This survey was too big and has been split into 2 parts.

This is Part 2

(For Part 1 look at the previous survey with same survey date)

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
	535013	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 49 at 2:40 PM, s/he said s/he had not received the 12 PM breathing treatment. The resident indicated s/he was short of breath. An interview with the resident later that day at 7:10 PM revealed s/he had not yet received the medication. Review of the 11/26/13 physician's order showed an order for Duoneb nebulizer treatments four times a day. Review of the 7/11/14 quarterly MDS assessment showed the resident had diagnoses to include COPD (chronic obstructive pulmonary disease). Further, it showed s/he was cognitively intact. Review of the July 2014 MAR showed there was no documentation to indicate the resident received or declined the medication on 7/30/14 at 12 PM, 4 PM or 8 PM. During an interview with the DON on 8/1/14 at 1:45 PM, she acknowledged the nursing staff needed to give the medication as ordered or indicate why it was not administered.	F 328	Monitoring: Medication and Treatment administration records will be monitored 3 X Week by the DNS/Designee for treatment administration as ordered. Identified trends will be submitted to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F329 Corrective Action: Resident # 96 reassessed for psychoactive medication use, regimen reviewed by physician, rationale for use specified, and behavior monitoring sheets clarified.	9/24/14

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F 329	Continued From page 50 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to adequately monitor 1 of 8 sample residents (#96) with antipsychotic drug use. The findings were: Review of the inpatient psychiatric evaluation dated 6/7/05 showed resident # 96 had diagnoses to include dementia and bipolar disorder. Further, the resident received the medications Zyprexa (antipsychotic) and trileptal (anti-seizure medication). Review of the June and July 2014 MAR showed the resident was ordered Zyprexa 15 mg at bedtime daily, and 10 mg every morning. In addition, trileptal 300 mg was to be given every 12 hours. Further review of the MAR showed the medications were ordered at the current dose on 9/22/10 for bipolar disorder. Review of the "Note To Attending Physician/Prescriber" dated May 2012 showed the resident's condition was stable. Further, it showed the following statement was checked; "Patient has had good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient and a reduction is likely to impair the resident's function and/or cause psychiatric instability..." Review of the	F 329	Identification of Others: An audit of residents with psychoactive medication will be completed to validate documented rationale for use, accurate behavior monitoring and care plan. System Change: Education will be provided by the SDC/Designee to nursing and social services personnel related to psychoactive medication use and behavior monitoring. Monitoring: The DNS/Designee will monitor behavior monitoring flow sheet records for accuracy weekly. Social Services/Designee will review psychoactive drug regimen for appropriate rationale for use and GDR needs, monthly for those scheduled for assessment according to the RAI schedule. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

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F 329	Continued From page 51 physician/ prescriber note dated 3/29/13 showed the same statement was checked. The "Unnecessary Drugs/Risk/Benefit Statement" dated 3/29/13 showed the following statement was checked; "The current medication regimen allows the resident to function at their highest practicable well being." The following concerns with medication management were identified: a. Observations on 7/30/14 at 3:40 PM and 8/1/14 at 9 AM showed the resident wandered in the hallways and common area of the unit. Interviews with CNAs #6, #8, and #9 on 7/30/14 at 3:40 PM revealed the resident wandered daily and had for at least a year. They further stated the resident kicked staff daily while attempting to provide care and the behavior had become worse recently. b. During an observation on 7/31/14 at 2:55 PM the resident was in bed and had removed his/her incontinence pad full of stool and thrown it across the room. Stool was also found in the bed with the resident. The ADON indicated the behavior was not unusual for the resident. c. Review of the 5/30/14 quarterly MDS assessment showed the resident had no behaviors to include wandering or rejection of care. Review of the antipsychotic behavior flow sheets showed behaviors to be monitored included agitation, yelling out and self isolation. There were no behaviors noted to show the resident wandered daily, kicked the staff or removed soiled incontinence pads and threw them across the room. d. A correspondence from the physician dated 8/6/14 showed he had been the resident's primary care provider since November 2013. Further it stated the medications had not been adjusted due to the resident was well controlled. He then reported the resident's behaviors	F 329		

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F 329	Continued From page 52 included agitation and aggression toward other residents and staff and these behaviors were monitored by staff each shift. However; review of the the behavior monitoring sheets and nurses notes for June and July 2014 did not indicate the behaviors observed were being documented and reported to the physician.			
F 332 S6=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to maintain a medication error rate under 6 percent (%). Three medication errors were observed out of 28 opportunities for error, which resulted in an error rate of 10.7%. The findings were: 1. Observation on 7/30/14 at 3:30 PM showed RN #2 administered resident #91 Simvastin 20 mg. Review of the physician orders dated 7/18/14 showed the medication was to be given at bedtime. 2. Observation on 7/30/14 at 4:15 PM showed RN #2 administered resident #90 Flomax 0.4 mg. Review of the physician's orders dated 6/12/14 showed the medication dose to be administered was 0.8 mg. In addition, the medication was to be given at bedtime. An interview with the ADON on 8/1/14 at 9:40 AM	F 332	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 9/27/14 F332 Corrective Action: Resident #90, #91 and #73 assessed and determined to have no adverse response associated with medication administration variances. Identification of Others: An audit of medication administration records for the previous 30 days completed for current residents. Physician notified, orders obtained/clarified if indicated, and care plan updated as appropriate.	

