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

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 _____	08/28/2014

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

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F 000	INITIAL COMMENTS A health comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on August 28, 2014 following a Wyoming Department of Health survey on July 10, 2014. Survey Dates - August 25, 2014 to August 28, 2014. Survey Census: 56 Medicare: 5 Medicaid: 29 Other: 22 Total: 56 Sample Size: 14 Supplemental Sample: 12	F 000		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure six residents (R20, R21, R22, R23, R24 and R25	F 167	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Korell — TITLE: Administrator — (X6) DATE: 10/1/14

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.

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F 167	Continued From page 1 and F1, a family member, had been apprised of the location and results of the most recent survey. Findings include: During the Group Interview on 8/26/14 at 9:45am the surveyor asked the residents in attendance "Do you know that you can see a copy of the facility's latest survey inspection results? Do you know where that report is kept here?" Six of twelve residents stated they did not know where the report was located or that they could read the report. Review of the Brief Interview for Mental Status (BIMS) scores with the Director of Nursing on 8/27/14 at 4pm for the six residents who stated they were unaware of the survey results revealed the following: R20 - 13/15 which indicated the resident was cognitively intact; R21 - 12/15 which indicated the resident was moderately impaired; R22 - 13/15 which indicated the resident was cognitively intact; R23 - 14/15 which indicated the resident was cognitively intact; R24 - 14/15 which indicated the resident was cognitively intact and R25 - 14/15 which indicated the resident was cognitively intact. During a family interview on 8/27/14 at 12:30pm, F1 was asked about the location and survey results. F1 stated she had not been informed about the location of the results, but would be interested in reading them. During an interview with the Administrator on 8/27/14 at 2pm about the residents and the family who were unaware of the survey results, the Administrator stated she was unaware that residents had not been apprised of survey	F 167		

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F 167	Continued From page 2 results.	F 167		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medical justification for use of the restraint; that it was the least restrictive method; and the risks and benefits of the restraints had been discussed with the family for one (R12) of one resident reviewed for restraints in a sample of 14. Findings include: During an initial tour of the facility on 8/25/14 at 5pm with the Director of Nursing (DON), R12 was observed seated in a wheelchair with a seat belt in place. During an introduction to the resident, the surveyor asked the DON if the resident could remove the seat belt. The DON asked R12 to remove the belt; R12 fumbled with the seat belt and did not seem to understand what was requested. R12 was unable to remove the seat belt. The DON stated the family requested the use of the seat belt to prevent falls. R12 was observed on 8/26 at 10am in a wheelchair with the seat belt in place, on 8/27/14 at 12pm in a wheelchair with the seat belt in place and on 8/28/14 at 9:45am in a wheelchair in the	F 221	F221 Correct deficiency to individual Resident #12 was identified as no longer having the physical and/or cognitive ability to open the self-releasing seat belt attached to her wheelchair. Resident's DPOA was contacted 9/16/14. The risk vs. benefits of self-releasing seatbelt were discussed and DPOA verbalized agreement to discontinue seatbelt use. Resident's primary care provider was telephone and orders were obtained to discontinue the use of the self-releasing seat belt. Seat belt was removed from R12's wheelchair 9/16/14 and pressure sensing alarms have been placed on resident's wheelchair and bed. Care plan has been updated. How others are identified and correction to others in similar situations: Currently no other residents use a self-releasing seat belt or restraining device. Going forward, the facility will ensure medical justification for use of any restraint and the risk vs. benefits of the restraint will be discussed with the family and primary care provider. Measures/Systematic changes to prevent recurrence: Charge nurses and the interdisciplinary team will be educated on using the least restrictive method of care to ensure resident safety. Monitor permanent solution: The ADON/designee will audit 2-3 resident's care plans each week for the next 90 days to make sure they are reflective of varied alternatives vs. restraints to assist residents with fall prevention. Results of audits will be discussed at monthly QA meetings.	10/9/14

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F 221	Continued From page 3 Activity Room with the seat belt in place. On 8/28/14 at 5pm, DA1 was asked if R12 could release the seat belt, DA1 stated that R12 needed supervision and cueing and was inconsistent in responding to questions. DA1 stated she was unsure if R12 could remove the seat belt. Interview with the Social Service Designee (SSD) on 8/28/14 at 2pm about R12's seat belt revealed that she was unsure if R12 could release the seat belt. The SSD stated that the seat belt had been applied as a result of R12's poor safety awareness. The SSD stated that R12 was unable to answer questions appropriately. Review of the "Face Sheet" in R12's medical record revealed that R12 was admitted on 4/4/11 with diagnoses that included: SP fracture of the acetabulum; pelvic fracture; vascular dementia with delirium; hypertension; difficulty in walking; and muscle weakness. Review of the quarterly Minimum Data Set (MDS) dated 5/20/14 revealed that R12 rarely or never understood, had moderately impaired decision making skills and required supervision and cues. The MDS further indicated that R12 required assistance with activities of daily living and had an unsteady balance during walking and transfers. Review of the "Pre-Restraining Evaluation" form dated 1/8/13 indicated that R12 had a fracture of the left humerus [upper arm bone] on 12/6/12, was unsteady with balance while seated and during transfers. Check marks in the "Restraint Alternative" section of the report revealed "exercise strengthening" with Occupational and	F 221	Measures/Systematic changes to prevent recurrence: Charge nurses and the interdisciplinary team will be educated on using the least restrictive method of care to ensure resident safety. Monitor permanent solution: The ADON/designee will audit 2-3 resident's care plans each week for the next 90 days to make sure they are reflective of varied alternatives vs. restraints to assist residents with fall prevention. Results of audits will be discussed at monthly QA meetings.	

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F 221	Continued From page 4 Physical Therapy." Review of documentation in the "Recommendations" section of the report revealed, "No falls since placement of self-releasing seat belt...family satisfied with the results of no falls. The self-release seat belt was applied..." There was no other documentation provided regarding attempted alternatives to the use of the seat belt. Review of the "Care Plan" revised 5/27/14 with a documented goal date of 11/20/14 revealed "Resident at risk for falls r/t [related to] impulsive behaviors: poor safety awareness..." Review of the section related to the "Goal" indicated "will not have a serious injury r/t falls...," "Interventions" revealed "to have self -releasing alarming belt on w/c [wheelchair] that she can release on own without difficulty." There was no other documentation regarding alternatives to restraint use. Review of the quarterly "Interdisciplinary Care Conference Worksheet" dated 8/26/14 revealed that a "self-releasing seat belt" was being used by R12. However there was no documentation regarding any attempted alternatives to the use of the restraint or how the seat belt would be discontinued. Review of the Restraint Evaluation, Care Plan, Quarterly Interdisciplinary Care Conference notes with the Assistant Director of Nursing (ADON) on 8/27/14 at 4:30pm revealed there was no documentation related to the use of alternative methods to reduce the restraints. The ADON stated that the family requested the use of the restraint because R12 had falls and the seat belt	F 221		

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F 221	Continued From page 5 was initiated on 1/8/13. When asked about medical justification for the use of the restraint, the ADON stated there was no documentation related to medical justification, nor was a physician's order available for review. When the surveyor asked the ADON about informing R12's legal representative about the risks and benefits of the restraint, the ADON referred the surveyor to the "Interdisciplinary Progress Notes" of 1/18/13. Review of documentation dated 1/18/13 revealed "Son is requesting additional alarm or intervention to signal staff when resident transfers independently. Discussed using self-releasing seat belt alarm...want to keep her safe as possible...w/c was fitted with self-releasing alarmed seat belt."	F 221		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that its abuse prohibition policy accurately specified that allegations of abuse, neglect, mistreatment or misappropriation of resident property should be reported "immediately" to the Administrator and to the State Agency (SA.) This had the potential to affect all 56 residents in the facility.	F 226		

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F 226	Continued From page 6 Findings include: Review of the policy titled "Abuse and Neglect Prevention Standard" dated 04/2009, revealed the following direction provided in section VII. Reporting/Response: "Report alleged incidents as required to all local/state/federal agencies within 24 hours of the allegation." The "Abuse Allegation Checklist" contained within the policy included additional verbiage for staff to report allegations of abuse and/or neglect... "as soon as possible, at least by the end of the shift" rather than "immediately" as required. During an interview on 8/27/14 at 4:45pm, the Social Services Designee (SSD) stated that it was her understanding that the facility had "up to 24 hours" to make an initial report to the SA. During an interview on 8/27/14 at 6:45pm and again on 8/28/14 at 9am, the Administrator reported that staff "have to report (alleged violations) within 24 hours to the State..."	F 226	F226 To prevent residents from being affected by this deficient practice, the Abuse and Neglect Prevention Standard has been revised to state that "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). All staff members are required to report suspected abuse immediately to the administrator of the facility and the administrator is responsible for immediately reporting the allegation to the appropriate state agencies. Staff education was completed on 9/18/14 at the monthly all staff meeting. New staff will be trained each month at New Employee Orientation as an ongoing measure of compliance. Current staff are educated at least yearly, or more often as is required by the Abuse and Neglect Prevention Standard. Administrator or designee will do a walk-around audit monthly to interview staff on the reporting process. Results will be reported at monthly QA Meeting.	10/9/14
F 272 SS=D	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;	F 272		

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F 272	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the unstageable wound had been assessed for one (R1) of eight residents at risk for pressure ulcers in the sample of 14. The findings include: Admission record review indicated R1 was admitted to the facility with diagnoses that	F 272	F272 10/9/14 Correct deficiency to individual: 08/05/2014 Quarterly MDS assessment for R1 will be changed to properly reflect the resident's risk for pressure ulcers r/t diagnoses of COPD and left above the knee amputation. This MDS will also be changed to reflect the current pressure ulcers and deep tissue injury and then re-submitted into CMS. See attached sheet for further diagnoses. Care plan for resident R1 has been updated to show that resident is at risk for skin breakdown, pressure ulcers, and the current interventions have been updated. How others are identified and correction to others in similar situations: Nurses will receive education in the next 30 days on the proper protocol of filling out the TAR upon admission and with the discovery of new wound and or pressure ulcers. The weekly pressure ulcer records will be checked during the MDS lookback period. Weekly skin issues are reviewed each week in the interdisciplinary Risk meeting. New skin issues are reviewed daily through the unusual occurrence reporting process. MDS Coordinators will update care plans based upon information gathered from the above sources.	

