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

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WY Dept of Health
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Healthcare Licensing
Survey

PRINTED: 08/28/2014
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
	535048	A. BUILDING ____ B. WING ____	C 07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 82401

(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 CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual.	
F 152 SS=D	483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a legal-surrogate was designated in accordance with State law for 1 of 15 sample residents (#11). The findings were:	F 152	**F152:** The facility will ensure a legal-surrogate is designated in accordance with State law. Corrective Action: The Advanced Directive for Resident #11 was signed by the resident on 08/11/2014. Identification of other residents potentially affected: Records of Residents in the facility were reviewed on 08/26/14. Issues identified will be corrected. System Changes: Going forward the facility will have the resident sign all admission paperwork including Advanced Directive if there is no	9/7/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 9/5/14

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.

The POC was accepted with changes. Changes were reviewed with Dee Ozzemo and Heidi on 9/17/14 at 1430 K Mayhew State Surveyor

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F 152	Continued From page 1 Review of the medical record for resident #11 showed the admission documents were signed by a "legal representative" and/or "responsible party." In addition, the advance directive was signed by the "surrogate." There was no (POA) power of attorney included in the record. An interview with the admissions coordinator on 7/24/14 at 11 AM revealed an Admission Agreement was signed naming a "fiduciary party" on 3/5/14, to in-part, assume responsibility for payment of any fee and costs the resident owed the facility. Further review showed only the fiduciary party and a facility representative signed the document. It was not signed by the resident or notarized and did not indicate the relationship of the fiduciary party to the resident. Review of Title 35-22-403 Article 4 of the Wyoming Health Care Decision Act showed; "(b) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health care decision the principal could have made while having capacity. The power must be in writing and signed by the principal or by another person in the principal's presence and at the principal's expressed direction." Further, "None of the following shall be used as a witness for a power of attorney for health care: (iii) The operator of a community care facility or employee of the operator or facility..." Review of Article 4, to include the list of definitions used in the Act, did not show the term fiduciary used or defined.	F 152	established Durable Power of Attorney or Guardian. If patient has not been deemed incompetent by physician, but facility feels that patient is not solely capable of signing, an immediate family member will witness. The Administrator will provide oversight to this process. Monitoring: The Social Services Director/Designee will audit all new admission records on the next business day after the resident has been admitted to determine accurate identification of the responsible party and accurate completion specifically to the Advanced Directive form. The Social Services Director will document the results for three months and will trend accuracy. Findings will be reported to the Quality Assessment and Assurance Committee monthly. Negative trends will be action planned for process improvement. or until substantial compliance met KRn Education was provided to Social Services and Administrative Staff related to DPOA and Advance Directives. KRn	
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section,	F 202	F 202 The facility will ensure documentation is completed in the medical record related to transfers.	

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F 202	Continued From page 2 the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure documentation was completed in the medical record related to a resident transfer for 1 of 2 closed records (#63) reviewed. The findings were: Review of the medical record for resident #63 showed s/he had diagnoses to include gastroenteritis and colitis (inflammation of the colon). Review of the nurses notes dated 6/6/14, timed 3 AM showed the resident vomited "brownish-yellow fluid." At 6:30 AM the documentation showed the resident complained of abdominal pain throughout the night. His/her abdomen was "very distended, firm, tender..." At 8:45 AM, the note indicated the resident was sent to the emergency room in the facility van. The notes did not indicate the physician was notified of the resident's condition at any time prior to the transfer. In addition, there was no documentation to show physician orders for the transfer were obtained. An interview with the DON on 7/24/14 at 10:33 AM confirmed there was no additional documentation to include notification of the physician or written orders for the transfer. Further, she acknowledged the information needed to be included in the medical record.	F 202	Corrective Action: Patient #63 primary physician was the Emergency Room MD and there was verbal notification, but it was not documented in resident medical record. Licensed staff ~~and/or designee~~ have been re-instructed to ensure that notification to the physician of resident #63 condition prior to a transfer, and documenting the physician's order for the transfer is reflected in the resident's medical record. Identification of other residents potentially affected: All residents are found to be potentially affected by this deficient practice. System Changes: The Director of Nursing and/or designee shall re in-service charge nurses on the importance of documenting a physician's order for transfer to the emergency room and notification to the physician of a resident's condition prior to the transfer out of the facility. License Nurses shall be responsible on each shift to ensure that residents' medical record includes documentation that an order was obtained for a transfer to the emergency room and the residents' physician has been notified of the resident's condition prior to a transfer out of the facility. Monitoring: The Director of Nursing and/or designee will audit transfers out of the facility the	9/7/14