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F 332	Continued From page 53 verified the medications Flomax and Simvastin were to be administered at bedtime. Further, the DON confirmed the most recent signed recapitulated physician orders showed the dose for Flomax was 0.8 mg, not 0.4 mg. 3. Observation on 7/28/14 at 5:35 PM showed resident #73 (who had a diagnosis of Diabetes Mellitus (DM) and was insulin dependent) was administered insulin Novolog 6 units with a reported BS (Blood sugar level) of 65 mg/dl at 4 PM, by RN #1. Review of the medical record revealed an order dated 7/28/14 at 3 PM to "hold 6 units of Novolog insulin when BS is < (less than) 70 [mg/dl]". Interview with LPN #1 on 7/30/14 at 6 PM verified the insulin should not have been given based on current physician orders.	F 332	System Change: Education and competency validation related to medication administration completed by the SDC/Designee for licensed nursing staff. Monitoring: The DNS/Designee will monitor medication administration records for indication of omission or error 3 X weekly. The DNS/Designee will conduct random observation of medication administration 3Xweekly. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to prevent a significant medication error for 1 of 2 sample resident (#73) related to insulin administration. The findings were: Observation on 7/28/14 at 5:35 PM showed resident #73 (who had a diagnosis of Diabetes Mellitus (DM) and was insulin dependent) was administered insulin Novolog 6 units with a	F 333	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 9/29/14 F333 Corrective Action:	

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F 333	Continued From page 54 reported BS (Blood sugar level) of 65 mg/dl (milliliters per decliter) at 4 PM by RN #1. The following concerns were identified: a. Review of the medical record revealed a new physician order dated 7/28/14 at 3 PM to "hold 6 units of Novolog insulin when BS is < (less than) 70 [mg/dl]", which was not updated on the MAR at the time of insulin administration. b. Review of the facility policy titled Diabetes Mellitus (DM), Guidelines for Management, revealed "the nurse is to compare the results of the blood glucose level with the ranges established by the physician, to notify the physician of blood glucose levels below or above the established ranges and implement any new orders as applicable"; to "monitor [resident] for hypoglycemic episodes (blood sugar results below 70 [mg/dl]) and to notify the physician." c. Staff interview with LPN #1 on 7/30/14 at 6 PM revealed the expectation for communicating new physician orders is to verbally, and in writing, pass on new physician orders to the next shift; if the nurse who receives the new order is not assigned to the resident, the expectation is to notify the assigned nurse. This was not done at the time the order was received and resulted in the resident receiving insulin when s/he should not have based on physician orders.	F 333	Resident #73: assessed and demonstrated no adverse response to insulin administration. Medication administration record updated to reflect physician ordered parameters. Identification of Others: Baseline audit of medication administration records for patients with orders for insulin, completed to validate administration records reflective of administration per physician orders. Physician notification completed as indicated. System Change: Education provided by the SDC/Designee to Licensed Nursing personnel regarding medication administration and prevention of medication errors. Monitoring: The DNS/Designee will monitor medication administration records for indication of omission or error 3 X weekly. The DNS/Designee will conduct random observation of medication administration 3Xweekly. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.			

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F 353	Continued From page 55 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, and staff, resident, and family interview, the facility failed to ensure adequate staff were assigned to provide for the physical, psychosocial, and quality of life needs for 6 of 33 sample residents (#7, #24, #73, #88, #96, #107). The findings were: 1. Observation during the initial tour of the facility on 7/28/14 at 9:35 AM revealed resident #96 was seated in the hall outside his/her room. The resident had long, jagged fingernails with chipped nail polish. The nailbeds on both hands were encrusted with thick, brown matter. The resident's pink t-shirt had visible food debris and stains, and his/her hair was uncombed. Observation of the evening meal on 7/28/14 at 5:55 PM showed the resident was seated in a wheelchair in the 3rd floor dining room. The resident continued wearing the t-shirt with visible food stains, his/her hair remained uncombed, the fingernails continued to have chipped polish and remained long, jagged,	F 353	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F353 9/24/14 Corrective Action: Resident #73, #96 and #107 assessed for dignity and hygiene needs and assistance required for completion of activities of daily living. Immediate needs addressed, soiled clothing washed or replaced and plans of care updated as indicated. RNA program for resident #7, #24, #88, were evaluated, revised as needed and care plans update as appropriate.	