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F 272	Continued From page 8 included but were not limited to chronic airway obstruction; left amputee above the knee and anxiety. Review of R1's pressure ulcer record with onset date of 7/7/14 indicated R1 had unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough and/or eschar in the wound bed) wound below the nares/nose. The wound measured one centimeter (cm) length by one cm width; depth was unknown. The record also indicated, "Purple black discoloration noted beneath nares..." Review of R1's pressure ulcer record with an onset date of 7/27/14 indicated R1's right heel had a DTI (purple or maroon area of discolored intact skin due to damage of underlying soft tissue). The wound measured 30 cm length by 25 cm width; depth was unknown. Review of R1's clinical observation note dated 7/27/14 indicated that R1's right heel had black callous, pain to touch and concern of deep tissue injury. The note also indicated that R1's right ear had a small open area caused by the oxygen tubing. Review of R1's quarterly MDS dated 8/5/14 under section M0210 indicated zero that meant, R1 did not have a pressure ulcer. On 8/26/14 at 11:03am, RN1 was observed to assess R1's ears, right heel and beneath her nares. RN1 described R1's right outer heel and beneath R1's nares with black "but lighter black in color, intact." RN1 described R1's right ear with an open area, approximately 0.5cm diameter, a Stage II pressure ulcer (partial thickness loss of	F 272	Measures/Systematic changes to prevent recurrence: Implementation of weekly meetings with ICN and MDS team to discuss all wounds. Monitor permanent solution: MDS audits of proper use of section M for R1 and other residents will be performed per assigned protocol. Audits will be completed by MDS coordinator and or designee and reported at monthly QA meetings.	

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F 272	Continued From page 9 dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister). During an interview on 8/26/14 at 1:10pm with MDS1 (MDS Coordinator), the surveyor asked MDS1 the basis of information when coding section M0210. The MDS1 stated that she would use the pressure ulcer reports, look at the treatment sheets and would ask RN4 (who was involved with wound care) for any additional information if necessary. During an interview on 8/26/14 at 1:20pm with the MDS2, she stated that she didn't know why section M0210 of the MDS was not coded as having a pressure ulcer when she knew R1 had a wound on her nares and right heel. "I must have missed it. It should have been coded as one [has pressure ulcer]." The MDS1 then asked RN4 for all R1's pressure ulcer assessments of her nares and right heel on or prior to 8/5/14 (from 7/8/14 to 8/5/14), RN4 stated she had none. During an interview on 8/26/14 at 11:11am with RN4, she stated that her role related to wound care was to visualize, measure the size and depth of the wound, describe the color and drainage if any, and stage the pressure ulcer weekly. The surveyor asked RN4 about the missing pressure ulcer assessments for R1 dated from 7/8/14 through 8/26/14, RN4 stated she had a new position and wasn't able to follow up her weekly assessments since her last note on 7/7/14 and stated, "I was busy doing other stuff." RN4 confirmed that she did not assess R1's nares from 7/8/14 through 8/26/14, right heel and right ear from 7/27/14 through 8/25/14.	F 272		

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F 272	Continued From page 10 During an interview on 8/28/14, RN4 stated that R1's pressure ulcer beneath her nares and right heel have not worsened since her last assessment. RN4 stated, "It had not changed at all, [R1's] heel is still with DTI and her nares are still unstageable." The MDS for R1 dated 8/5/14 was not coded accurately and completely as follows: Section M0210 - Unhealed Pressure Ulcer; Section M0300 - Current number of healed pressure ulcer at each stage; Section M0610 - Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar; Section M0700 - Most Severe Tissue Type for Any Pressure Ulcer and Section; Section M0800 - Worsening in Pressure Ulcer Status Since Prior Assessment. Review of the Resident Assessment Instrument (RAI) manual dated 10/2013 indicated the following coding instructions under Section M0210: Unhealed Pressure Ulcer with the question of, does the resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? "Code based on the presence of any pressure ulcer (regardless of stage) in the past 7 days." "Code 0, no: if the resident did not have a pressure ulcer in the 7-day look-back period. Then skip items M0300-M0800." "Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to Current Number of Unhealed Pressure Ulcers at Each Stage Item (M0300)."	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 11 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §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 observation, interview and record review, the facility failed to develop a comprehensive care plan to address a methicillin-resistant staphylycoccus areaus (MRSA) wound infection and use of contact isolation precautions for one (R5) of two residents reviewed for infection in the sample of 14. The findings include: On 8/25/14 at 6pm, R5 was observed in the Dining Room with dry dressing around his right foot. On 8/26/14 at 2pm, R5 was observed in his room with a dry dressing around his right foot and ankle foot orthosis (AFO - foot device) applied to his right foot.	F 279	Correct deficiency to individual: Care plan was updated for Resident #R5 to include contact precautions with dressing changes. Staff was educated verbally and on assignment sheets of the need for contact precautions during dressing changes, per facility policy. Resident still receives dressing changes to wound on foot, and contact precautions are used at this time. How others are identified and correction to others in similar situations: Residents with infectious processes requiring isolation precautions are identified on admission, and measures to provide precautions will be prepared at this time, and staff will be educated. When a current resident is diagnosed with a condition requiring infection precaution besides standard precautions, the resident will receive the proper precautions and staff will be educated. Measures/systematic changes to prevent recurrence: The interdisciplinary team reviews each resident's record prior to admission, and will make admitting nurse aware of history of infectious disease and need for precautions. All current infections are reviewed by the interdisciplinary team, during weekly Risk meetings. Monitor permanent solution: Care plan audits to be completed by assigned team members, e.g.: MDS coordinator and or designee, on a weekly basis, for the next 90 days. Results of audits will be discussed at monthly QA meetings.	10/9/14

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F 279	Continued From page 12 Review of R5's admission record revealed R5 was admitted to the facility of 7/21/14 with diagnoses that included but not limited to decubitus ulcer Stage III, diabetes mellitus and cerebrovascular accident. Review of R5's progress notes from the hospital dated 7/21/14 revealed, "Culture obtained of R [right] heel wound. Pt [patient] MRSA [methicillin-resistant staphylococcus areaus - refers to Staphylococcus aureus bacteria that are resistant to treatment with semi-synthetic penicillins, e.g., Oxacillin/Nafcillin/Methicillin] positive." Review of R5's antimicrobial susceptibility and organism identification report with a date reported on 8/12/14 revealed two organisms found on R5's right heel wound: Escherichia coli (name of a type of bacteria that lives in the human intestine) and MRSA. Review of R5's physician's order dated 8/13/14 indicated, "I.V. [intravenous] Vanco [vancomycin]...1 gram via every 24 hours for ten days...Keflex 250 milligram (mg) QID [four times a day] for seven days." (Vancomycin is an antibiotic medication that has been considered to be the reference standard for the treatment of MRSA infections.) Review of R5's care plan problem with onset date of 7/29/14 indicated Stage III pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone and tendon or muscle are not exposed) on right heel noted upon admission. R5's care plan problem with onset date of 7/29/14 also revealed R5 "at risk for dehydration related to...infection of wound and antibiotic treatment."	F 279		

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F 279	Continued From page 13 Further review of R5's care plan revealed no documentation to address R5's MRSA wound infection on the right heel. R5's care plan also revealed the lack of the necessary interventions to prevent the spread of infection including use of contact isolation precautions. During an interview on 8/26/14 at 2:45pm, the Assistant Director of Nursing (ADON) stated that R5 was on contact isolation due to MRSA on his right heel wound. The ADON reviewed R5's care plan and confirmed that contact isolation precaution was not addressed in the care plan. During an interview on 8/26/14 at 2:50pm with the Minimum Data Set Coordinator (MDS1), she stated that she was aware of R5's infection on the right heel wound because R5 was receiving antibiotic medication. MDS1 also reviewed R5's care plan and confirmed that the facility failed to develop a comprehensive care plan that addressed the MRSA wound infection on R5's right heel including the use of contact isolation precautions. Review of the facility's policy dated, "Revised December 2011" titled, "MRSA - Management of Recurrent Skin and Soft Tissue Infection" revealed, "CDC [Centers for Disease Control and Prevention] recommends contact precautions when the facility (based on national or local regulations) deems MRSA to be of special clinical and epidemiologic significance."	F 279		
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	F 280		

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F 280	Continued From page 14 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, interview and record review, the facility failed to ensure that care plans were reviewed and revised after each fall for two (R3 and R9) of five residents reviewed for falls in a sample of 14. Findings include: 1. Observation during the initial tour of the facility on 8/25/14 at 5pm revealed that R9 was seated in the hallway propelling her wheelchair. Observation revealed that a nasal cannula was in place with oxygen being administered continuously at 2 liters per minute. Review of the quarterly Minimum Data Set (MDS) assessment dated 6/10/14 revealed that R9 was	F 280	F280 Correct deficiency to individual: Charge nurses have been educated on the importance of updating the care plan after each fall, and helping to provide interventions to prevent falls in the future. Residents R9 and R3's care plans have been updated to reflect that they are at a high risk for falls, and current interventions have been brought up to date. Direct caregivers have been educated on the interventions in place for these residents to reduce risk of falls How others are identified and correction to others in similar situations: A review will be completed within the next 30 days to identify residents who are at a high risk for falls, and these care plans will be reviewed to make sure they include interventions to prevent falls. Any falls from this point forward will be reviewed by the interdisciplinary team, as part of the unusual occurrence process. At this time, the MDS coordinator or their designee will be responsible for reviewing and updating the care plan to reflect new and current interventions. The MDS coordinator will also be responsible for updating the assignment sheets to communicate to direct staff the new plan of care for each resident after a fall. Measures/systematic changes to prevent recurrence: All falls will be reviewed by the interdisciplinary team as part of the unusual occurrence process. All unusual occurrences are also discussed at weekly risk meetings.	10/9/14

