering behaviors, had fallen since the last assessment, and required supervision. Review of the care plan updated 7/6/14 identified the resident as having wandering behaviors and falls. Interventions included placing a code alert bracelet (a device that sounded an alarm when the resident attempted exiting the building) on the resident's ankle, and maintaining an environment free of safety hazards. Review of nursing notes showed the resident had experienced unwitnessed falls on 4/14/14, 5/27/14, and 6/21/14. The falls on 4/14/14 and 6/21/14 resulted in transfers to the emergency department and involved injuries. After the fall on 5/27/14, the resident was referred to physical therapy (PT) to assess balance and transfer safety. Review of a PT screening note dated 6/3/14 revealed "Patient unable to respond appropriately to any questions. Refused to walk or stand for the therapist, appeared very confused, could not articulate thoughts about problems with mobility and did not mention recent falls or remember them. The best options for safety and fall prevention are to encourage	F 323	**How others are identified and correction to others in similar situations--**The Interdisciplinary Team identifies those residents at risk for elopement based on nursing assessments at admission, quarterly, and as needed. --All nursing and activities staff have been educated on the necessity of all residents at risk for elopement being monitored at all times during activities outside of the facility. If activities staff is not available to stay with residents at all times, they will request that another staff member be present in their absence. **Measures/systematic changes to prevent recurrence--**The raised, uneven concrete area near the patio will be fixed. An outside agency will be contacted for consultation. Staff will be educated to the fall risk of the patio area at this time, and will be asked to avoid taking residents with walkers or who are at risk for falls near this area. **Monitor permanent solution--**Outdoor activities will be audited for the next 60 days by the DON, ADON, or their designee, to ensure that a staff member is present with residents during the entire activity. --Code alert bracelets will be audited weekly for the next 60 days by the Social Services designee, to make sure they are in place on residents at risk for elopement. --Results of audits will be discussed at monthly QA meetings.	

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F 323	Continued From page 7	F 323		

participation in exercise class, supervised walks and to increase supervision." In addition, review of nursing notes dated 4/18/14 and 5/8/14 revealed the resident had attempted to exit the facility, however, his/her code alert bracelet set off door alarms and staff intervened. The following concerns were identified:

a. Observation on 7/8/14 at 12:20 PM showed the resident being assisted by two facility staff ambulating with a wheeled walker to the main dining room. The resident was unsteady and was given recurrent verbal reminders how to use the walker.

b. Observation of the front outdoor patio on 7/8/14 at 4 PM revealed 6 residents, including resident #31, and 1 visitor were walking or seated on the patio. No staff were present on the patio. The patio was constructed of blocks of concrete which were noted to be uneven with raised edges between the blocks measuring approximately one-half inch to one and one-fourth inch.

c. Observation on 7/8/14 at 4:20 PM showed the resident was sitting outside wearing a code alert bracelet on his/her left ankle. No staff were present on the patio. The resident was confused asking questions about "Paul climbing over the fence." At 4:30 PM RN #1 came out to the patio to encourage the resident to go inside for dinner, the resident was confused and commented, "I don't live here." Two staff were then observed to come out and assist the resident into the building using a wheeled walker. The resident was observed to be unsteady with ambulation and had to be given recurrent verbal reminders by staff how to utilize the walker. The resident walked through the double doors and his/her ankle alarm sounded.

d. Interview with CNA #3 on 7/9/14 at 10:05 AM verified the resident was unsteady, was at

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F 323	Continued From page 8 risk for falling, and required assistance from staff when ambulating. In addition, the resident had exhibited wandering behaviors and wore a code alert bracelet alerting staff if s/he attempted to exit the facility. The CNA verified staff were supposed to supervise the resident during activities on the patio. e. Interview with the activities director on 7/9/14 at 12:30 PM confirmed staff had walked in and out of the facility "about every 10 minutes" to check on residents. Interview further verified "usually staff were present with residents at all times," and staff should have remained with the resident. f. Interview with the administrator on 7/10/14 at 9:10 AM revealed the resident had a history of falls, and had attempted to exit the facility. She indicated staff were present in the dining room and able to visualize the residents on the patio; however, staff should have remained with the resident while the resident was outside on the patio. Interview with the administrator additionally indicated she had not noticed the raised, uneven edges of concrete on the patio but verified the raised, uneven edges were a potential fall hazard and needed to be fixed.	F 323		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care;	F 328	Treatment/Care of Special Needs F 328 **Correct deficiency to individual--**Resident #16 was being treated at the time of survey for signs and symptoms of heart failure. Her BNP was 472 on 7/8/14. New medications were started for treatment, and communication occurred between facility and MD office on multiple dates for increased edema, shortness of breath, wheezing. PRN albuterol inhaler was used for relief of symptoms on 7/7/14, 7/8/14, and 7/10/14; diuretics were in use as well. Resident ultimately was hospitalized for chronic kidney disease and acute respiratory failure. When she was discharged to the facility she received scheduled nebulizers and comfort care through hospice services.	8/22/14