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F 353	Continued From page 56 and encrusted with thick, brown matter. In addition, the resident had dried food at the corners of his/her mouth. Observation on 7/30/14 at 3:35 PM showed this same resident, #96, had a soiled shirt and over-blouse. The clothing appeared to have spilled food and fluids down the front of both articles of clothing. At 6 PM that same day, the resident had the same soiled clothing on. Observation on 8/1/14 at 9 AM showed the resident wandering on the unit wearing a soiled sweatshirt. Review of the 5/30/14 quarterly MDS assessment showed the resident was severely cognitively impaired. Further, the MDS assessment revealed the resident required extensive assistance with dressing and personal hygiene. 2. Observation on 7/30/14 at 12:30 PM showed resident #107 was wearing a soiled shirt with food and debris on the lower right hand corner. At the time of the observation, the resident was riding the elevator down to the main lobby on first floor. Interview with the resident at the time revealed s/he was embarrassed by the soiled shirt but was unable to change it him/herself and staff was too busy to help. The resident also said staff was supposed to check him/her for incontinence and change the brief when wet or soiled. However, the resident went on to say many times s/he had to visibly see his/her wet clothing and call for staff assistance because staff did not check for incontinence as often as they were supposed to. At the time of this observation and interview the resident smelled of urine. According to the 7/30/14 quarterly MDS assessment, this resident was cognitive but required extensive assistance of 1 for dressing, toileting, and bathing related to his/her diagnosis of multiple sclerosis.	F 353	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Identification of Others: Baseline audit of current residents completed related to dignity, hygiene, ADL (activity of daily living) needs and Care Plans updated as indicated. Baseline review for all patients with orders for restorative nursing program completed. Plans were evaluated, revised as needed and care plans updated as appropriate. System Change: Education provided to care staff by the SDC/Designee related to dignity, hygiene, and assistance with Activities of Daily Living. Education provided by SDC/Designee to Restorative Nurse, Restorative Aide, and Therapy Program Manager regarding provision of restorative nursing program, oversight of programs and documentation of provided services.	

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F 353	Continued From page 57 In addition, review of the medical record for the resident showed a restorative nursing care referral dated 3/8/14 for restorative services 3 to 5 times weekly to assist the resident with transfers, gait length of parallel bars forwards and backwards, nu-step level 3 resistance, increase as tolerated, and if the resident declines to transfer onto the nu-step the program should be completed in parallel bars. Review of the restorative care flow record revealed the restorative program was initiated on 3/13/14. The resident received restorative services on 3/13/14, 3/18/14, 3/20/14, 3/27/14, and 3/31/14, not the recommended 3 to 5 times per week. Review of the April 2014 restorative care flow record showed 2 entries on 4/10/14 and 4/14/14 in which it was documented, "resident refused to work with restorative today." No additional documentation was made available that showed whether staff attempted further restorative therapy or if the restorative program was discontinued. Interview with the resident on 7/30/14 between 10:45 AM and 11:20 AM revealed s/he was supposed to perform exercises weekly but staff just "stopped coming." 3. Review of the quarterly MDS assessment dated 6/7/14 revealed resident #73 had diagnoses including Parkinson's disease; the resident needed setup assistance with transfers, eating and personal hygiene, and had a physical impairment in an upper extremity which limited the resident's range of motion. The resident depended on staff for ADL help. Observation on 7/31/14 at 9:05 AM revealed the resident's room had a strong smell of urine. Interview with the resident at that time revealed s/he had knocked the urinal over and the urine spilled onto the floor; the resident further said staff had not emptied it	F 353	Monitoring: The DNS/Designee will conduct random monitoring rounds associated with resident dignity, hygiene, and ADL needs 3XWeekly. DNS/designee monitor restorative program flow sheets and program review documentation weekly Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly and as needed for review by the IDT until a lesser frequency is deemed appropriate. The facility will continue to actively recruit and hire Qualified Staff. JC	

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F 353	Continued From page 58 "again." Another observation on that same day at 12:30 PM revealed the resident had a partially full urinal placed on the nightstand. Observation showed CNA #2 entered the resident's room to take vital signs, but did not empty the urinal. Interview with the CNA at 12:35 PM that same day revealed she emptied the urinal or not "depending on how much time I have." The CNA did not empty the urinal at that time and left the room. Additionally, review of the quarterly MDS assessment dated 6/7/14 revealed the resident had diagnoses which included Parkinson's, and had a physical impairment in one of his/her upper extremities that limited range of motion. Review of the medical record for the resident revealed restorative nursing services for maintenance were ordered to begin on 5/5/14 and to include standing hip abduction, heel raises, hip extension, and hip check with fourth resistance (March) 3 times per week. The services were not performed three times a week as ordered on the following dates: the week of 5/5/14 through 5/11/14, the week of 5/26/14 through 6/1/14, the week of 6/9/14 through 6/15/14, the week of 6/23/14 through 6/29/14, the week of 6/30/14 through 7/6/14. 4. Review of the 6/20/14 quarterly MDS assessment showed resident #7 required limited assistance of one person for bed mobility and transfers. For ambulation the resident required only supervision and one person. Further review showed the resident was unsteady during ambulation and utilized a walker. Review of the 4/29/14 restorative care plan showed the resident required lower extremity exercises including utilization of the nu-step (stool) five times per week to improve or maintain the resident's self	F 353		