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F 280	Continued From page 15 admitted on 5/10/11 with diagnoses that included: pre-senile dementia, depressive disorder, anxiety state and hypertension. Review of the "Cognitive Status" of the MDS revealed that R9 rarely or never understood and was moderately impaired in decision making. Review of the "Functional Status"revealed R9 was non-ambulatory and required assistance with activities of daily living. Review of "Fall Risk Assessment" dated 6/6/14 indicated the total score was "20" which indicated that R9 was at "high risk" for falls. Review of the "History of Falls" revealed the following: 12/23/13 - two falls; 3/19/14 - two falls; 5/8/14 - two falls; and 6/6/14 - two falls. Review of the "Track Risk Accurately, Consistently and Easily" (T.R.A.C.E) form and the "Interdisciplinary Progress Notes" indicated that R9 incurred the following incidents: 8/4/13 - 9:00pm - Review of the IDT Notes indicated "Resident observed on floor by couch in hallway on floor near couch... No injury noted. Was observed sitting on floor." Review of the documentation revealed there were no IDT Notes regarding recommendations to prevent recurrence. 10/20/13 - 2pm Review of the IDT Notes indicated "Resident fell while attempting to transfer self from couch to w/c. Resident missed seat of w/c and landed on bottom on floor." Review of the IDT Notes dated 10/20/13 indicated "Have staff be aware of resident's location in hallways and couches at end of hallway." Review of the "CNA [Certified Nurse Assistant] Care	F 280	Monitor permanent solution: Chart audits will be completed for the next 60 days by the MDS Coordinator or their designee, to ensure that residents at a high risk for falls have a current care plan, reflective of the interventions in place to prevent further falls. Results will be reported at the monthly QA Meeting.	

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F 280	Continued From page 16 Guide dated August 2014 revealed there was no documentation regarding guidance for staff to follow regarding resident's supervision in order to prevent recurrence of falls. Review of R9's Care Plan indicated "Encourage resident to call for assistance with transfers and toileting." 11/25/13 5:05pm - Review of the IDT notes revealed "Resident observed on floor, no injuries noted" Review of the documentation revealed there were no IDT Notes regarding recommendations. However, review of the Care Plan revealed "PT screen strengthening."Review of the PT notes indicated R9 required increased supervision. 12/23/13 6:30pm - Review of the IDT notes revealed "Resident was observed on floor in room. No injury noted." Review of the IDT notes dated 12/24/14 indicated "No injuries when self-transfers. Will place on restorative plan for strengthening." 3/20/14 - 12:35am - Review of documentation in the IDT Notes revealed "Observed on floor in sitting position attempting to scoot toward doorway. Sustained a 1 cm [centimeter] skin tear to right eyebrow...friction abrasions noted to right shoulder and right knee. Swollen hematoma present to dorsal aspect of right hand." Review of the IDT notes dated 3/20/14 indicated "Resident has been ill with gastroenteritis, increased confusion/weakness. Continue to follow care plan." There was no documentation	F 280		

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F 280	Continued From page 17 related to recommendations to prevent recurrence of falls. 3/31/14 - 11:05am - Review of documentation in the IDT Notes indicated "Transferred from wheelchair to recliner and fell." No injury. Review of the Care Plan indicated there was no documentation to indicate that R9's Care Plan had been revised. 5/8/14 4:10pm - Review of the IDT Notes indicated "Walked to doorway unassisted and without w/c and fell on bottom. Notified by CNA that resident was on floor. No injuries noted" Review of the IDT Notes dated 5/9/14 indicated "Low grade temp [temperature] of 99 noted, also has periods of fatigue. Physician will be faxed with above concerns and request for UA/CS [urinalysis and culture and sensitivity]." On 8/27/14 at 5:15pm, the surveyor asked the ADON about follow up information related to the fax and the UA. The ADON reviewed the documentation in the clinical record and was unable to locate any information regarding this recommendation. 6/6/14 - 12:45pm - Review of the IDT Notes indicated Domestic Aide heard resident fall but didn't see her fall. Resident observed on the floor lying on her left side next to lounge chair at end of A Hall." No injury. Review of the Interdisciplinary (IDT) Team Notes dated 6/9/14 indicated "Resident cognition is not always present. She self-transfers with poor safety awareness on regular basis. Resident also does not remember to lock the wheelchair (w/c) brakes, continue to encourage resident to do this.	F 280		

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F 280	Continued From page 18 Continue with current plan of care." Review of the intervention on the TRACE form dated 6/6/14 indicated "Continue to encourage resident to not self-transfer." There was no documentation on the Care Plan that this information had been included in the interventions. The surveyor reviewed the Care Plan and documented interventions following each incident with the Assistant Director of Nursing (ADON) on 8/27/14 at 5:15pm. The ADON confirmed that interventions had not been revised following each incident. The ADON stated that interventions were not consistently effective and lacked measurable outcomes. Review of the "CNA Care Guide" related to R9 revealed there was no documentation to guide the CNA's regarding supervision and/or care to prevent R9 from further falls. Review of the "Fall - Clinical Protocol" dated April 2013 indicated in the section related "Monitoring and Follow-Up," "The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling." 2. Review of R3's annual comprehensive Minimum Data Set (MDS) assessment dated 1/28/14 and quarterly MDS assessment dated 7/15/14, revealed R3 was independently ambulatory with a walker, with supervision. The 1/28/14 MDS assessment noted a BIMS [Brief Interview for Mental Status] score of "5/15" which indicated that R3's cognition was severely	F 280		

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F 280	Continued From page 19 impaired. R3's "Fall Risk Assessment" dated 8/20/14, had a total score of "17." A total score of 10 or more is an indication that R3 was at "high risk" for falls. R3 was assessed as having a fall risk score of "19" on 7/15/14 and 4/22/14, and a score of "21" on 4/8/14, indicating that R3 had been consistently assessed throughout the year as being at high risk for falls. On 8/26/14 at 2:50pm, R3's clinical record was reviewed jointly with MDS2 and MDS1. The review revealed R3 had experienced a total of nine falls in the seven month period from 1/26/14 - 8/20/14. Of the nine falls, R3's clinical record reflected that the following seven falls resulted in injury or required further evaluation in the Emergency Room: 2/20/14 - 1 cm abrasion to R3's mid-spine; 3/24/14 - 12cm x 3cm abrasion to R3's mid-spine; 4/8/14 - 2cm x 2cm abrasion to R3's right forehead. R3 was sent to the Emergency Room for evaluation; 5/20/14 - blood pressure 170/120. R3 was sent to the Emergency Room for evaluation; 5/21/14 - 4cm x 2cm hematoma beneath R3's left eye; 8/13/14 - 4cm x 0.5cm bruise to the out aspect of R3's left eye and a 18cm x 15cm bruise to R3's upper arm; 8/20/14 - Bruising to R3's left eye and left upper	F 280		

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F 280	Continued From page 20 arm; R3's care plan was reviewed on 8/26/14 at 2:50pm, in the presence of MDS2 and MDS1. R3's care plan contained the following fall related problem: "[R3] is at risk for falls r/t [related to] hx [history] of falls, orthostatic hypotension." This problem was dated " /9/14 [sic]." The goal listed for R3's fall related problem was, "[R3] will not have serious injuries related to falls." The revision date for this goal was listed as "7/28/14." Interventions listed for addressing R3's problem with falls were: "Keep walker within [R3's] reach at all times; [R3] needs a night light on to help see at night; Encourage [R3] to ask for assist with ambulation prn [as needed]; Monitor for changes in [R3's] condition that may warrant increased supervision/assistance and notify the physician." During the review of R3's care plan on 8/26/14 at 2:50pm, MDS2 and MDS1 were asked if any of the nine falls that occurred between 1/26/14 and 8/21/14, had been determined to be attributable to the lack of R3's walker being in close proximity, or to the lack of a night light. MDS2 replied "No," none of the falls had been attributed to R3's walker not being readily accessible. MDS2 also reported that the night light was a standard intervention for residents. When asked if there had been any change in the level of supervision required for R3 to ambulate, MDS2 reported there had been no changes and that R3 was still able to ambulate independently with her walker.	F 280		

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F 280	Continued From page 21 Documentation pertaining to each fall was reviewed with MDS2 and MDS1 to determine whether R3's care plan interventions had been reviewed or revised following the fall. MDS2 and MDS1 reported the interdisciplinary team (IDT) reviewed each fall after it occurred. However, neither MDS2 nor MDS1 were able to present evidence to show that R3's care plan had also been reviewed after each fall to determine if current care plan interventions were appropriate, if revisions were warranted to prevent additional falls from occurring, or if there was any identifiable factors corresponding to R3's falls.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to monitor existing pressure ulcers and ensure preventive measures were in place to prevent the development of pressure ulcers for two (R1 and R6) of eight residents at risk for pressure ulcer in the sample of 14. Findings include:	F 314		

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F 314	Continued From page 22 1. During the initial tour of the facility with the Director of Nursing (DON) on 8/25/14 at 5pm, R6 was observed seated in a recliner in her room. A Foley catheter bag was observed attached to the third handle of the bedside table and was resting directly on the floor. During the observation the DON informed the surveyor that R6 had a macerated area on the buttocks. Review of the "Face Sheet" in R6's medical record indicated that R6 was admitted to the facility on 6/16/11 with diagnoses that included: general muscle weakness, difficulty in walking, edema and chronic kidney disease. Review of the quarterly Minimum Data Set (MDS) dated 5/27/14 indicated a Brief Interview for Mental Status (BIMS) Score of "13" which indicated R6 was cognitively intact. Review of the "Functional Status" revealed R6 required extensive assistance for bed mobility, activities of daily living and transfers. The MDS further indicated that R6 required an indwelling catheter. Review of the section related to "Skin Conditions" indicated R6 was at risk for developing pressure ulcers. Review of the "Report of Consultation" dated 2/11/14 and signed by the Registered Dietitian (RD) indicated "Reason for Visit" and "Wound Review." Documentation revealed, "RD informed open areas to R [right] and L [left] buttock - reported unimproved." Review of the 3/24/14 RD report revealed "Reason for Visit" and "Wound on bilateral buttocks reported unimproved by nursing." "Continue current plan of nutrition care."	F 314	F314 Correct deficiency to individual R6 wound evaluated excluding measurement and staging by RN. Started weekly wound assessment. MD faxed on area deterioration. Resident refused referral to specialist initially has since agreed to go to appointment and an appointment was made on Thursday 9/18/14. R1 wounds were evaluated with measurements and wound staging performed by RN. Started weekly wound assessment. MD faxed on areas of concern. Foam padding applied and present to O2 tubing. Mepilex foam to heel for protection, skin prep applied to ears for protection, tab to o2 nasal tubing was clipped to prevent further pressure to area. Staff educated on need to loosen o2 tubing. Care plan and care guide (assignment sheet) updated. Social services is working with family to obtain new shoes. How others are identified and correction to others in similar situations: Review of residents at risk for pressure ulcers to identify all residents with areas of concern. Residents with pressure ulcers have been assessed and weekly skin assessment forms have been completed and are up-to-date. Care plans and treatments have been updated to address those residents at risk of developing pressure ulcers.	10/9/14