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on an ongoing basis KR

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F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**F 272** The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Corrective Action: 1. The Cognitive loss/dementia, ADL Function, Falls, and Pressure Ulcers CAAs on the 04/25/2014 Significant Change MDS assessment on resident #47 have been modified to include/identify causes and contributing factors, nature of issue/condition, complications, risk factors, any additional factors/issues specific to the resident, and if referrals are needed making it a full comprehensive summary reflecting the need for the care planning decision. 2. The Cognitive loss, behavior symptoms, activities, falls, and pressure Ulcers CAAS on the 03/31/2014 annual MDS assessment on resident #15 have been modified to include/identify causes and contributing factors, nature of issue/condition, complications, risk factors, any additional factors/issues specific to the resident, and if referrals are needed making it a full comprehensive summary.	9/7/14 9/7/14

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F 272	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure MDS assessments were comprehensive in a variety of areas for 7 of 13 sample residents (#11, #15, #17, #47, #50, #55, #57). The findings were: 1. Review of the 4/25/14 significant change MDS assessment for resident #47 showed several areas were triggered for additional assessments. Review of these individual CAAs showed they failed to summarize the data that was collected to demonstrate the need for the care planning decision. These areas that triggered and had non-comprehensive CAAs were as follows: Cognitive loss/dementia, ADL function, Falls, and Pressure Ulcers. 2. Review of the medical record showed resident #15 had diagnoses to include dementia, BPH (benign prostatic hypertrophy) and pressure ulcers. Review of the 3/31/14 annual MDS assessment, section V, showed the following areas triggered; cognitive loss, behavioral symptoms, activities, falls, and pressure ulcers. Review of the CAA summary report did not include the causes or contributing factors related to the identified problems. In addition, a comprehensive analysis of findings was not completed to include any risk factors associated with the care areas. 3. Review of the 8/1/13 significant change MDS assessment for resident #50 showed several areas were triggered for additional assessments. Review of these individual CAAs showed they failed to summarize the data that was collected to	F 272	3. The Delirium, Cognitive loss/dementia, Mood, and Nutritional Status CAAs on the 08/01/2013 Significant Change MDS Assessment on resident #50 have been modified to include/identify causes and contributing factors, nature of issue/condition, complications, risk factors, any additional factors/issues specific to the resident, and if referrals are needed making it a full comprehensive summary reflecting the need for the care planning decision. 9/7/14 4. The Cognitive Loss, Psychosocial Well-being, Urinary Incontinence, Falls, and Dehydration CAAs on the 04/03/2014 Admission MDS Assessment on resident #11 have been modified to include/identify causes and contributing factors, nature of issue/condition, complications, risk factors, any additional factors/issues specific to the resident, and if referrals are needed making it a full comprehensive summary. 9/7/14 5. The Delirium and Falls CAAs on the 07/21/2013 Annual MDS Assessment on resident #57 have been modified to include/identify causes and contributing factors, nature of issue/condition, complications, risk factors, any 9/7/14	