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F 353	Continued From page 59 performance of walking, with or without assistive devices. Review of the 5/4/14 general care plan showed interventions included working with the restorative CNA on the nu-step and therapy bands. The following concerns were identified: a. Review of the June 2014 restorative care flow record showed the resident received restorative services only once per week during the first and second weeks. Restorative was provided three times during the third week of June 2014 then not again until 7/3/14. b. Review of the July 2014 restorative care flow record showed the resident two times during the first and second weeks and one time during the third week. The resident received no further restorative services the remainder of July 2014. c. Review of the records showed no evidence the resident refused restorative therapies during either month. 5. Review of the 7/26/14 annual MDS assessment showed resident #88 required limited assistance of one person for bed mobility and ambulation, and extensive assistance of two persons to transfer. Review of the 4/23/14 general care plan showed the resident had impaired mobility related to a hip fracture and decreased cognition. Interventions included restorative services as needed. Review of the 5/30/14 restorative care plan showed the resident was to receive lower extremity strengthening exercises and range of motion (ROM) and gait training with a front-wheeled walker and caregiver assistance three to five times per week. The following concerns were identified: a. Review of the June 2014 restorative care flow record showed the resident received restorative therapy only one time during the first week, two times during the second week and one	F 353		

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F 353	Continued From page 60 time during the third week. The fourth week in June showed no evidence the resident had any restorative therapy at all. b. Review of the July 2014 restorative care flow record showed the resident received restorative services one time during the first week, two times during the second week, and one time during the third and fourth weeks. c. Review of the records showed no evidence the resident refused restorative therapies during either month. 6. Review of the medical record for resident #24 showed a restorative nursing care referral dated 5/14/14 for a functional maintenance program. The program included range of motion and stretching exercises to both lower extremities 3 times a week. Review of the May 2014 restorative care flow record showed entries dated 5/16/14, 5/19/14, and 5/15/14 where the resident refused exercises. Review of the restorative care progress notes revealed the restorative nursing program was discontinued 5/31/14 related to resident refusals. No further documentation was provided indicating staff attempts to perform restorative service 3 times weekly as ordered. 7. Interview with the restorative CNA on 7/30/14 at 3 PM showed the restorative nursing department staff were responsible for assisting residents with recommended exercises. The interview further revealed the restorative nursing program had been without a supervising nurse for the last month, since the previous supervisor had resigned. In addition, she revealed residents were not receiving restorative exercises because there was not enough staff and she was required to work on the floor. The interview further revealed several residents who had previously received	F 353		

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F 353	Continued From page 61 restorative exercises had experienced an increased number of falls. 8. Interview with PT #1 on 7/31/14 at 3:30 PM verified residents had not been receiving restorative nursing services as recommended by the therapist for maintenance of ADLs. 9. While interviewing the administrator and DON about the quality improvement program on 7/31/14 at 3 PM, staffing was brought up as an issue. During the discussion, the administrator said she did not feel there was an "actual" staffing issue but that it was just "staff's perception." However, she was unable to explain why resident care was not being performed adequately and in a timely manner.		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	F356 Corrective Action: Nurse Staffing board was updated to reflect current staffing data. Identification of Others: No other residents have the potential to be affected by this System Change: Education was provided to staffing coordinator regarding updating nursing staffing data.	9/31/14

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F 356	Continued From page 62 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the total number of nursing staff and their actual hours worked for 4 of 5 days of observation. The findings were: Observation of the nurse staffing board on 7/28/14 at 10:45 AM showed the board was dated 7/28/14 and there were 16 licensed staff working the day shift, 16 licensed staff working the evening shift, and 10 licensed staff working the night shift. The column listing unlicensed nursing staff was blank for all shifts. In addition, the data was not divided by the categories of registered nurses, licensed practical nurses and certified nurse aides. Observations on 7/29/14, 7/30/14, 7/31/14, and 8/1/14 showed no changes were made to the board; it remained dated 7/28/14 and was not updated. Interview with the DON on 8/1/14 at 11:55 AM confirmed the board had not been updated, and should have been.	F 356	Monitoring: ED/designee will verify accuracy of nursing staffing information 3Xweekly. Results of the audit will be brought to the center Performance Improvement Committee monthly and as needed for review by the IDT until a lesser frequency is deemed appropriate.	

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F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and resident and family interview the facility failed to ensure foods were palatable and served at proper temperatures for 1 of 2 dining observations. The findings were: Interview with resident #74 and his/her POA on 7/28/14 from 1:45 PM to 2:50 PM revealed hot foods were cold during all meals. The resident and his/her POA talked with administrative staff about their concerns about 2 months ago and it was discovered the buffet was not being plugged in and this was determined to be the source of the cold food. However, the resident shared that s/he continued to receive cold food, specifically the tater tots and french fries were, "undercooked and cold in the middle, soups were cold and the sandwiches were soggy". During an observation of the evening meal on 7/28/14 at 6:07 PM the resident received a fruit and yogurt plate, which s/he stated, "this is what I usually eat in the evening, but the yogurt's warm." During an observation of the evening meal on 7/30/14 at 6:20 PM a test tray which consisted of tater tots, tomato soup, and a grilled cheese sandwich was obtained from the buffet cart on the 3rd floor. The internal temperature of the tater tots was 72 degrees and were frozen in the center, the tomato soup was 108 degrees and was lukewarm	F364	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F364 9/29/14 Corrective Action: Resident #74 interviewed regarding specific satisfaction concerns associated with food temperature and palatability. Care plan updated as appropriate. Identification of Others: All interviewable residents will be interviewed for satisfaction concerns associated with food temperature and palatability. Specific concerns will be addressed and plans of care updated.	