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F 314	Continued From page 23 During an interview with RN1 on 8/26/14 at 5:10pm regarding open areas on R6's buttocks, the RN confirmed that there was no documentation available for review regarding the measurement or stage of the areas. RN1 stated she had observed the areas on 8/21/14. At that time, R6's coccyx area was described as "reddened" with a purple area approximately 4 inches by 5 inches in circumference. RN1 also reported a Stage 2 open area on the left buttock approximately 3.5 cm by 2.0 cm, with occasional bleeding noted to the area. RN1 described the right buttock as a Stage 2 approximate 1.5 x 1.0 cm open area with occasional bleeding. RN1 stated both areas had been "acquired." Review of the R6's August, 2014 "Treatment Orders" revealed there was no documentation related to treatment of the open areas on the buttocks. Review of an undated "Policy for Wound Care and Documentation" indicated, "It is the policy of this facility to provide wound care as needed and to record care given. Wound assessment documentation will be completed at least weekly and as changes in the wound are apparent. Weekly documentation will include a description of the area, including color, size, depth, location, extent of any drainage; condition of the wound area, as well as surrounding area; assess for pain; determine any isolation precautions needed." 2. Admission record review for R1 indicated R1 was admitted to the facility with diagnoses that included but were not limited to chronic airway obstruction; left amputee above the knee and	F 314	F314 Correct deficiency to individual R6 wound evaluated excluding measurement and staging by RN. Started weekly wound assessment. MD faxed on area deterioration. Resident refused referral to specialist initially has since agreed to go to appointment and an appointment was made on Thursday 9/18/14. R1 wounds were evaluated with measurements and wound staging performed by RN. Started weekly wound assessment. MD faxed on areas of concern. Foam padding applied and present to O2 tubing. Mepilex foam to heel for protection, skin prep applied to ears for protection, tab to o2 nasal tubing was clipped to prevent further pressure to area. Staff educated on need to loosen o2 tubing. Care plan and care guide (assignment sheet) updated. Social services is working with family to obtain new shoes. How others are identified and correction to others in similar situations: Review of residents at risk for pressure ulcers to identify all residents with areas of concern. Residents with pressure ulcers have been assessed and weekly skin assessment forms have been completed and are up-to-date. Care plans and treatments have been updated to address those residents at risk of developing pressure ulcers. Staff education was provided by the SDC on 9/18/14 on pressure reduction strategies. In-service on wound prevention and treatment will be provided to all charge nurses on October 7th and 9th. Systematic changes to prevent reoccurrence Weekly skin assessments will be performed on all residents. Additional area specific weekly assessments will be performed on residents who are found to have areas of concern. Weekly wound assessments will be re-introduced to floor nurses within the next 90 days to enhance continuance of care. Monitor permanent solution SDC/ICN or designee will audit weekly skin assessments for completeness and any concerns that arise will be corrected immediately. Yearly I services will be provided to staff to enhance knowledge of pressure sores and their treatment. Results of audits will be discussed at monthly QA meetings.	10/9/14

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F 314	Continued From page 24 anxiety. Review of R1's pressure ulcer record with an onset date of 7/7/14 indicated R1's below the nares/nose had an unstageable wound (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed). The wound measured one centimeter (cm) length by one cm width; depth was unknown. The record also indicated, "Purple black discoloration noted beneath nares..." Review of R1's pressure ulcer record with an onset date of 7/27/14 indicated R1's right heel had a deep tissue injury (DTI - purple or maroon area of discolored intact skin due to damage of underlying soft tissue). The wound measured 30 cm length by 25 cm width; depth was unknown. Review of R1's clinical observation note dated 7/27/14 indicated that R1's right heel had black callous, pain to touch and concern of deep tissue injury. The note also indicated that R1's right ear had a small open area caused by the oxygen tubing Review of R1's physician orders indicated the following treatment orders: 7/8/14: Cleanse beneath nares or center of nose with normal saline, apply skin prep and comfeel dressing, check daily and change every three days. 7/8/14: Try to reduce tension at nose and ears after oxygen application. 7/28/14: Continue to pad tubing in the ear or nose	F 314		

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F 314	Continued From page 25 irritation or breakdown. Have physical therapy evaluate heel. 8/1/14: Float/pad heel at night, continue to reduce tension or pad on nasal tubing under nose and behinds ears. Review of R1's care plan problem dated 7/7/14 indicated a purple or black discoloration beneath nares or center of nose that included approaches, but not limited to reposition oxygen cannula every two hours and as needed and remind resident to reduce oxygen tubing tension at nose and ears. R1's care plan dated 7/27/14 indicated a problem of posterior right ear with an open area due to oxygen tubing that included approaches but not limited to frequently assess oxygen tubing, keep loose, and use of skin protectant to non-open area. Review of the Physical Therapy (PT1) notes dated 8/8/14 indicated, "Also visualized R[right] heel. Area is purple and tender with palpation. Recommended to nursing that they apply mepilex foam to cushion area, find open heeled shoes and use booties/cushion to float heels at night." On 8/26/14 at 11:03am, RN1 was observed to assess R1's ears, right heel and beneath her nares.The surveyor observed R1 did not have protector on her oxygen tubing behind her ears. R1 was also observed wearing a closed shoe on the right foot. When RN1 removed R1's shoe, R1's right heel was observed without the use of a mepilex foam to cushion the area. RN1 then proceeded to describe R1's right outer heel and underneath R1's nares with black, "but lighter black in color, intact."	F 314		

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F 314	Continued From page 26 RN1 took off the oxygen tubing behind R1's right ear and examined R1's right ear. RN1 stated there was no skin breakdown and began to put the oxygen tubing back behind R1's right ear. The surveyor requested RN1 to remove the oxygen tubing and re-assess R1's right ear with the use of a flashlight. When RN1 examined and re-assessed R1's right ear, RN1 stated, "Yes, I see there is a open area there." RN1 described R1's right ear, located on the top area with an open wound approximately 0.5 cm in diameter, superficial, Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister). RN1 stated, "It's related to pressure of the oxygen tubing." During an interview on 8/26/14 at 11:15am with RN1, when asked the type of treatment and intervention for R1's right ear in order to prevent R1 from developing a pressure ulcer, RN1 stated, "We are to reduce the tension of the oxygen tubing. I am going to put the oxygen padding on now and will notify the physician." Review of R1's pressure ulcer record dated 8/26/14 with onset date of 8/26/14 indicated R1 had a Stage II pressure ulcer on the right ear. The pressure ulcer measured 0.5 cm length by 0.4cm width. The pressure ulcer record also indicated, "Noted Stage II pressure wound to R [right] superior ear from 02 [oxygen] tubing." Further review of R1's nurse's notes indicated that on 3/14/14, R1 complained of pain behind her right ear and noted to have two reddened	F 314		

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F 314	Continued From page 27 areas, one located at the top and the other located in the middle behind the ear. During an interview on 8/26/14 at 11:11am, RN4 stated that her role with wound care was to visualize, measure the size and depth of the wound, describe the color and drainage if any and stage the pressure ulcer weekly. RN4 stated, on 3/14/14 she was still working as a floor nurse and was not involved with wound care. RN4 stated that she could not locate the assessment of R1's right ear for 3/2014. The surveyor asked RN4 if she had done weekly pressure ulcer assessments for R1's right heel, beneath the nares and right ear from 7/8/14 through 8/26/14, RN4 stated she had a new position and wasn't able to follow up her weekly assessment since her last note on 7/7/14. "I was busy doing other stuff." RN4 confirmed that R1 did not have pressure ulcer assessments on her right heel, beneath the nares and right ear from 7/8/14 through 8/26/14. During an interview on 8/26/14 at 1:40pm, the Director of Nursing (DON) stated, "The first one to identify the wound is responsible for filling out the pressure ulcer report ...then the wound is evaluated weekly by [RN4]." The DON also stated that they have implemented a new intervention of using foam pad wrap around the oxygen tubing for those residents who are using oxygen. The DON stated that the Domestic Aides are the ones putting the foam at the beginning of each month. During an interview on 8/26/14 at 2pm with DA1 and DA2, DA2 stated that she recalled being instructed by the ADON to pad the oxygen tubing. DA2 stated, "Whenever we see that they [residents] don't have one [pad], we put them on.	F 314		

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Two weeks ago I put them on; I check them as I see them. I haven't seen [R1] yesterday." DA1 also stated, "I have not also seen [R1] yesterday. DA2 stated, we should be looking at every one of them. We have different duties every day. Someone has to look at them once a week."

During an interview on 8/26/14 at 4:45pm, R1 stated, "It hurts in the middle and on the top of my ear." When asked if she has had the oxygen tubing padded before, R1 stated that she never had one. "They just put that today. I don't have the pain if I have a pad on my oxygen and I feel the pressure if with no pad."

On 8/27/14 at 12:21pm, R1 was observed in the main dining room eating lunch. On 8/27/14 at 12:25pm, the surveyor asked LPN1 the interventions for R1's open area on the right ear. LPN1 stated, "To monitor her ear every shift, she should have the green protector on the tubing." When LPN looked at the oxygen tubing on R1's right ear, the pad was not placed behind her ear. LPN stated, "This pad is misplaced and should be behind her ears."