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F 272	Continued From page 6 demonstrate the need for the care planning decision. These areas that triggered and had non-comprehensive CAAs were as follows: Delirium, Cognitive loss/dementia, Mood, and Nutritional Status. 4. Review of the medical record showed resident #11 had diagnoses to include dementia and hemiplegia (paralysis on one side of the body). Review of the 4/3/14 admission MDS assessment, section V, showed the following care areas were triggered; Cognitive Loss, Psychosocial Well-being, Urinary Incontinence, Falls and Dehydration. Review of the CAA summary report did not include the causes or contributing factors related to the identified problems. In addition, a comprehensive analysis of findings was not completed to include any risk factors associated with the care areas. 5. Review of the 7/21/13 annual MDS assessment for resident #57 showed several areas were triggered for additional assessments. Review of these individual CAAs showed they failed to summarize the data that was collected to demonstrate the need for the care planning decision. These areas that triggered and had non-comprehensive CAAs were as follows: Delirium and Falls. 6. Review of the medical record showed resident #17 had diagnoses to include paraplegia, neurogenic bladder and dementia. Review of the 6/13/14 admission MDS assessment, section V, showed the following areas triggered; Falls, Pressure Ulcers and ADL function. Review of the CAA summary report did not include the causes or contributing factors related to the identified problems. In addition, a comprehensive analysis	F 272	additional factors/issues specific to the resident, and if referrals are needed making it a full comprehensive summary reflecting the need for the care planning decision. 6. The Falls, Pressure Ulcers, and ADL Function CAAS on the 06/13/2014 Admission MDS Assessment on resident #17 have been modified to include/identify causes and contributing factors, nature of issue/condition, complications, risk factors, any additional factors/issues specific to the resident, and if referrals are needed making it a full comprehensive summary. 7. The Cognitive Loss/dementia CAA on the 04/25/2014 Annual MDS for resident #55 have been modified to include/identify causes and contributing factors, nature of issue/condition, complications, risk factors, any additional factors/issues specific to the resident, and if referrals are needed making it a full comprehensive summary reflecting the need for the care planning decision. Identification: All residents are found to be potentially affected by the deficient practice.	9/7/14 9/7/14

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F 272	Continued From page 6 of findings was not completed to include any risk factors associated with the care areas. 7. Review of the 4/25/14 annual MDS assessment for resident #55 showed the area of Cognitive Loss/dementia was triggered for additional assessment. Review of the CAA showed no summary of the data that was collected to demonstrate the need for the care planning decision. 8. Interview with the MDS assessment coordinator on 7/24/14 at 8 AM revealed she and other professionals were responsible to complete specific CAAs. After reviewing some of the above examples, the coordinator verified additional education was needed on how to complete the analysis of findings.	F 272	System Changes: On 08/12/2014 the MDS and Care Planning team was in-serviced by facility's Corporate Regional MDS Coordinator on the correct practices on how to complete the analysis of the findings. Going forward all CAAs will be reviewed and corrected as needed by responsible disciplines before transmission. The MDS Coordinator and/or designee will oversee this process. Monitoring: The facility MDS Coordinator and/or designee will monitor weekly for the first three (3) months then monthly thereafter. Issues identified will be corrected at that time. To ensure sustained compliance, the Director of Nursing/Designee will review a minimum of 10% MDS assessments monthly. Negative trends will be action planned and prioritized for process improvement. The MDS Coordinator will report findings monthly to the Quality Assessment and Assurance Committee.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced	F 274		

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F 272	Continued From page 6 of findings was not completed to include any risk factors associated with the care areas. 7. Review of the 4/25/14 annual MDS assessment for resident #55 showed the area of Cognitive Loss/dementia was triggered for additional assessment. Review of the CAA showed no summary of the data that was collected to demonstrate the need for the care planning decision. 8. Interview with the MDS assessment coordinator on 7/24/14 at 8 AM revealed she and other professionals were responsible to complete specific CAAs. After reviewing some of the above examples, the coordinator verified additional education was needed on how to complete the analysis of findings.	F 272		
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F 274	Continued From page 7 by: Based on medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 1 of 4 sample residents (#47) requiring this type of assessment. The findings were: Review of the medical record showed resident #47 was transferred to the hospital and was found to have a hip fracture. The resident had surgery to repair the hip and returned to the facility on 6/20/14. Review of the 4/25/14 significant change MDS assessment showed the resident was independent for ADLs with the exception of toileting/hygiene and bathing prior to the injury. Review of the 7/1/14 - 7/22/14 resident personal care record documentation showed the resident now required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting, personal hygiene, and bathing. Interview with the MDS coordinator on 7/22/14 at 4:33 PM verified the resident had a decline in ADL's and a significant change MDS assesment may be required based on the resident's significant change in functional status.	F 274	Disciplinary Team will review records of residents residing at facility to determine if a significant change in the resident's physical or mental status has occurred. This review will include the comparison between the most recent Minimum Data Sheet to the prior Minimum Data Sheet. If a significant change in status was determined a significant change in status assessment will be completed. System Changes: The Inter Disciplinary Team will review the status of residents each quarter. Additionally, Monday through Friday, barring holidays and weekends, the IDT is responsible to review residents with changes of conditions, as reported by the Director of Nursing and/or designee in the daily stand-up to determine if a significant change MDS assessment may be required. If the team determines that a significant change has occurred the assessment will be completed by the 14th calendar day following the determination. The Interdisciplinary Team, which includes Social Services Director, Certified Dietary Manager, MDS Coordinator, and Activities Director has been re-in-serviced by the Corporate Regional MDS Coordinator on 08/12/14 with regards to this process. The Director of Nursing/Designee will oversee this process.	
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	F 279		