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F 364	Continued From page 64 (temperatures recorded in Fahrenheit), and the grilled cheese sandwich was soggy.	F 364	Systems Change: Education will be provided by the SDC/Designee to Dietary and care staff regarding appropriate food temperatures for service, validation of food temperatures prior to service and appropriate storage/service interventions to assist in maintaining temperatures. Monitoring: The ED/Designee will monitor food temperatures prior to service and during meal service at random meals 3Xweek. The ED/Designee will conduct random interviews with interviewable residents weekly regarding food/dining satisfaction. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F368 Corrective Action:	
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to offer each resident a bedtime snack. The facility census was 108. The findings were: Confidential interview with residents on 7/29/14 at 10 AM revealed the facility failed to offer each resident a bedtime snack. Each resident confirmed they could ask for a snack and would receive one, but said they were not routinely offered a snack at bedtime. During an interview on 7/30/14 at 2:45 PM, the DON confirmed there was no documentation showing all the residents			

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F 368	Continued From page 65 were offered a bedtime snack. Interview on 7/31/14 at 5:10 PM with CNA #3 revealed staff offered snacks to some of the residents but not all of them. She further verified the resident's acceptance or refusal of a snack was not documented.	F 368	No residents were specified. HS (Hour of Sleep) snacks addressed and offered to all center residents. Identification of Others: All center residents have the potential to be affected. Interviewable residents will be interviewed to determine satisfaction related to provision of HS snacks System Change: Education will be provided by the SDC/Designee to care staff related to offering HS snacks to all residents. Monitoring: The ED/Designee will interview random residents 3XWeek regarding satisfaction related to offering of HS snacks by staff. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	9/29/14
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in 1 of 5 food preparation/storage areas (the main kitchen). The findings were: Observation on 7/28/14 at 8:40 AM showed the following areas/equipment which required more frequent cleaning: a. The ceiling of the walk-in refrigerator had a buildup of blackish spots near the condenser fan. b. The ceiling vents and the ceiling tiles throughout the kitchen including over the food preparation tables and clean dish storage areas were soiled with grease, dust, and splattered foods/liquids. c. The wall and floor behind the oven and			

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F 371	Continued From page 66 range unit were noted to be heavily soiled with food debris and grease. d. The hood vents above the griddle had areas of solidified whitish grease build up. There was also grease visible on the pipes for the fire suppression system near these hood vents. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." Interview with the dietary manager on 7/28/14 at 3:50 PM verified the maintenance department was responsible for some of the cleaning, and they had been short staff for about 2 months. In addition, he stated the dietary department had also been short, and recently filled vacant positions which would allow them to now catch up on these cleaning items.	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F371 9/27/14 Corrective Action: No residents were specified. Ceiling of the walk-in refrigerator has been cleaned. The ceiling vents in the kitchen have been cleaned. The ceiling tiles in the kitchen have been cleaned and vendor contacted for repainting of the ceiling. The wall and floor behind the range unit have been cleaned and debris removed. The hood vents above the griddle has been cleaned. Identification of Others: Weekly environmental rounds completed in the kitchen area to identify areas of concern. System Change: Education will be provided by the ED/Designee to dietary staff related to kitchen sanitation and cleaning schedules.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			

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F 425	Continued From page 67 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure medications were available in a timely manner for 2 of 33 sample residents (#33, #58). The findings were: 1. Review of the medical record showed resident #58 was noted to have a red raised rash on the left side of his/her upper back on 7/1/14. The physician ordered Valtrex 1 mg three times per day for five days on 7/1/14 for a diagnosis of possible shingles. According to Taber's Cyclopedic Medical Dictionary, 20th Edition, 2005, page 990, Shingles is the reactivation of the varicella virus years after the initial infection with chickenpox. Pain often develops and persists for months after resolution of the rash. "This discomfort, which may be severe in patients older than 50, is known as postherpetic neuralgia...and may intensify at night or worsen when clothes rub against the skin." Further, medications such as Valtrex "...are effective in reducing viral shedding and nerve pain damage if administered within 3 days of onset of the rash." However, review of the July 2014 MAR for this resident showed s/he did not receive the first dose until the end of the day on 7/3/14, day three after the onset of the rash, because it was "not available from pharmacy." Review of the July 2014 MAR	F 371	Monitoring: The ED/Designee will conduct random tours of the kitchen 3XWeek regarding sanitation. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F425 Corrective Action: Pain assessment was complete for resident #33 and care plan updated. Psychosocial assessment was complete for resident #58. MD was notified of results. Care plan updated to reflect current status.	9/24/14