Review of the facility's undated policy titled, "Policy for Prevention of Pressure Ulcers" revealed, "Relief/reduction of pressure as needed...Assess skin that is susceptible to friction forces carefully and document.

Review of the facility's undated policy titled, "Policy for Wound Care and Documentation revealed, "It is the policy of this facility to provide wound care as needed and to record care given. Wound assessment documentation will be completed at least weekly and as changed in the wound are apparent. Weekly documentation will

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F 314	Continued From page 29 include a description of the areas, including color, size, depth, location, extent of drainage, condition of the wound area, as well as surrounding area; assess for pain...weekly documentation of skin care also will include measures used to prevent the development of pressure ulcers..."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each fall was assessed to determine the effectiveness and appropriateness of current and new interventions for two (R3 and R9) of six residents who had incurred falls in a sample of 14. Findings include: 1. Observation during the initial tour of the facility on 8/25/14 at 5pm revealed that R9 was in the hallway propelling her wheelchair. Observation revealed that a nasal cannula was in place with oxygen being administered continuously at 2 liters per minute. Review of the quarterly Minimum Data Set (MDS) dated 6/10/14 revealed that R9 was admitted on	F 323	F323 Correct deficiency to individual: Nurses were educated on 9/4/14 on the importance of unusual occurrence reports/investigations when a resident has a fall. Charge nurses have been educated on the importance of updating the care plan after each incidence, and providing new interventions to prevent falls in the future. Charge nurses are responsible for reviewing current interventions to ensure they are still valid and if they are not, they need to update them on the care plan. The DON has spoken with the therapy department about the necessity of referrals for PT/OT screens on every fall. How others are identified and correction to others in similar situations: The interdisciplinary team will review all unusual occurrence/unusual investigation reports related to falls. All residents who have experienced a fall will have a referral for a PT/OT screening. Resident's care plans will be updated with new interventions for each fall.	10/9/14

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F 323	Continued From page 30 5/10/11 with diagnoses that included: pre-senile dementia, depressive disorder, anxiety state and hypertension. Review of the "Cognitive Status" of the MDS revealed that R9 rarely or never understood and was moderately impaired in decision making. Review of the "Functional Status" revealed R9 was non ambulatory and required assistance with activities of daily living. Review of the "Fall Risk Assessment" dated 6/6/14 indicated the total score was "20" which indicated that R9 was a "risk" for falls. Review of the "History of Falls" revealed the following 12/23/13 - two falls; 3/19/14 - two falls; 5/8/14 - two falls; and 6/6/14 - two falls. Review of the "Track Risk Accurately, Consistently and Easily" (T.R.A.C.E) form and "Interdisciplinary Progress Notes" (IDT) indicated that R9 incurred the following incidents: 8/4/13 - 9:00pm Review of the IDT Notes indicated "Resident observed on floor by couch in hallway on floor near couch... No injury noted. Was observed sitting on floor." Review of the documentation revealed there were no IDT Notes regarding recommendations to prevent recurrence. 10/20/13 - 2pm Review of the IDT Notes indicated "Resident fell while attempting to transfer self from couch to w/c. Resident missed seat of w/c and landed on bottom on floor." Review of the IDT Notes dated 10/20/13 indicated "Have staff be aware of resident's location in hallways and couches at end of hallway." Review of the "CNA [Certified Nurse Assistant] Care	F 323	Residents who are reluctant to have therapy or restorative services interventions after falls will have documented education on the benefits of these services, and family members will receive documented education as well. Measures/systematic changes to prevent recurrence The interdisciplinary team will discuss resident's fall risk, dates and times of previous incidences, current interventions, and new interventions. Changes to residents' care plans will be communicated to nursing staff, along with a list of those residents at a high risk for falls. Interventions as a result of therapy screens will be presented at IDT meetings. Monitor permanent solution Weekly audits will be performed by the DON, ADON, or their designee, to check the completeness of unusual occurrence reports, changes to the care plan, and the new interventions that have been put in place as a result of the IDT meetings. Results of audits will be discussed at monthly QA meetings.	

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F 323	Continued From page 31 Guide" dated August 2014 revealed there was no documentation regarding guidance for staff to follow regarding resident's supervision in order to prevent recurrence of falls. Review of R9's Care Plan indicated "Encourage resident to call for assistance with transfers and toileting." 11/25/13 5:05pm - Review of the IDT notes revealed "Resident observed on floor, no injuries noted" Review of the documentation revealed there were no IDT Notes regarding recommendations. However, review of the Care Plan revealed "PT [Physical Therapy] screen strengthening." Review of the PT notes indicated R9 required increased supervision. 12/23/13 6:30pm - Review of the IDT notes revealed "Resident was observed on floor in room." No injury noted. Review of the IDT notes dated 12/24/14 indicated "No injuries when self-transfers. Will place on restorative plan for strengthening." 3/20/14 - 12:35am Review of documentation in the IDT Notes revealed "Observed on floor in sitting position attempting to scoot toward doorway. Sustained a 1 cm [centimeter] skin tear to right eyebrow...friction abrasions noted to right shoulder and right knee. Swollen hematoma [localized swelling filled with blood] present to dorsal aspect of right hand." Review of the IDT notes dated 3/20/14 indicated "Resident has been ill with gastroenteritis, increased confusion/weakness. Continue to	F 323		

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F 323	Continued From page 32 follow care plan." There was no documentation related to recommendations to prevent recurrence of falls. 3/31/14 - 11:05am - Review of documentation in the IDT Notes indicated "Transferred from wheelchair to recliner and fell." No injury. Review of the Care Plan indicated there was no documentation to indicate that R9's Care Plan had been revised. 5/8/14 4:10pm Review of the IDT Notes indicated "Walked to doorway unassisted and without w/c and fell on bottom. Notified by CNA that resident was on floor. No injuries noted" Review of the IDT Notes dated 5/9/14 indicated "Low grade temp [temperature] of 99 noted, also has periods of fatigue. Physician will be faxed with above concerns and request for UA/CS [urinalysis and culture and sensitivity]." On 8/27/14 at 5:15pm, the surveyor asked the ADON about follow up information related to the fax and the UA. The ADON reviewed the documentation in the clinical record and was unable to locate any information regarding this recommendation. 6/6/14 - 12:45pm Review of the IDT Notes indicated Domestic Aide heard resident fall but didn't see her fall. Resident observed on the floor lying on her left side next to lounge chair at end of A Hall." No injury. Review of the IDT Notes dated 6/9/14 indicated "Resident cognition is not always present. She self-transfers with poor safety awareness on regular basis. Resident also does not remember to lock the wheelchair (w/c) brakes, continue to	F 323		

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F 323	Continued From page 33 encourage resident to do this. Continue with current plan of care." Review of the intervention on the TRACE form dated 6/6/14 indicated "Continue to encourage resident to not self-transfer." There was no documentation on the Care Plan that this information had been included in the interventions. The surveyor reviewed the Care Plan and documented interventions following each fall with the Assistant Director of Nursing (ADON) on 8/27/14 at 5:15pm. The ADON confirmed that interventions had not been revised following each fall. The ADON stated that interventions were not consistently effective and lacked measurable outcomes. Review of the "CNA (Certified Nurse Assistant) Care Guide" related to R9 revealed there was no documentation to guide the CNA's regarding supervision and/or care to prevent R9 from further falls. Review of the "Fall - Clinical Protocol" dated April 2013 indicated in the section related "Monitoring and Follow-Up," "The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling." 2. Review of R3's clinical record revealed R3 had a total of nine falls during the seven month period from 1/26/14 - 8/26/14. Review of the "Unusual Occurrence Report" for each of the nine falls revealed the following: 1/26/14 at 4:40pm - R3 was "attempting to sit [and] stated she missed the chair. Pt [patient]	F 323		

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F 323	Continued From page 34 found sitting on floor on buttocks [with] legs out in front of her..." 2/20/14 at 7:40am - "Observed [R3] on floor in her room sitting on buttocks at foot of bed. Knocked over bedside table; noted 1 cm diameter abrasion mid back on spine." 3/24/14 at 11:30pm - "Found [R3] on floor with back resting against wooden vanity. [R3] reports was [up] to bathroom and just 'sat down'..." 4/8/14 - R3's Interdisciplinary Progress Notes dated 4/8/14 at 11:30pm noted R3 had been found lying on the floor under the sink with a 2cm x 2cm abrasion to her right forehead. 4/8/14 at 3:20pm - "[R3] sent to Lander Hospital ER [Emergency Room] R/T [related to] orthostatic hypotension..." The report indicated R3 sustained an abrasion to her right forehead as a result of the 4/8/14 fall. 5/20/14 at 1:30pm - R3 was observed on the floor. The Unusual Occurrence Report indicated R3 denied pain and her range of motion was within her normal limits. 5/21/14 at 8:30am - R3 was observed on the floor. R3's Interdisciplinary Progress Notes dated 5/21/14 at 11:35am documented that R3 was "somewhat lethargic [and] diaphoretic..." and had a "4cm x 2cm hematoma below [left] eye." 8/13/14 at an "unknown" time - R3 "fell into wall" and sustained bruises to her left arm and the outer aspect of her left eye. R3's Interdisciplinary Progress Notes described a "4cm x 0.5cm bruise to outer aspect of [left] eye [and] 18cm x 15cm	F 323		

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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 _____	08/28/2014