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F 328	Continued From page 9 Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview the facility failed to ensure respiratory treatment, care and assessment were provided for 2 of 3 sample residents (#5 and #39), and 1 non-sample resident (#16) with respiratory care requirements. The findings were: 1. Observation of resident #16 on 7/8/14 at 9:58 AM showed the resident was participating in a group meeting of residents. The resident was noted to be visibly short of breath and wheezing loudly. Interview with the resident at that time revealed the resident received breathing treatments for his/her wheezing, but that s/he had not had a treatment that morning. At the conclusion of the meeting, activity staff and nursing staff returned and interacted with the residents. The following concerns were identified: a. Interview with the activity assistant on 7/8/14 at 10:02 AM revealed she was aware the resident was wheezing, but she had never been instructed to report such things to nursing. b. The resident's pulse oximetry (a measurement of blood oxygen saturation), taken by CNA #4 at 10:10 AM showed variable measurements, registering as low as 84%. (Normal blood oxygen saturation levels are above 90%). c. Interview with LPN #1 on 7/8/14 at 10:18 AM revealed she had received no report of a resident complaining of wheezing or shortness of breath.	F 328	--No adverse effects were suffered by resident #5 and #39. Oxygen tanks were replaced and oxygen saturations increased to greater than 90%. **How others are identified and correction to others in similar situation--**All nursing staff will be educated on continuous monitoring of oxygen tank levels. --A CNA each shift will be assigned to monitor all oxygen tanks during each meal during the day. --Implementation of an internal tool for staff from all departments (as well as visitors and volunteers) will be put into use so that any person in contact with the resident can notify the charge nurse of any changes. **Measures/systematic changes to prevent recurrence--**Inservice related to internal notification tool and SBAR form will be implemented on or before August 22nd to educate staff on communication of resident change of condition. --All current staff will be educated by August 22nd, 2014 on continual monitoring of O2 tank levels, and notification of proper staff to replace as needed. --All new staff will be oriented to monitor O2 tanks and change/notify as needed. **Monitor permanent solution--**DON, ADON or designee will audit staff over the next 60 days to ensure training has been adequate and correct any errors found immediately. --Random weekly audits will be performed for the next 60 days by the SDC/ICN or their designee to ensure that O2 tanks are full. --Results of audits will be discussed at monthly QA meetings.	

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F 328	Continued From page 10 d. Review of physician orders showed the resident had an order for Albuterol (a medication used to treat wheezing and shortness of breath), 2 puffs every 6 hours as needed for wheezing and shortness of breath. e. Review of the resident's MAR documentation on 7/8/14 revealed the resident received Albuterol at 4:15 PM (more than six hours after the complaints of shortness of breath.) f. Interview with the DON on 7/10/14 at 8:55 AM revealed the facility expectation was for resident symptoms, such as wheezing and low pulse oximetry, to be reported to the nurse on duty. 2. Observation of resident #5 on 7/7/14 at 5:30 PM revealed the resident was seated in his/her wheelchair in the main dining room and received oxygen therapy through nasal cannula tubing. The resident was noticeably short of breath. Observation of the oxygen canister's gauge indicated the canister was empty. The following concerns were identified: a. Staff were observed assisting the resident with the evening meal; however, neither the resident's shortness of breath nor the empty oxygen canister were addressed until 5:50 PM, at which time the empty oxygen canister was replaced and staff assessed the resident's blood oxygen saturation at 87% (normal blood oxygen saturation levels are above 90%). b. Interview with the ADON on 7/9/14 at 1:10 PM revealed all staff were responsible for checking resident oxygen canisters as needed. 3. Review of the medical record for resident #39 showed the resident was admitted to the facility on 11/6/12 with diagnoses including chronic	F 328		