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	535048	A. BUILDING _____ B. WING _____	C 07/24/2014

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F 274	Continued From page 7 by: Based on medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 1 of 4 sample residents (#47) requiring this type of assessment. The findings were: Review of the medical record showed resident #47 was transferred to the hospital and was found to have a hip fracture. The resident had surgery to repair the hip and returned to the facility on 6/20/14. Review of the 4/25/14 significant change MDS assessment showed the resident was independent for ADLs with the exception of toileting/hygiene and bathing prior to the injury. Review of the 7/1/14 - 7/22/14 resident personal care record documentation showed the resident now required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting, personal hygiene, and bathing. Interview with the MDS coordinator on 7/22/14 at 4:33 PM verified the resident had a decline in ADL's and a significant change MDS assesment may be required based on the resident's significant change in functional status.	F 274	Monitoring: The Director of Nursing, Material Data Nurse and/or Designee will be responsible to review MDS assessments upon completion x 3 weeks, then random selection of 3 charts monthly x 3, then random selection of 3 charts quarterly to determine if a significant change MDS assessment may be required based on the residents' significant change in functional status Issues identified will be corrected at that time. Negative trends will be action planned and prioritized for process improvement. Findings will be reported to the Quality Assessment and Assurance Committee.	
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	F 279	**F 279** The facility will use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. Corrective Action **Resident #11** – Care Plan was modified on 07/25/2014 by the Director of Nursing and/or Designee to ensure that all the triggered areas (cognitive impairment, ADL	9/7/14

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F 279	Continued From page 8 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a comprehensive care plan was developed for 2 of 13 sample residents (#11, #15). The findings were: 1. Review of the CAA summary for the 4/3/14 admission MDS assessment for resident #11 showed a care plan was to be developed for cognitive impairment, ADL function, urinary incontinence, psychosocial well-being, activities, falls, nutritional status, dehydration, physical restraints and pain. There were no care plans developed for these areas until 6/24/14, 80 days after the completion of the admission assessment. 2. Review of the 3/31/14 annual MDS assessment showed resident #15 had diagnoses to include dementia. Section V of the assessment showed care plans were to be developed for the following areas; behaviors, cognition and nutrition. Review of the care plan for behaviors and cognition showed they were not developed	F 279	function, urinary incontinence, psychosocial well-being, activities, falls, nutritional status, dehydration, physical restraints, and pain) were carried over from the initial care plan, dated 03/05/2014, to the comprehensive care plan, dated 06/24/2014, accordingly with the initial problem date. **Resident #15** – Care Plan was modified on 07/25/2014 by the Director of Nursing and/or Designee to ensure that all triggered areas (behaviors, cognition, and nutrition) were carried over from the initial care plan to the updated comprehensive care plan. Identification Residents residing in the facility are potentially affected by this alleged statement of deficient practice. A review of current residents' care plans will be completed by 09/07/14 by the IDT to ensure residents have a comprehensive care plan developed specific which shall include cognitive impairment, ADL function, urinary incontinence, psychosocial well-being, activities, falls, nutritional stats, dehydration, physical restraints, pain, and behaviors, as determined by the CAA summary, section V. Systemic Changes Residents will be reviewed upon admission, quarterly, annually, and with significant change of condition utilizing the	9/7/14