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

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F 323	Continued From page 35 bruise to distal upper arm." The progress notes further indicated R3 complained of soreness to the area on her left arm and that she "lost her balance [and] fell into wall in bathroom." 8/19/14 at 2:30pm - R3 "fell while ambulating out of activities room [after] completing Bingo activity." R3's Interdisciplinary Progress Notes dated 8/20/14 at 3:00am documented" Bruising noted to [left] eye and left [upper] arm." 8/20/14 at 6:15pm - R3 was observed on the floor. There were no injuries listed on the Unusual Occurrence Report for this incident. However R3's Interdisciplinary Progress Notes dated 8/20/14 at 11:30pm, noted that R3 was again found on the floor and had "lost her balance" while "attempting to close the blinds." Review of R3's Interdisciplinary Progress Notes, dated 8/21/14 at 9:50am, noted that R3's physician had been notified of nine falls since January, 2014. The documentation also noted that R3 "continues to have vertigo [with] position changes." Review of R3's "Fall Risk Assessments" revealed on 8/20/14, R3 was assessed as having a score of "17." A score of 10 or more is considered to be at "high risk" for falls. Review of R3's "Fall Risk Assessments" prior to 8/20/14 revealed the following assessment scores: 8/14/14 - "15" ; 5/20/14 - "19" ; 4/8/14 - "19" and 4/8/14 - "21," indicating that R3 was consistently determined to be at high risk for falls during the previous six months. During an interview on 8/26/14 at 3:30pm, the ADON was asked if there was any documented	F 323		

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F 323	Continued From page 36 analysis of R3's falls to reflect determination of factors contributing to the falls, as well as development or revision of interventions to prevent future falls from occurring. The ADON reported that adjustments had been made in R3's medication because R3's vital signs reflected postural hypotension on several occasions but was unable to show that any further fall preventive action had been taken. When asked whether R3 had been assessed as requiring increased supervision to prevent falls, the ADON reported on 8/26/14 at 3:30pm, that R3 was able to get up independently to toilet. MDS1 noted at that same time, that R3 "was not one to ask for assistance." When asked if current care plan interventions were effective in preventing R3's falls, the ADON reported they had "not been aggressive enough" and "had not taken ownership" to provide additional assistance and supervision when R3 ambulated or needed to toilet in an effort to reduce her falls. During the interview on 8/26/14 at 3:30pm, MDS2, MDS1 and the ADON reported that R3's falls had lessened during a period when R3 was on rehabilitative services. They also noted that R3 had refused restorative nursing services after her period in rehabilitative services had been completed and had begun to experience an increase in falls. MDS2, MDS1 and the ADON were asked if R3, or her son, who was listed as her power of attorney, had been educated regarding the risks and benefits associated with restorative nursing services, including the potential to reduce fall related injuries. MDS2 reported there had been no education regarding the benefit of restorative services provided to R3, or her son, as a means of encouraging R3 to	F 323		

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F 323	Continued From page 37 participate in the restorative nursing program, even though it was felt that R3 would have benefited from restorative nursing services. Review of the facility policy titled, "Falls - Clinical Protocol" with a revision date of April 2013, revealed the following Policy Statement: "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." The policy continued with the following direction for ongoing assessment of the resident's falls: "The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls...If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable...If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions...The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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F 332	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the facility was free of a medication error rate of five percent or greater. The facility had a medication error rate of ten percent, three errors out of 30 opportunities for error involving three residents (R5, R15 and R16) out of 11 residents who were observed during the medication pass. The findings include: 1. Review of R1's physician order dated 11/06/12 indicated, Duoneb (a sterile inhalation solution containing a combination of albuterol and ipratropium which are bronchodilators that relax muscles in the airways and increase air flow to the lungs) treatment four times a day while awake. On 8/25/14 at 12:06pm, LPN1 was observed to prepare R1's nebulizer (is a drug delivery device used to administer medication in the form of a mist inhaled into the lungs that treats asthma, chronic obstructive pulmonary disease and other respiratory diseases) treatment. LPN1 went to R1's room to administer the nebulizer treatment. LPN1 squeezed three milliliters (ml) of the Duoneb into the chamber of the nebulizer. LPN1 attached the facemask to the drug chamber and then placed the face mask onto R1's face. LPN1 told R1 she would return in 10 minutes. LPN1 left R1's room. The surveyor did not observe LPN1 instruct R1 to breathe in slowly and evenly until R1 inhaled all the Duoneb solution. The surveyor continued to observe LPN1 for other medication	F 332	F332 Correct deficiency to individual No adverse effects were experienced by residents R1, R5, R15 or R16. Charge nurses were educated on 9/4/14 on the importance of cleaning nebulizer masks before using them, making sure that laxatives are mixed with the correct amount of water, and having residents rinse their mouth after use of inhaled corticosteroids. How others are identified and correction to others in similar situations Nurses have received education on instructing residents to breathe slowly and evenly when administering nebulizer treatment, to stay with the resident during administration, and to make sure the full dose of medication is administered each time. Nurses have received education on the correct administration of laxatives and inhaled corticosteroids. Five ounce glasses are provided on the nurses' med cart for use in rinsing the mouth, and larger glasses are available in the dining room during mea times for laxatives requiring more than five ounces of liquid for administration. Education has been given to nurses about the of rinsing the mouth and spitting, not swallowing, after being given inhaled corticosteroids. Nurses have also been educated on the importance of reading the	10/9/14

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F 332	Continued From page 39 pass while R1 was left in the room unsupervised with the nebulizer treatment. On 8/25/14 at 12:21pm, LPN1 returned to R1's room. Upon entering R1's room, R1 was observed without the face mask on. The face mask was observed on R1's bed. The surveyor asked LPN1 how many milliliters of medication were left in the chamber, LPN1 looked at the chamber and said, "2 ml." LPN1 proceeded to wheel R1 to the main dining room. The surveyor did not observe LPN1 encourage R1 to finish her nebulizer treatment. Therefore, R1 received an incomplete dose of the Duoneb medication. During an interview on 8/25/14 at 3pm, LPN1 stated she was told not to be in the room when administering a nebulizer treatment. LPN1 also stated, "I should have encouraged [R1] to finish her treatment, but because [R1] wants to go the dining room I just assumed she didn't like to finish her treatment." During an interview on 8/26/14 at 4:45pm with the Assistant Director of Nursing (ADON), the surveyor asked the ADON her expectations when a nurse gives nebulizer treatment. The ADON stated, the nurse needs to return in five minutes to check the contents, "and if something is left in the container [chamber] to continue the administration..." Review of the facility's policy dated, "Revised October 2010" titled, "Administering Medications through a Small Volume (Handheld) Nebulizer" indicated, "...15. Instruct the resident to take a deep breath...17. Remain with the resident for the treatment...23. Administer therapy until medication is gone..."	F 332	labels for administration of over the counter medications. Monitor permanent solution The DON, ADON, or their designee will perform weekly med pass audits to ensure that nebulizer masks are clean, laxatives are given with the appropriate amount of water, and residents are asked to rinse their mouth after use of inhaled corticosteroids. Results of audits will be discussed at monthly QA meetings.	

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F 332	Continued From page 40 2. On 8/25/14 at 12:15pm, LPN1 was observed to prepare R15's medication. LPN1 took two teaspoons of Fiber therapy powder from the medication bottle as ordered by the physician. LPN1 was observed to mix the powder with 120 milliliter (ml) of water and then administered the medication to R15. Review of the medication label of the Fiber therapy powder indicated to mix one teaspoon in eight ounces of fluid. LPN1 failed to follow the direction of medication label regarding the correct amount of fluids to use when mixing the medication. During an interview on 8/25/14 at 3pm, LPN1 stated that there was no order that specified the amount of fluid when mixing the laxative [Fiber powder]. LPN1 stated that 120 ml was sufficient to mix R15's fiber powder medication. During an interview on 8/26/14 at approximately 10:30am, the pharmacist stated one teaspoon of the Fiber powder medication should be diluted with eight ounces of water. The surveyor asked the pharmacist if they provide medication label instructions for each medication. The pharmacist stated, "We don't provide label if its over the counter (OTC) medication. The laxative powder was a facility house stock, an OTC medication. The nurse should be reading the directions at all times." 3. On 8/25/14 at 4:35pm, RN3 was observed to prepare R16's medication, Symbicort inhaler. RN3 took R16's inhaler from the medication cart. RN3 shook the inhaler prior to administering R16's inhaler. After RN3 administered R16's inhaler, RN3 left the room. The surveyor noted	F 332		

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F 332	Continued From page 41 RN1 did not offer water to rinse R16's mouth after R16's inhaler was administered. During an interview on 8/26/14 at approximately 10:30am, the pharmacist stated Symbicort has an ingredient that can cause oral thrush if mouth was not rinsed after use. The pharmacist stated, that it is recommended to rinse the resident's mouth after each use. During an interview on 8/26/14 at 4:40pm with RN3, when asked if she offered R16 water after she administered his inhaler, RN3 stated, "No, I did not offer the water to rinse his mouth after I gave his medication. I normally do, but yesterday I don't know why I didn't." Review of Symbicort manufacturer's guidelines and recommendation indicated, "Rinse your mouth with water and spit the water out after each dose (2puffs) of SYMBICORT. Do not swallow. This will help to lessen the chance of getting a fungus infection (thrush) in the mouth and throat."	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that food items were discarded from the refrigerator after their expiration date or their "use by" date. This had the potential to affect all 56 residents in the facility. Findings include: During the initial tour of the kitchen on 8/25/14 at 9:35am in the accompaniment of E2, the following food items were found in the refrigerator: A glass containing a mushy beverage dated "8/11." E2 identified the beverage as a smoothie that should have been discarded 8/13. A dish of cottage cheese and sliced banana dated "8/16." E2 stated this item should have been discarded 8/19. A bowl of salad with dressing dated "8/21." E2 reported this item should have been discarded 8/24. A small plastic container containing a solid, unidentifiable substance, dated "8/16." E2 identified this item as bacon grease. A bowl of chicken salad, undated. A bulging quart of fat free milk with manufacturer's expiration date of "7/26." A slightly bulging quart of milk with manufacturer's expiration date of "8/10."	F 371	F 371 FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY 9/9/2014 an in-service was given to the dining staff reviewing the policy of labeling and dating food items to be refrigerated and used within 3 days or discarded. The walk-in and reach-in coolers will be checked daily for unlabeled and outdated food items. Any items found will be discarded. Effective immediately the discard date will be added to the label; written and circled in red marker. These procedures will be spot checked for 60 days. At that time if in compliance monitoring will be done monthly and reported at QA for 3 months. DOUBLE OVEN AND RANGE The double oven and range were professionally cleaned 9/3/2014. A suitable oven cleaning product has been purchased that all staff will be able to use. The range is expected to be replaced with a new range by the middle of October 2014. The ovens and range will be deep cleaned monthly. Daily and weekly cleaning will be spot checked for 60 days. At that time if in compliance monitoring will be done monthly and reported at QA for 3 months.	10/9/14