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F 328	Continued From page 11 obstructive pulmonary disease and received continuous oxygen therapy through nasal cannula tubing. The following concerns were identified: a. Observation on 7/8/14 at 9:35 AM revealed the resident self propelled his/her wheelchair into the bathroom in front of the nursing station. At 9:50 AM CNA #2 assisted the resident out of the bathroom, and the resident was heard to say, "I'm short of breath." CNA #2 started to walk away from the resident, and was stopped by CNA #1 who asked, "Did you check [resident's name] oxygen canister?" CNA #2 replied, "No." CNA #2 stated, "It's empty and needs to be changed." CNA #2 then replaced the oxygen canister; however, neither CNA #1 nor #2 assessed the resident's blood oxygen saturation or reported the resident's complaint of shortness of breath to nursing staff. b. Interview with CNA #3 at 11:10 AM verified CNAs were responsible for making sure oxygen canisters were not empty. Interview further revealed oxygen canisters were supposed to be checked when resident's were provided assistance with ADLs, and were usually checked when the resident was assisted with getting up in the morning. c. Interview with the ADON on 7/9/14 at 1:10 PM revealed all staff were responsible for checking resident oxygen canisters as needed.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F 371 #1** --The cleaning process of the double oven and convection oven will be modified from every 2 months to once a month and as needed. An in-service will be provided to all dining staff covering proper sanitary cleaning procedures of kitchen equipment and cross contamination, by 8/22/2014. Ovens will be cleaned routinely following the Policy: Cleaning Instructions: Ovens.	8/22/14

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F 371	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility cleaning records, the facility failed to ensure a sanitary environment was maintained in the kitchen and fixed food contact equipment located in the dining room and main lobby were maintained in a sanitary condition. The findings were: 1. Observation on 7/7/14 at 2:35 PM and 7/9/14 at 11:20 AM showed the following equipment was identified as requiring additional cleaning: a. The back and sides of the double oven and the convection oven had black burned on food that was crumbling and flaking on the floor of the oven. b. The top and back of the range top were coated with black grime. c. The side of the convection oven standing beside the range top was coated with blackened grime. d. The automated juice dispenser located in the dining room was coated with dried juice splatter near the dispenser. e. The automated cappuccino dispenser located in the dining room was coated with dried splatter near the dispenser. Interview with cook #1 at the time of the observation verified the ovens, juice and cappuccino dispensers should have been cleaned.	F 371	Compliance of deep oven cleaning will be recorded monthly. Daily and weekly cleaning of equipment will be audited for 60 days; at that time if in compliance monitoring will be done once a month. Reporting will be done at QA meetings. --The cooks will be reeducated on daily cleaning of the range with a review of the Policy: Cleaning Instructions: Ranges. Deep cleaning of the range will be done monthly and as needed. --Cleaning of the convection oven side that is next to the range will also be included in the above review. These procedures will be audited for 60 days at that time if in compliance monitoring will be done monthly. --7/11/2014, a hands on in-service was given to the dining staff pertaining to proper cleaning of the juice machine. This included the procedures of the juice machine being completely wiped down and sanitized after breakfast, lunch and dinner meals, once a week juice containers will be removed and clean water run through the dispenser nozzle. --This procedure will be monitored for 60 days, at that time if in compliance monitoring will be done monthly. --The cleaning procedure and a hands on in-service for the cappuccino dispenser will be reviewed with dining staff, by August 22, 2014. This procedure will be monitored for 60 days at which time if in compliance monitoring will be done monthly	

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F 371	Continued From page 13 Review of facility cleaning logs dated 2014, showed the last documentation the ovens had been cleaned was 1/22/14. 2. Observation of the automated soft serve ice cream dispenser located across from the front desk on 7/8/14 at 2 PM and 7/9/14 at 8:30 AM and 3:30 PM showed the drip tray had dried pink food splatter. Interview with LPN #3 on 7/9/14 at 3:30 PM revealed the ice cream dispenser was supposed to be cleaned daily, and verified staff should have cleaned the machine. 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." 3. Observation during the initial tour of the the kitchen on 7/7/14 at 2:35 PM showed the CDM failed to wear any hair restraint while working with cook #1 who was preparing food. Observation at 3:15 PM showed the CDM continued to work in the food preparation area without any hair restraint. Observation the same day at 5:15 PM showed the CDM was wearing a hair restraint, however it did not cover all her hair. Interview with the RD on 7/8/14 at 11 AM verified all staff working over food prep areas should wear hair restraints that covered all their hair. According to Food Code 2013, U.S. Public Health Service: 2-402.11 " (A) ...FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE	F 371	F 371 #2 --The hospitality center is checked on the A.M. shift and the P.M. to make sure all items are stocked and the area is neat and clean. The check times will be changed to twice on A.M. shift and twice on P.M. shift. Facility staff will be instructed to contact dining if the ice cream machine drip tray needs to be cleaned. --An in-service will be given to all dining staff on Policy: Employee Sanitary Practices; specifically addressing the wearing of hair restraints. This will be monitored on a daily and continuous basis. Noncompliance will result in proper disciplinary actions for the staff member.	