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F 425	Continued From page 68 showed the resident's pain was rated as 6 on a scale of 0 to 10 with 10 being the worst (6/10) on the 6 AM to 2 PM shift of 7/3/14; prior to the medication being started and 3 days within the onset of the rash. On the 6 AM to 2 PM shift on 7/4/14 the resident's pain was noted to be 6/10. Review of the 6/7/14 quarterly MDS assessment showed the resident had pain on 1 to 2 days during the 7 day look back period of assessment. Further review of the July 2014 MAR showed the resident only exhibited pain 4 other times during the month which was level 2/10. Interview with the DON on 8/1/14 at 12:30 PM revealed the facility should have been able to obtain a back up supply from another pharmacy and was unsure why that did not happen. 2. Review of the 7/25/13 the nurse's note dated 6/21/14 and timed 9:33 AM showed resident #33 had hallucinations and started "to scream out in fear." The nurse notified the physician on call and received an order for Ativan to be given as needed. Review of the June 2014 MAR showed Ativan 0.5 mg was to be given every 6 hours as needed for "anxiousness." On 6/29/14, the medication dose for Ativan was circled on the MAR. Review of the nurse's medication notes showed the medication was not given due to its unavailability. Review of the nurse's note dated 6/29/14 timed at 12:36 PM revealed the resident was crying out with "visual hallucinations and trembling."	F 425	Identification of Others: Baseline audit of medication availability per physician orders was complete. Medications obtained as needed. System Change: Education was provided to nursing staff regarding ordering and obtaining medication. Procedures were reviewed from the pharmacy. Monitoring: DNS/designee will perform audits based on new orders to verify medication available 3XWeekly. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly and as needed for review by the IDT until a lesser frequency is deemed appropriate.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 69 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility policy for hand hygiene, the facility failed to ensure staff followed acceptable infection	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F441 9/27/14 Corrective Action: Education and skills validation regarding hand hygiene provided, surface sanitation when providing meals and care of urinals to C.N.A. #4, C.N.A. #10, and Nurse #1. Identification of Others: All residents have the potential to be affected. System Change: Education provided by the SDC/Designee for Licensed Nurses and Certified Nursing Assistants for hand hygiene, Standard Precautions including surface sanitation when providing meals and care of urinals.	

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KINDRED TRANSITIONAL CARE AND REHABILITATION-CHEYE	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 70 control practices during 9 random observations. The findings were: 1. Observation on 7/29/14 at 4:40 PM revealed CNA #4 uncovered the plastic on the dessert and beverage cart for the Expressions unit. Continued observation showed the plastic cover was dragged along the floor in the dining room. After providing a beverage to one resident, the CNA placed the plastic cover back onto the food cart. In the process, the portion of the plastic container that was drug across the floor touched a piece of cake which was later served to a resident. Interview with the Infection control coordinator on 8/1/14 at 11 AM verified the plastic cover should not have been placed back onto the food cart after it touched the floor. She said a new cover should have been obtained and utilized. 2. Observation on 7/29/14 at 12:00 showed CNA #10 walked resident #81 to the bathroom. The resident was assisted to the toilet and urinated on the floor. The CNA took a towel located on the towel bar and proceeded to wipe the urine with the towel pushing it along the floor with her foot. The CNA then picked up the urine saturated towel with her gloved hand and disposed of it. However, she did not clean the bottom of her wet shoes before leaving the resident's room. In addition the floor was not cleaned by housekeeping. 3. Observation on 7/28/14 at 4:50 PM showed nurse #1 coughed into her left hand and did not wash or sanitize her hands. She proceeded to carry the glucometer (machine used for blood sugar testing) into resident #68 room, donned gloves, and tested the resident's BS (Blood sugar). The nurse removed her gloves, but did not perform hand hygiene before donning gloves	F 441	Monitoring: The SDC/Designee will monitor random staff for hand hygiene during provision of care 3 X week. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

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F 441	Continued From page 71 again to clean the glucometer. 4. Observation on 7/28/14 at 5:05 PM showed nurse #1 did not perform hand hygiene before donning gloves to administer insulin to resident #14. The nurse did not perform hand hygiene after removing gloves. 5. Observation on 7/28/14 at 6:10 PM showed dietary aide #1 wrapped the cord of the food service cart with a gloved hand, and proceeded to serve a resident's food with the same gloved hand. 6. Observation on 7/30/14 at 1:45 PM showed CNA #1 donned gloves, removed the wet incontinence brief for resident #6, performed pericare, replaced the incontinence brief with a new one, did not remove her gloves, placed the resident's blanket over the lower half of the resident's body, removed her gloves, and removed the garbage bag from the container. The CNA then repositioned the resident in bed without having washed or sanitizing her hands after performing the previous tasks. Interview of the CNA following this observation verified she should have removed her gloves and performed hand hygiene before touching the resident. 7. Observation on 7/28/14 at 10 AM showed resident #73 had a full urinal on the over-the-bed table next to the water jug. Another observation on 7/30/14 at 5:30 PM showed the resident again had a urinal on the over-the-bed table. During this observation an unidentified CNA removed the urinal but did not clean the table before placing the resident's food tray down. 8. Interview with resident #74 and his/her POA on	F 441		

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F 441	Continued From page 72 7/28/14 at 2:50 PM revealed they had concerns about staff not being able to clean the wall around the sink in the resident's bathroom. Observation at that time revealed an area surrounding the sink that measured approximately 5 inches by12 inches where the wall paper was torn away and plaster was exposed, creating a non-cleanable surface. The resident and POA stated the wall had been that way for, "about 2 months." 9. Observation on 7/29/14 at 5 PM revealed CNA #11 was bare handed and carrying a bag of soiled linen in her left hand and 2 water pitchers in her right hand down the 300 hall. The CNA proceeded down the hall and entered the soiled utility room, discharded the soiled linen into a bin while continuing to hold the 2 water pitchers in her right hand. The CNA then entered the nourishment room, filled the water pitchers with ice and water, and returned them to the residents. 10. Interview on 8/1/14 at 11 AM with the staff development coordinator/infection control coordinator confirmed the expectation was to perform hand hygiene between resident contact, after coughing, and before and after removing gloves. She also verified the examples noted in this document staff did observe and use proper infection control practices. Review of the policy titled Hand Hygiene/Handwashing revealed " Hand hygiene is to be performed: Before donning gloves for working with food; After touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; After coughing, sneezing, or blowing the nose; Intermittently after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments."	F 441		
F 468	483.70(h)(3) CORRIDORS HAVE FIRMLY	F 468		