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F 279	Continued From page 9 until 5/16/14, 46 days after the assessment was completed. In addition, the care plan for nutrition was not developed until 5/23/14, 53 days later. 3. During an interview with the DON on 7/23/14 at 8:15 AM, she acknowledged the care plans should have been developed at the time the problem was identified.	F 279	admission/MDS/RAI/ Care planning process. Care plans will be developed to include services provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being, including ensuring a care plan is in place to address the resident's cognitive impairment, ADL function, urinary incontinence, psychosocial well-being,	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was revised to reflect the resident's	F 280	activities, falls, nutritional status, dehydration, physical restraints, behaviors, and pain. The Director of Nursing and/or Designee will re-in-service the Inter Disciplinary Team and Nursing staff on care plan preparation. Nursing staff unable to attend will be provided re-in-servicing , upon return to work and/or at a designated time . Monitoring Individual care plans to be reviewed and revised, to include services provided based on individual need, upon admission and quarterly, annually and with change of condition. Care plan documentation review will be completed quarterly. Issues identified through this review will be discussed at the Quality Assessment and Assurance Committee meetings for the purpose of process improvement and to ensure the plan has been implemented, sustained and evaluated for its effectiveness. The Director of Nursing is responsible to ensure compliance is achieved and sustained.	

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was revised to reflect the resident's	F 280	**F 280** The facility will ensure that a comprehensive care plan is developed within 7 days after the completion of the comprehensive assessment. Corrective Action **Resident #15** – Care Plan was updated to reflect the use of the padded foot peddles (foot buddy) and that the right heel is a scabbed pressure ulcer (closed) and an order was clarified to moisturize feet during dressing change. **Resident #47** - Care Plan was updated to reflect the need for extensive staff assistance with ADL's. Identification All residents are found to be potentially affected by this deficient practice. For identification purposes, a review of current residents' care plans will be completed to pinpoint residents at the facility potentially at risk for care plans lacking specific details regarding ADL function and adaptive equipment.	9/7/14 9/7/14

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F 280	Continued From page 10 current status for 2 of 13 sample residents (#15, #47) The findings were: 1. Observation on 7/22/14 at 10:10 AM showed RN #1 change the wound dressing for resident #15. The wounds were located on the left and right heels. Eucerine cream was applied to the intact skin surrounding the wound. Further, the resident's wheelchair had padded foot peddles to reduce further skin breakdown. Review of the care plan for pressure ulcers showed the resident only had a wound on the left heel. Further, it did not indicate the resident was to use padded foot peddles while in the wheelchair. During an interview with the DON on 7/24/14 at 8:15 AM, she acknowledged the care plan needed to be updated. 2. Review of the July 2014 "Resident Monthly Personal Care Record" showed resident #47 required extensive assistance with two person support for all ADLs. Prior to a hip fracture and return to the facility on 6/20/14, the resident was coded on the 4/25/14 significant change MDS as independant in most ADLs. Review of the care plan for help with ADLs showed it was last reviewed and updated on 5/15/14. The increased need for extensive staff assistance with ADLs was not reflected on the care plan. Interview with the MDS coordinator on 7/24/14 at 8 AM verified the care plan was in need of updating.	F 280	System Changes: Residents will be reviewed upon admission, quarterly, annually, and with significant change of condition utilizing the admission/MDS/RAI/ Care planning process. Care plans will be developed to include services provided to attain or maintain their highest practicable physical, mental, and psychosocial well-being, including ensuring a care plan is in place to address the resident's adaptive equipment, pressure ulcers, and ADL Function. The Director of Nursing and/or Designee will in-service the Interdisciplinary Team and Nursing staff on care plan preparation by 09/07/2014. IDT and/or Nursing staff unable to attend will be provided in-servicing upon return to work and/or at a designated time. Monitoring: The MDS Coordinator and/or designee shall conduct random review of 3 residents' records, specific to care plans weekly x 3 weeks, than monthly x 3 than quarterly until compliance achieved and sustained. Based on the findings, immediate corrective action shall be taken, if necessary. Results of the random record reviews shall be reported to the Director of Nursing for review and reporting to the	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	Quality Assessment and Assurance Committee meetings for the purpose of process improvement and to ensure the plan has been implemented, sustained and evaluated for its effectiveness.	