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

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F 371	Continued From page 14 and SINGLE-USE ARTICLES. "	F 371		8/22/14
F 441 SS=E	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 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	Infection Control/Prevent Spread F 441 **Correct deficiency--**An audit has been completed on all current infections and records have been updated, including organisms found(if cultured), treatment, and resolved date if applicable. No individuals were identified. **How others are identified and correction to others in similar situation--**An inservice will be planned on or before August 22nd on performance of hand hygiene, glove use, and peri care to help prevent the spread of infection. --Peri care will be completed on all residents using proper technique. --All handwashing and gloving will be completed using proper technique. --A facility schematic will be placed in the nurses report station and updated with current infections and isolation rooms if indicated. --Will in-service staff and update care plans related to increasing hydration of residents at risk for UTIs. A cross-departmental team has been assigned to complete a Performance Improvement Project related to increasing hydration. **Measures/systematic changes to prevent recurrence--**Proper peri care/ handwashing/ and gloving training will be provided to current staff by August 22nd, 2014. Staff was trained on proper c-diff isolation/ cleaning/ and linen removal and washing on July 15, 2014. Staff was also given corrective education on biohazardous waste removal and disposal with the head of Environmental Services on that same date. All incoming staff will be oriented with proper training on hand washing/ gloving/ isolation precautions/ and proper linen removal.	

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on staff interview,and review of the facility's infection prevention and control program data and facility policy, the facility failed to maintain a complete and accurate infection control program that included tracking, trending, and ongoing surveillance of facility infections. The findings were: Facility infection surveillance records were reviewed with the DON and the MDS coordinator on 7/10/14 at 10:50 AM. The following concerns were identified: a. Review of a facility document entitled, "Infection Rate Analysis Report" dated 3/1/14 through 5/31/14 showed the infection rate for the facility was 13.13%. The facility had a total of 26 infections, 11 or 42.5% of which were identified as urinary tract infections. Of the 11 urinary tract infections 7 had organisms which were isolated and identified by lab culture, 3 were reported as unknown, and 1 was reported as other. No documentation for infections was available from 6/1/14 through 7/9/14. No additional documentation was provided that showed evidence the infections were investigated for cause, trends, clusters, or that recommendations for corrective action had been developed and implemented to reduce or prevent infections. b. Interview with the DON at that time revealed she had only been in her position for a couple weeks. Interview further revealed the infection control position had been vacant for several weeks. The DON verified she and the MDS coordinator were currently overseeing the	F 441	**Monitor permanent solution--**The Staff Development Coordinator/Infection Control Nurse (SDC/ICN) or their designee w ill audit staff over the next 60 days to ensure training w as adequate and w ill correct any problems identifled immediately. --SDC/ICN or designee w ill maintain yearly competences of staff related to infection prevention techniques, and proper care for an infected individual. --Results of audits w ill be discussed at monthly QA meetings.	

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F 441	Continued From page 16 infection control program, The DON and MDS coordinator confirmed no additional documentation was available that identified clusters, trends of infections, or surveillance activities that monitored and investigated the cause of infections, therefore no recommendations or plans had been developed as preventative measures. In addition, documentation failed to show dates resident infections were resolved. c. Review of an undated facility policy entitled, "Infection Prevention and Control Program" showed, "The infection preventionist...is responsible for the quality of resident care as it relates to the investigation control, and prevention of infection...this includes perform surveillance, identify clusters of infection in a timely manner...track trends within the facility...identify infection control issues and make recommendations for corrective action...direct short and long range planning activities for infection prevention and control."	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility failed to ensure a safe environment was maintained for residents, staff, and visitors to the facility. The findings were:	F 465		