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F 468 SS=D	Continued From page 73 SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to equip corridors with firmly secured handrails on each side for 2 of 3 floors (second floor and third floor) in the facility. The findings were: Observation of the facility on 7/30/14 beginning at 6:05 PM revealed the following: 1. Handrails were missing on the second floor between the "Unit Manager" and the "Trash Biohazard Bin." 2. Handrails next to room 229 was very loose. 3. Handrails were missing on the third floor between "Office" and "Trash Biohazard Bin." 4. Handrails were missing on the third floor between "Clean Linen Room" and "Clean Utility" rooms. 5. The handrail on "Elk Mountain Hall" next to "Soiled Linen" was very loose, and came off the wall when pulled on. Tour and interview with the maintenance director on 8/1/14 beginning at 10:15 AM confirmed the missing and loose handrails. The maintenance director further stated that he was new to the job and only beginning to assess the facility's maintenance needs.	F 468	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F468 Corrective Action: No residents were specified. All handrails identified in 2567 repaired or replaced as need. Identification of Others: Baseline audit of handrails completed System Change: Education provided to Maintenance Director on maintenance schedule of handrails and PM practices. Monitoring: The Maintenance Director and EVS Director/Designee will conduct random Environmental rounds associated with resident rooms, hallway and common areas. Auditing of resident rooms, hallways and common areas will be completed by the ED/Designee 3X Weekly. Identified trends will be reported to the Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	9/24/14
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED			

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F 513	Continued From page 74 The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a diagnostic procedure report was included in the resident's clinical record for 1 of 2 sample residents (#89). The findings were: Review of the medical record for resident #89 on 7/30/14 at 9:45 AM showed an order for a CT (Computed Tomography) scan (an imaging method that uses X-rays to create pictures of cross-sections of the body) dated 7/16/14. The results of the CT were not located in the medical record, and there was no documentation that showed the results had been communicated to the physician. Interview with the DON at that time confirmed the results were not in the chart.	F 513	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F513 Corrective Action: CT scan results were obtained for resident #89 and placed in chart. Identification of Others: Baseline audit was performed of orders in last 30 days for diagnostic reports and results present in chart. Results were obtained and placed in chart as needed. Systemic Change: Education was provided to nursing staff regarding obtaining results, placing in chart, and physician notification.	9/24/14
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any			

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F 514	Continued From page 75 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure medical record notations were accurate and complete in regard to medication administration for 4 of 33 sample residents (#24, #42, #60, #107). The findings were: 1. Review of the behavioral monitoring flow sheets for resident #42 revealed there were 2 monitoring flow sheets each month, one for negative statements and another for severe anxiety. Copies of two months worth of flow sheets were provided by the facility, however, there were no dates on any of the flow sheets. Interview with the DON on 8/1/14 at 12:30 PM revealed her expectation was all medical record documents would be dated and inaccuracies should not have occurred. 2. Review of the physician order recapitulation for the month of July, 2014 showed resident #60 had orders for Zoloft (an anti-depressant) and Ativan (an anti-anxiety medication). Review of behavior monitoring documentation for the resident showed the resident was being monitored for crying, calling out, and restlessness in relation to these medications. The following concerns were identified: a. Review of behavior monitoring documentation for the month of June 2014 showed the resident had experience no episodes of crying in the month, and a single episode of	F 513	Monitoring: DNS/designee will perform an audit for diagnostic results present in chart 3XWeekly. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly and as needed for review by the IDT until a lesser frequency is deemed appropriate. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 9/27/14 F514 Corrective Action: Resident # 24, #42, #60 and #107 reassessed for psychoactive medication use, regimen reviewed by physician, rationale for use specified, and behavior monitoring sheets clarified.	