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	F 371 The facility will procure food from sources approved or considered satisfactory by	

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F 371	Continued From page 11 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the cleaning schedule, the facility failed to ensure a sanitary environment in 2 of 2 areas (the kitchen, and the break room) where food and food equipment was stored. The findings were: 1. Observation on 7/21/14 at 4:25 PM showed the juice dispenser located on the counter near the service window in the kitchen had dripping juice on the nozzles and in the drip tray. In addition, the drain from the drip tray was a plastic tube that drained into an open movable bucket on the floor. The bucket contained 6 to 8 inches of juice that had drained and appeared to be bubbled on the surface and had a foul odor. Additionally, the hood vents located above the range had buildup of grease and dust. Observation on 7/23/14 at 1:30 PM showed the vents remained unclean. 2. Observation on 7/23/14 at 1:30 PM showed the ice machine located in the employee break room had a broken cracked plastic part inside where the lid came down. The broken area created a condition which was unable to be cleaned. In addition, the white interior part of the machine where the ice fell behind into the bin was noted to have areas of a blackish substance. 3. Interview with the dietary manager on 7/23/14 at 1:30 PM verified the juice machine was to be	F 371	Federal, State, or local authorities and store, prepare, distribute, and serve food under sanitary conditions. Corrective Action: 1. a) The juice machine was cleaned thoroughly on 07/25/14. The machine has been placed on cleaning list to be cleaned at the end of each AM Dietary Aide shift and PM Dietary Aide shift. 9/7/14 b) The hood vents above the range were cleaned thoroughly on 07/25/14. This task will be done each week by the dietary aide that is responsible for putting freight away. 9/7/14 c) The drain line of beverage dispenser to be re-routed to in-direct waste pipe by certified licensed plumber. 9/7/14 2. a) The ice machine in Employee Break room was cleaned thoroughly on 07/23/14 by Certified Dietary Manager. The Dietary Aide that is responsible for putting freight away will be responsible for cleaning ice machine weekly. 9/7/14 b) The facility's Refrigerator Repair Company has been contacted and they have ordered a new frame for	