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F 371	Continued From page 43 A one quart container of egg beaters with a "use by" date of "7/14." A quart of buttermilk with manufacturer's expiration date of "8/18." During an interview with the prep cook at the time of the finding, E2 reported that perishable foods were good for three days and then were to be discarded. Review of the policy titled, "Food Storage" dated "2010," directed that "Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded." Observation of the kitchen on 8/26/14 at 5:20pm revealed the interior base portion and doors of the double oven contained caked, black, carbon residue. Also, black, carbon residue was observed on the backsplash panel of the double oven. Interview with the Dietary Manager at the time of the observation revealed dietary staff were in the process of trying to remove the residue but had incurred a delay in cleaning because the current chemicals used for cleaning the oven were found to be too harsh for staff to use.	F 371		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 44 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medication had not expired and were properly discarded when expired. This had the potential to affect 56 residents currently residing in the facility,	F 431	F431 Medication will be destroyed timely, this means at least twice monthly. The medication destruction policy has been updated to reflect the administrative nurses who will be responsible for medication destruction. Each time medications are destroyed, the nursing staff will check the Medication Room Refrigerators as well as the refrigerator in the Infection Control Nurses' office for outdated vaccine as well as outdated medications in the medication room storage. Outdated medications will be destroyed with the other medications that are being destroyed. A monthly audit of the medication room cupboards, medication room refrigerator, and nursing carts will be done monthly by the ADON or her designee. Results of the audit will be reported at the monthly QA meeting.	10/9/14

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F 431	Continued From page 45 The findings include: On 8/25/2014 at 11am, an inspection of the Medication Storage Room with RN1 was completed. The following mediations were observed inside the refrigerator in the Medication Storage Room: a. One multidose vial of Pnemovax (Pneumococcal vaccine) - the label indicated expiration date of 7/14. b. One multidose vial of Tuberculin Purified Protein Derivative - the label indicated expiration date of 7/14. c. Three intravenous antibiotics of Cefepime one gram - the label indicated expiration date of 7/22/14. On 8/28/14 at 9:27am, LPN2 accompanied the surveyor to the Medication Storage Room. Seven more vials of Pneumovax were found in the refrigerator with expiration date of 5/9/14. The following medications that either have been discontinued or the resident had been discharged from the facility or the resident had expired were also found in the Medication Storage Room: a. Atropine Solution one percent - R17 expired on 5/27/14 b. Nitrostat 0.4mg tablets - R18 was discharged on 7/10/14 c. Bactrim DS tablets - R5's discontinued medications on 8/13/14 d. Keflex 500mg capsules and Clindamycin 150mg capsules - R19 was discharged on 8/20/14. During an interview on 8/27/14 at 2:55pm with the Director of Nursing (DON), she stated, "Discontinued medications are disposed of every	F 431		

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F 431	Continued From page 46 month." During an interview on 8/28/14 at 9:30am with LPN2, she stated, "The TB [Tubeculin Purified Protein Derivative] and the pneumovac are multi-vials and can be used by every resident, both for 100 and 200 hallways." On 8/27/14 at 2:55pm, the DON provided the surveyor with the medication destruction log binder. Review of the destruction log for discontinued medications revealed the latest medication destruction was done on 7/27/2014. Review of the facility's policy dated, "Revised April 2007" titled, "Storage of Medications" revealed, "...The facility shall store all drugs and biologicals in a safe, secure and orderly manner...4. The facility shall not use discontinued, outdated or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed."	F 431		
F 441 SS=F	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	F 441		

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F 441	Continued From page 47 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that its infection control program gathered sufficient information to accurately and thoroughly track and trend resident infections. Furthermore, the facility failed to implement contact isolation precautions for residents with communicable diseases; provide timely remedial training for staff to address causal factors promoting infections; and ensure that bio-hazardous waste materials were appropriately contained. This had the potential to affect all 56 residents in the facility.	F 441	F441 Correct deficiency to individual R20's chart has been reviewed. Antibiotic therapy was initiated on 8/1/14 and completed on 8/4/14, which completed the three day course as prescribed. Resolved date was changed in TRACE. R26's chart has been reviewed. Antibiotic therapy was initiated on 8/2/12 and completed on 8/8/14, completing the 7 day course as prescribed. Resolved date was updated on TRACE. Reviewed isolation policies related to resident R5. Resident is on standard precautions and wound and drainage is contained by dressing. Contact precautions are used during dressing changes. Personal protective equipment and biohazard bags are provided in room with dressing change materials. Staff has been educated related to precautions. Staff assignment sheets have been updated to reflect precautions for R5. Sign has been placed on resident's door to alert staff and visitors to check with the charge nurse for the need for caution due to resident's infection. Staff has been notified on precautions and to separate linen for proper washing procedures. How others are identified and correction to others in similar situations: Hand hygiene and peri care education have been provided for all nurses and CNAs. Employees have been educated on contact precautions, biohazard disposal, linen separation for residents with communicable diseases. Assignment sheets have been updated to reflect current plans of care.	10/9/14

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F 441	Continued From page 48 Findings include: 1. During an interview on 8/27/14 at 2:30pm, the Infection Control Coordinator was asked about the facility's system for tracking and trending infections. The Infection Control Coordinator pulled up a program on the computer and reported that data was entered into the system whenever any resident was identified with an infection. After reviewing the data entries, the Infection Control Coordinator was asked about the dates that were listed for each resident's entry. The Infection Control Coordinator was unable to identify if the "start" dates were the dates the infections were identified or the dates antibiotics were started. When asked if there was any tracking of changes to antibiotics, e.g., if one antibiotic was prescribed and then discontinued and another antibiotic ordered, the Infection Control Coordinator reported there was no place in the system for such information to be entered. The Infection Control Coordinator was unable to differentiate whether the "end" date signified the end of antibiotics or the resolution of the infection. The infection control log also did not contain information regarding when symptoms first appeared, only the date a diagnosis was made. The log contained discrepancies in information including the following: R20 was listed as starting antibiotics on 8/1/14 and finishing them on 8/5/14. The Infection Control Coordinator reported the physician had ordered a three day course of antibiotics but was unable to account for why the start and stop dates did not coincide with a three	F 441	Measures/Systematic changes to prevent recurrence: Training will be provided in the next 30 days for all CNAs on proper cleansing of the whirlpool tubs. Education has been provided on hand hygiene and peri care. All new CNAs and nurses will be educated on handwashing and peri care. Current staff will receive continuing education on infection control annually and PRN. When residents are admitted with contact precautions, or current residents have a need for additional precautions, signs will be posted on the doors of these residents' rooms and staff will be informed at the beginning of their shifts as to the necessary precautions needed. Training for staff members will be held for each of these new cases in the facility. Assignment sheets are not updated by MDS at the same time that care plans are updated, to ensure that staff have the most current information readily available to the Biohazardous waste bins have been removed from the unlocked soiled utility rooms and are now located in the locked mechanical room. Portions of the APIC manual have been updated with the most current policies. Education has been provided to staff related to weekly skin assessments, and wound care treatment in-services will be held for all charge nurses on October 7th and 9th. All floor nurses will share the responsibility for completing weekly sink assessments within the next 90 days to assure continuity of care.	

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F 441	Continued From page 49 day period. R26 was listed as being prescribed a seven day course of antibiotics that was started on 8/1/14 and finished on 8/9/14. The Infection Control Coordinator reported this was a longer period than seven days but could not explain the discrepancy. Review of R5's entry for August, 2014, revealed he had a diagnosis of Methicillin Resistant Staphylococcus Aureus (MRSA) infection. When asked if R5 was on contact isolation precautions, the Infection Control Coordinator reported he was on "standard precautions." Review of the procedural manual titled, "Infection Prevention Manual for Long-Term Care Facilities" revealed the following direction in the section titled "Contact Precautions:" "...In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact....The above includes epidemiologically important organisms (multidrug-resistant organisms) such as MRSA...." Appendix A of the same manual noted the following in the section "Type and Duration of Precautions Recommended for Selected Infections and Conditions:" "...Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings..." Review of the monthly infection control log for the six month period of March 2014 - August 2014, revealed the following: August - Three of six total infections were urinary tract infections (UTI's)	F 441	Monitor permanent solution: SDC or their designee will perform random hand washing and peri care audits over the next 60 days to ensure proper technique is being used and provide on-the-spot training for any concerns. Bath tubs will be checked randomly for the next 60 days for cleanliness, with immediate correction of any concerns. Weekly skin/wound assessments will be reviewed from completeness and training will be provided as needed for documentation, by the SDC. Contact precaution care will be observed randomly for the next 60 days to ensure proper precautions are being followed, along with disposal of biohazard waste, and on-the-spot training will be provided if there are any concerns. Results of audits will be reported by staff development/infection control nurse at monthly QA meetings.	