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F 514	Continued From page 76 calling out or restlessness on 6/13/14. However, review of the pain monitoring flowsheet for the month of June 2014 showed the resident was treated with pain medication on 6/1, 6/2, and 6/7 for "crying," and was treated with pain medication on 6/1, 6/14, and 6/27 for restlessness and/or calling out. b. Interview with the DON on 8/1/14 at 11:55 AM confirmed the facility expectation that behavior monitoring will be appropriately documented. 3. Review of the medical record showed resident #107 was admitted to the facility 2/26/08 with diagnoses including multiple sclerosis, non-Alzheimer's dementia, and depression. Review of the quarterly MDS assessment dated 4/20/14 showed the resident was moderately cognitively impaired and had signs and symptoms of depression. Review of the care plan updated 5/18/14 identified the resident as using an antidepressant, antianxiety medication, and psychotropic medications related to neuropathic pain management. Interventions included staff monitoring and recording behaviors, and reporting increased behaviors to the physician. Review of the MAR 4/1/14 through 7/30/14 showed 7 behavior monitoring sheets for monitoring signs and symptoms associated with anxiety, depression, and antipsychotic drug side effects, however, there was only 1 sheet that was dated for 4/2014. On the 4/2014 it was indicated staff were supposed to monitor for behaviors associated with anxiety 3 times daily, there were 93 blank spaces where behaviors were assessed. Interview with LPN #3 on 7/30/14 at 4:30 PM confirmed the behavior sheets were not dated but should have been. Review of mental health psychotherapy progress notes dated 6/5/14,	F 514	Identification of Others: An audit of residents with psychoactive medication will be completed to validate documented rationale for use, accurate behavior monitoring and care plan. System Change: Education will be provided by the SDC/Designee to nursing and social services personnel related to psychoactive medication use and behavior monitoring. Monitoring: The DNS/Designee will monitor behavior monitoring flow sheet records for accuracy weekly. Social Services/Designee will review psychoactive drug regimen for appropriate rationale for use and accurate behavior monitors, monthly for those scheduled for assessment according to the RAI schedule. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	

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F 514	Continued From page 77 6/7/14, 7/7/14, 7/14/14, 7/28/14 and 7/29/14 listed presenting behaviors/symptoms of depression, irritability, anxiety, despair, and withdrawal. Additional review of the medical record showed the following mental health psychotherapy progress notes; 5/5/14 the resident was, "yelling at staff, "you always forget me" the therapist intervened". 6/7/14 the resident, "was quite depressed and said I don't like anything about myself". 7/7/14 the resident reported, "[resident's name] reported increased depression and said I'm bored everyday I'm here they are all the same", 7/28/14 the resident reported, "I'm 47 and I hate it here; no one helps me". 4. Review of the medical record showed resident #24 was admitted to the facility 1/11/13 with diagnoses including non-Alzheimer dementia, Huntington's disease, and arthritis. Review of the annual MDS assessment dated 7/1/14 identified the resident as having signs and symptoms of depression and no behaviors were recorded. Review of the CAA dated 7/23/14 showed the resident triggered for antipsychotic, antianxiety, and antidepressant medications and should have a care plan developed. Review of the care plan updated 7/5/13 revealed the resident had the potential to demonstrate physical behaviors, and mood problems related to actual depression. Interventions included developing a behavior monitor to track the resident's behaviors. Review of MARs dated 4/1/14 through 7/30/14 undated behavior tracking sheets for Celexa (antidepressant med), Ativan (antianxiety med), Seroquel (behaviors associated with dementia). The sheets were not dated with a month or year and included zeroes for every entry, indicating the resident had not experienced any behaviors or signs and symptoms of depression. However,	F 514		

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F 514	Continued From page 78 review of mental health psychotherapy progress notes dated 5/15/14 and 7/28/14 the resident presented with behavior symptoms of depression, irritability, and anxiety.		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and family interview, and review of medical record, the facility failed to ensure the performance	F 520	F520 Corrective Action: No residents specifically identified. Year in review of the QA/PI process and follow-up and identification of trends. Identification of Others: All resident potential to be effected. Systemic Change: Education was provided to Management staff regarding QA/PI procedures, goals and expectations, District Team Designee. Monitoring: Monthly QA/PI minutes will be submitted for review to the District Team Designee; monthly and as needed until a lesser frequency is deemed appropriate.	9/24/14

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F 520	Continued From page 79 Improvement (PI) program was effective in maintaining and sustaining improvement in repeating deficient practices identified and cited over the past four surveys. The findings were: Three examples where the care plan was not updated to reflect the current resident status during the 2014 survey is detailed in Federal citation F280. Deficient practice in regard to not updating care plans was also written in 2010, 2011, and 2013. Failing to follow professional standards of care was cited as deficient practice in 2012, 2013, and again in 2014 (refer to Federal citation F281). Refer to Federal citation F282 for evidence facility staff did not follow the care plan for residents during four surveys, 2010, 2012, 2013 and 2014. Federal citation F309 describes how staff did not provide the necessary care and services for residents in 2011, 1012, 2013, and again in 2014. Federal citation F312, toileting, grooming, and care/assistance with activities of daily living, was cited as a deficiency in 2010, 2011, 2012, and 2013. This personal care tag will again be cited in 2014. Federal tag F323 regarding providing supervision to prevent accidents was cited in 2011, 2012, and 2013. This citation will again be cited during this current survey and was the focus of an immediate jeopardy called during the 2014 survey. Federal tag F328 regarding the utilization of oxygen therapy was cited in 2012,2013 and will be cited in 2014. A citation regarding clean and sanitary conditions in the kitchen was cited in 2010, 2013, and will cited in 2014. Federal citation F329 regarding unnecessary medications will be cited in 2014 and was also cited in 2010 and 2012. Finally, F253 in regard to housekeeping and maintenance was cited in 2010, 2011, and 2013. F253 will again be cited during the current survey.	F 520		

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F 620	Continued From page 80 Interview with the administrator and DON on 8/1/14 at 3 PM revealed these were areas being monitored in PI. However, each of these areas continued to be cited as areas of deficient practice during the most current survey.	F 620		

8/28/14