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F 371	Continued From page 12 cleaned at the end of each shift. The bucket containing the overflow was to be emptied with the cleanings, and this was the usual method for collecting the liquid. During the interview, the dietary manager referred to the kitchen cleaning list to see when the hood vents were last cleaned. Review of this list showed they were cleaned that day 7/23/14; however, upon inspection the dietary manager confirmed a more detailed cleaning was needed. She also verified the ice machine was in need of cleaning and the broken part needed to be replaced. 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." According to Food Code 2013, U.S. Public Health Service: 4-204.121 "...(B) VENDING MACHINES that dispense liquid FOOD in bulk shall be: (1) Provided with an internally mounted waste receptacle for the collection of drip, spillage, overflow, or other internal wastes; and (2) Equipped with an automatic shutoff device that will place the machine out of operation before the waste receptacle overflows. (C) Shutoff devices specified under Subparagraph (B)(2) of this section shall prevent water or liquid FOOD from continuously running if there is a failure of a flow control device in the water or liquid FOOD system or waste accumulation that could lead to overflow of the waste receptacle."	F 371	around the door of the ice machine – it will be replaced when parts ordered obtained. 3. a) The juice machine was cleaned thoroughly on 07/25/14. The machine has been placed on cleaning list to be cleaned at the end of each AM Dietary Aide shift and PM Dietary Aide shift. 9/7/14 b) The hood vents above the range were cleaned thoroughly on 07/25/14. This task will be done each week by the dietary aide that is responsible for putting freight away. 9/7/14 c) The drain line of beverage dispenser to be re-routed to in-direct waste pipe by certified licensed plumber. 9/7/14 Identification of other residents potentially affected: All residents are found to be potentially affected by this deficient practice. System Changes: The Dietician and Certified Dietary manager will in-service all dietary staff on August 20, 2014 to review new weekly and daily cleaning lists and the expectations for these and all cleaning jobs in the Dietary Department.	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 371	Continued From page 12 cleaned at the end of each shift. The bucket containing the overflow was to be emptied with the cleanings, and this was the usual method for collecting the liquid. During the interview, the dietary manager referred to the kitchen cleaning list to see when the hood vents were last cleaned. Review of this list showed they were cleaned that day 7/23/14; however, upon inspection the dietary manager confirmed a more detailed cleaning was needed. She also verified the ice machine was in need of cleaning and the broken part needed to be replaced. 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." According to Food Code 2013, U.S. Public Health Service: 4-204.121 "...(B) VENDING MACHINES that dispense liquid FOOD in bulk shall be: (1) Provided with an internally mounted waste receptacle for the collection of drip, spillage, overflow, or other internal wastes; and (2) Equipped with an automatic shutoff device that will place the machine out of operation before the waste receptacle overflows. (C) Shutoff devices specified under Subparagraph (B)(2) of this section shall prevent water or liquid FOOD from continuously running if there is a failure of a flow control device in the water or liquid FOOD system or waste accumulation that could lead to overflow of the waste receptacle." F 441 483.65 INFECTION CONTROL, PREVENT	F 371	Monitoring: The Certified Dietary Manager and/or designee will monitor weekly for the first three (3) months and then monthly ongoing if satisfactory. Findings will be reported to the Quality Assessment and Assurance Committee monthly. Negative trends will be action planned for process improvement. F 441 The facility will establish and maintain and	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	C 07/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441 SS=D	Continued From page 13 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 Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Corrective Action: On 07/28/14 the Director of Nursing re-inserviced RN, CNA #1, and CNA #2 on the facility's Infection Control practices to ensure proper hand washing, Identification: Identification of other residents potentially affected: All residents are found to be potentially affected by this deficient practice. Rounds were made in the facility on August 8, 2014 by the Director of Nursing and/or Designee to identify any infection control issues. Issues identified were corrected at that time. Systemic Changes: The Director of Nursing and/or Designee will in-service the RN's, LPN's, and C.N.A's on or before date of compliance the facility's Infection Control practices as they pertain to ensuring proper hand washing and ensuring there is no Food/fluids stored on the medication carts. Nursing staff unable to attend will be provided re-education upon return to work by the Director of Nursing and/or a qualified designee.	9/7/14

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F 441	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of education check lists, the facility failed to ensure infection control practice were followed during 2 random observations. The findings were: 1. Observation on 7/22/14 at 10:10 AM showed RN #1 provide wound care for resident #15. The RN removed the dressing from the resident's left heel. She removed the old dressing with gloved hands then remove the gloves and donned a second pair without first washing her hands. The RN then proceeded to apply the clean dressing. 2. Observation on 7/22/14 at 8:40 AM showed resident #55 was assisted with toileting and transferred to bed by CNA #1 and CNA #2. The CNAs used a sit-to-stand mechanical lift to transfer the resident from the wheelchair to a standing position. While up in the lift the CNAs changed the resident's soiled brief, both aides wore disposable gloves. After changing the brief, the aides removed the soiled gloves and proceeded to provide care for the resident without any hand hygiene. The care included CNA #2 arranging the resident's blankets and putting the oxygen cannula on the resident's face. Interview with CNA #2 on 7/23/14 at 9:50 AM verified they were taught to wash their hands after removing the soiled gloves. During an interview with the infection control nurse on 7/23/14 at 1 PM, she confirmed hands needed to be cleansed after gloves are removed. Review of the undated skills check list for perineum care showed gloves are to be removed	F 441	Monitoring: The Director of Nursing and/or Designee will complete visual rounds of care delivery three (3) times weekly for one (1) month, then weekly for one (1) month, then monthly and prn thereafter to ensure staff are washing hands per policy. Issues identified will be tracked and corrected at that time, trends as well as infection control reports will be presented in the Quality Assessment and Assurance meeting by the Director of Nursing and/or Designee to ensure plan has been implemented, sustained, and evaluated for its effectiveness. The Director of Nursing shall be responsible to ensure compliance achieved and sustained.	

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F 441	Continued From page 15 and hands washed "before adjusting clean clothing an/or personal items i.e. oxygen tubing/cannulas."	F 441		