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F 441	Continued From page 50 July - Nine of 18 (50%) infections were UTI's. June - Four of 11 (36%) infections were UTI's May - Seven of 16 (44%) infections were UTI's April - Three of eight (37%) infections were UTI's March - Two of three (66%) infections were UTI's The information contained in the infection control log reflected a urinary tract infection rate of 45% over the past six months. When asked if this presented a problem, and if so, what was being done to address the problem, the Infection Control Coordinator reported that the previous month (July) a staff member had identified that the tubs were "grimy." The Infection Control Coordinator reported that one of the nurse aides was "going to put together information and lead a discussion about how to properly clean the tubs." The Infection Control Coordinator reported this training for bath aides who cleaned the tubs would occur in approximately "another month" which represented a two month period from when the tubs were identified as being grimy to the point when training occurred for how to properly clean and disinfect the tubs. When asked if residents continued to be bathed in the tubs even through bath aide staff had not yet received training on proper cleaning, the Infection Control Coordinator replied, "Yes." The Infection Control Coordinator reported that there was no housekeeping involvement with cleaning tubs. 2. On 8/25/14 at 6pm, R5 was observed in the dining room with dry dressing around his right foot. On 8/26/14 at 2pm, R5 was observed in his room with dry dressing around his right foot and ankle foot orthosis (AFO) applied to his right foot. Review of admission record revealed R5 was	F 441		

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F 441	Continued From page 51 admitted to the facility of 7/21/14 with diagnoses that included but not limited to decubitus ulcer stage III, diabetes mellitus and cerebrovascular accident. Review of R5's progress notes from the hospital dated 7/21/14 revealed, "Culture obtained of R [right] heel wound. Pt [patient] MRSA [methicillin-resistant staphylococcus areaus - refers to Staphylococcus aureus bacteria that are resistant to treatment with semi-synthetic penicillins, e.g., Oxacillin/Nafcillin/Methicillin] positive." Review of R5's antimicrobial susceptibility and organism identification report with a date reported on 8/12/14 revealed two organisms found on R5's right heel wound: Escherichia coli (name of a type of bacteria that lives in the human intestine) and MRSA. Review of R5's physician's order dated 8/13/14 revealed, Vancomycin (an antibiotic medication that has been considered to be the reference standard for the treatment of MRSA infections) one gram via intravenous every 24 hours for ten days and Keflex 250 milligram (mg) for seven days. Review of R5's care plan with problem onset date on 7/29/14 revealed stage three pressure on right heel upon admission. R5's care plan with the same onset date also revealed R5, "at risk for dehydration related to history of...infection of wound and antibiotic treatment." Review of R5's pressure ulcer report on the right heel dated 7/25/14 indicated, Stage IV (full thickness loss with exposed bone, tendon or muscle) measuring 3.6 centimeters (cm) by 2.8	F 441		

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F 441	Continued From page 52 cm and unable to determine the depth. The report also indicated, "The wound had small amount of thick yellow-green drainage." Review of R5's pressure ulcer report on the right heel dated 8/20/14 indicated, Unstageable (Full thickness tissue loss in which the base of the ulcer is covered with slouch and or eschar in the wound bed) measuring 3.3 cm by 1.8cm. The report also indicated the peri-wound area is pink with maceration, yellow-green drainage in moderate amount, foul and strong in odor. During an interview on 8/26/14 at 2:35pm with the Assistant Director of Nursing, she stated that R5 was on contact isolation due to R5's MRSA on his right heel. The surveyor asked the ADON if the facility used signage on the resident's doorway to alert anyone from entering the room that R5 required contact precaution. The ADON stated, "The company does not prefer putting signage due to violation of resident's rights and privacy." The surveyor further asked the ADON the type of method used to communicate to a nursing assistant when a resident required contact precautions. The ADON stated, "By word of mouth, the nurse will report to the nursing assistant." During an interview on 8/26/14 at 3:15pm with RN2, she stated RN2 knew that R5 had an open wound and had received intravenous antibiotics every 24 hours due to [R5] had positive MRSA. RN2 further stated, "I don't know if [R5] is still on contact isolation. I did not receive a report from the outgoing nurse regarding [R5's] status on contact isolation. I don't know what to tell the C.N.A (certified nurse assistant) because I don't know if he [R5] is still on contact isolation. There	F 441		

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F 441	Continued From page 53 are no isolation kits nor carts in his [R5] room, no signage on the doorway; [R5's] linen doesn't get separated from the other linen carts." During an interview on 8/26/14 at 4:10pm with the Infection Control nurse (ICN), she stated that she oversees the Infection Control Program. The ICN stated that one of her roles was to educate the staff to "make sure that they were aware of how a certain organism like, MRSA can spread and be contagious and what precautions to take." The ICN also stated that R5's last culture was on 7/21/14, positive for MRSA on his right heel. The ICN stated the R5 was placed on a standard precaution because it is only the wound that is contagious. If the wound is contained, there is not fear of passing the infection." During an interview on 8/26/14 at 4:35pm with NA1, she stated she has only been employed with the company for one week. NA1 was assigned to R5 on second shift. When asked if she knew any type of precautions for R5, NA1 stated, "I don't know, the nurse would know that. I just look at his comfort, and the nurse will deal with the drainage. I am not sure if [R5] is on contact isolation, that's for the nurse to know." NA1 also showed to the surveyor her assignment sheet. Review of the assignment sheet updated on 8/22/14 indicated the following information for R5: "Heart healthy diet, Regular liquids, Can bear weight on both feet for transfers; needs a boost to stand up...1 person assist with ADLs (activities of daily living)...alert and oriented...float heels, diabetic..." The assignment did not indicate R5 was on contact isolation precaution.	F 441		

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F 441	Continued From page 54 On 8/26/14 at 5pm, the ADON confirmed the assignment sheet for R5 did not have information on his contact isolation precaution. The ADON stated, "ICN updates this [assignment sheet] but because ICN was on leave the information was not updated." On 8/27/14 at 11:15am, E1, the housekeeper was observed mopping R5's room. During an interview on 8/27/14 at 11:25am with E1, she stated, she takes care of cleaning the rooms for 100 and 200 hallways. The surveyor asked E1 if she knew of any resident that would require contact precautions. E1 stated, "Not yet." The surveyor further asked E1 how she would know if a resident requires contact precaution. E1 stated, she would get a report from her supervisor or "a nurse will tell us." During an interview on 8/27/14 at 12:10pm with LPN2, the surveyor asked LPN2 if she informs the housekeepers the type of isolation precaution a resident requires. LPN2 stated it was their supervisor that tells them. When asked how she informs the nursing assistant the type of isolation precaution required for a resident, LPN2 stated, they have their care guide [assignment sheet]. When asked how the family/visitor would know about the type of isolation precaution, LPN2 stated, "We usually put a sign on the door, to see the nurse before entering the room so we can discuss in private the status of the infection. LPN2 confirmed that R5 did not have any signage on his door. During an interview on 8/27/14 at 12:30pm with LPN2 the surveyor asked if she had seen R5's wound on his right heel. LPN2 stated R5's	F 441		

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F 441	Continued From page 55 dressing changes weren't due till 8/29/14. LPN2 also stated she was not sure if R5 was still on contact precautions because R5 had just completed his IV antibiotics on 8/25/14. LPN2 stated she will obtain more information about the status of R5's wound from the wound clinic and will also call R5's attending physician to clarify the status of R5's infection. On 8/27/14 at 1pm, LPN2 provided the surveyor R5's wound clinic report dated 8/6/14. The report indicated, "Wound status open...measurement 2 cm by 2.5 cm by 0.3 cm...small purulent yellow, brown, green exudate. LPN2 also provided R5's physician's order dated 8/27/14 that indicated a clarification if R5 should be on universal or contact precaution related to right heel wound that was positive for MRSA. The physician order indicated, "would advise just continuing contact precautions." During an interview on 8/28/14 at 10:45am with the Housekeeping Director (HD), when asked how was she informed of a resident requiring contact precautions. The HD stated she got the information during their morning meeting. The ICN gets the isolation cart ready. The HD stated, "We have all the bins ready for isolation that is found under the sink in the soiled utility room. The personnel protective equipment (PPE) should be in front of the resident's room. I inform the laundry and housekeeping staff verbally for any residents requiring isolation." When asked if the nursing department had shared information regarding a resident in the facility that required contact precaution, the HD stated, "No." Review of the facility's policy dated, "Revised December 2011" titled, "MRSA - Management of	F 441		

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F 441	Continued From page 56 Recurrent Skin and Soft Tissue Infection revealed, CDC [Centers for Disease Control and Prevention] recommends contact precautions when the facility (based on national or local regulations) deems MRSA to be of special clinical and epidemiologic significance." Review of the facility's undated policy, titled, "Procedure of Isolation: Initiation of Isolation Precautions revealed, "...Contact Precautions:...use Contact Precautions for residents known or suspected to be infected with microorganism that can be easily transmitted by direct or indirect contact...includes epidemiologically important organism (multi-drug resistant organisms) such as methicillin-resistant Staphylococcus Aureus (MRSA)..." On 8/27/14 at 1:40pm, the environmental tour was conducted with the maintenance director. Hallways 100 and 200 each have an unlocked soiled utility room. Inside the soiled utility room was an unlabeled red trash bin. The bin was filled with biohazard waste (infectious) materials.The maintenance director stated that at the end of the day, the trash were brought to a designated biohazard area. During an interview on 8/28/14 at 9:40am, LPN2 stated they used the soiled utility room to dump the biohazard waste and when the trash gets full it goes to the back room with locked doors. During an interview on 8/28/14 at 10:45am with the housekeeping supervisor, she stated the CNA takes the trash out when it is full and brings it to the mechanical room. The maintenance director calls the waste management company for a pick up.	F 441		

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F 441	Continued From page 57 On 8/28/14 at 11:30am, the soiled utility room for both 100 and 200 hallways remain unlocked. The unlabeled red trash remained full wtth biohazard materials. E1 went to 100 hall soiled utility room to check the red trash bin. E1confirmed that the bin did not have a "biohazard" warning label. The trash bin in the 200 hall soiled utility room was also observed without biohazard warning label. During an interview on 8/28/14 at 11:45am, the DON stated, "It has been the practice to throw the biohazard waste in those unlocked soiled utility rooms. Then it's brought to the main designated biohazard room. No one told us before that we can't keep those trash [infectious waste] in an unlocked room. I understand it is not safe for any resident since they can access those rooms. Now, we know better." On 8/28/14 at 11:30am, the Miinimum Data Set (MDS1) coordinator provided the surveyor with a list of residents that were mobile with cognitive impairment. MDS1 identified there were 32 residents who were mobile with cognitive impairment. Review of the facility's policy dated 6/30/08 titled, "Blood Borne Pathogens" revealed, "...Section IV Biohazard Warnings...The biohazard warning label should appear on: Bags and cartons for dipsosal of potentially infectious materials (regulated waste)...Coolers/containers used to temporarily store/transport blood or body fluid specimens...Laundry bags anbd containers containing/in contact with infectious materials."	F 441		