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F 465	Continued From page 17 Observation of the front outdoor patio on 7/8/14 at 4 PM revealed 6 residents and 1 visitor walking or seated on the patio. The patio was constructed of blocks of concrete which were noted to be uneven with raised edges between the blocks measuring approximately one-half inch to one and one-fourth inch. Resident #3 was ambulating with a wheeled walker around the perimeter of the patio weeding the raised flower beds. Observation further revealed the resident lifted up on the front of the wheeled walker over one section of raised uneven concrete (that measured approximately one and one-fourth inch) to assist the walker over the raised edge. Interview with the administrator on 7/10/14 at 9:10 AM revealed she had not noticed the raised, uneven edges of concrete on the patio. She also verified the raised, uneven edges were a potential fall hazard and needed to be fixed.	F 465	**F465** The facility maintenance department will ensure a safe walking surface for residents, visitors, and staff on the front patio area. The concrete will be shaved by a local contractor to eliminate the large level differences in the concrete. This work will be performed by a local contractor and will be assessed by the Maintenance Director for completion. During maintenance walk-arounds, the maintenance department employees will check for uneven surfaces and if they are found, they will be responsible to have them fixed. Results of any problem areas identified during walk-arounds will be reported to the Safety Committee.	8/22/14
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure adequate ventilation was maintained for 1 of 2 public/resident bathrooms (left side of nurses' station). The findings were: Observation of the public bathroom used by both residents and visitors (located across from the nursing station to the left side) on 7/7/14 at 6 PM,	F 467	**F 467** The proper ventilation in the public bathroom was restored and the vent cleaned on 7/10/14. The maintenance department is responsible for monitoring and fixing, and cleaning the ventilation as soon as an issue is identified. The maintenance director will check ventilation bi-monthly and the vents will be maintained in working order. Results of the ventilation checks will be reported to Safety Committee each month for 90 days.	8/22/14

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F 467	Continued From page 18 revealed there was a strong odor in the bathroom. Observation further revealed there was no window ventilation to the outside of the building and the mechanical vent located above the commode was covered with dust. Additional observation with the maintenance director on 7/10/14 at 12:15 PM showed the mechanical vent above the commode continued to be covered with dust. Interview with the maintenance director at the time of the observation confirmed the mechanical vent was not functioning properly.	F 467		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the physician of a laboratory result for 1 non-sample resident (#4). The findings were: Review of admission/re-admission orders dated 6/25/14 showed the resident #4 was re-admitted to the facility with orders for Coumadin (a blood thinning medication) 1 mg by mouth daily for 2 days, skipping the 3rd day, and repeating the pattern. Review of the history and physical signed 5/16/14 showed the Coumadin was used to prevent blood clots after a surgery to repair a fractured hip. Review of a physician's order dated 6/23/14 showed INR (International Normalized Ratio - a measurement of how quickly blood clots) results were to be communicated to the resident's orthopedic surgeon, and not to the	F 505	Promptly Notify Physician of Lab Results F 505 **Correct deficiency to individual**--Resident #4's orthopedic surgeon was notified via fax and multiple telephone calls on 7/10/14 regarding 1.4 INR level. He reported on a consult that this is the INR level he would like her to be at, and has not changed her dose since this time. Coumadin has since been discontinued. --No adverse effects were suffered by resident #4 due to subtherapeutic INR. **How others are identified and correction to others in similar situations**--Residents with coumadin prescribed by orthopedic surgeon will be identified on admission, and note will be made on MAR and in the chart that all INR results are to be sent to the surgeon, not the primary care provider. --All residents receiving coumadin will be identified weekly by the DON, ADON, or their designee, and will be presented at an Interdisciplinary Team Meeting.	8/22/14

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F 505	Continued From page 19 primary care physician. The following concerns were identified: 1. Review of laboratory results dated 7/1/14 showed the resident's INR was 1.3. There was no indication either the orthopedic surgeon or the primary care physician were notified of this result. 2. Review of laboratory results dated 7/8/14 showed the resident's INR was 1.4. The result was faxed to the primary care physician, but not to the orthopedic surgeon as ordered. 3. Interview with RN #1 on 7/10/14 at 8:55 AM confirmed the resident's Coumadin therapy was being managed by the orthopedic surgeon, and INR results should have been communicated to him.	F 505	**Measures/systematic changes to prevent recurrence**--A INR communication form will be implemented on or before August 22nd, 2014 to be used by nurses when contacting practitioners. Form will state current INR level, date it was drawn, current coumadin orders, and request notification of change of dose (if dose change is necessary) and date that next INR should be drawn. The form will state that a reply is requested before the end of business on the current date. --Nurses will also be asked to call the physician's office to notify them that the fax has been sent. If a reply has not been received by the end of the nurse's shift, the completed form will be given to the oncoming nurse, who will attempt to call the provider as well. The form will not be filed in the chart until a reply has been received from the practitioner. --The medical records designee has provided the clinics with a copy of each resident's face sheet, with the facility phone number highlighted, and has requested that the facility be called for notification of all physician communication of lab values. --Nurses will receive education regarding new INR communication form, and use of PT/INR flow sheet in MAR. --General fax communication form will be updated to ensure that facility name and phone number are clearly visible. **Monitor permanent solution**--Residents who are taking coumadin will be audited once a week by the DON, ADON, or their designee, for the next 60 days. Audit will include current labs, use of communication form, change of orders, and calendar used to schedule lab draws. --Results of audits will be discussed at monthly QA meetings.	